

The Canadian Journal of Medicine and Surgery

A JOURNAL PUBLISHED MONTHLY IN THE INTEREST OF
MEDICINE AND SURGERY

VOL. XII. TORONTO, SEPTEMBER, 1902. NO. 3.

Original Contributions.

OPERATIVE TREATMENT OF ASCITES DUE TO CIRRHOSIS OF LIVER, BY IMPLANTATION OF THE OMENTUM INTO THE ABDOMINAL WALL.*

BY GEORGE A. PETERS, M.B., F.R.C.S.(ENG.),

Associate Professor of Surgery and Clinical Surgery, University of Toronto, Toronto.

THE treatment of ascites due to cirrhosis of the liver by surgical measures constitutes one of the most recent instances in which the surgeon seems to have invaded the domain of the physician. The operation as now performed is based upon observations which were made originally by Talma of Utrecht, and were subsequently acted upon first in Holland in 1889 by Van der Meule, by Schelkly in 1891, and by Lens in 1892. None of these cases, however, lent much encouragement to the idea, as they all died uncured of the ascites. In 1894 Drummond and Morison claim to have independently conceived of the same idea as that which was described by Talma, and operated upon two cases, in one of which a brilliant result was achieved. Since the publication of the paper by Drummond and Morison in the *British Medical Journal* of September 19th, 1896, numerous operators in Great Britain, on the Continent, in America, and in Canada, have practised the operation with widely varying results, but on the whole with such a degree of success as to encourage further efforts. In a very able and comprehensive paper published in the *American Journal of the Medical Sciences* for March, 1901, Packard and Le Conte have collected and collated twenty-two cases, and numerous cases are scattered throughout medical literature subsequent to that date.

* Read before the Ontario Medical Association, June, 1902.

After a full analysis of the results of all the operations, having regard to errors of diagnosis, imperfections of technique, avoidable disasters, and complications which occurred in various cases, these writers summarize their conclusions very succinctly in these words: "Contrasting the worst view with the very best possible construction we can place on this table, we have the operative mortality lying somewhere between 23 per cent. and 7 per cent.; and the recoveries between 41 per cent. and 64 per cent.

Having regard to the well-known hopelessness of the treatment of cirrhosis of the liver by medicinal means, and taking into view the observations of Hale White, that the average length of life in cases of ascites sufficiently marked to call for tapping is only 63 days, it is surely not too much to claim that these statistics afford ground for encouragement in the practice of this operation.

One may perhaps with advantage review very briefly the phenomena upon which the operation of establishing a communication between the veins of the portal circulation and those of the abdominal parietes is based. (Fig. 1.) It is very well known that not by any means all cases of cirrhosis are accompanied by ascites. Lange found among 56 cases of cirrhosis of the liver of varying degree, that ascites was present only in 34 per cent., and the explanation of its absence in the remaining 65 per cent. appears to be found in the fact that in these fortunate and favorable cases there occurs an adequate collateral circulation between the venules of the portal circulation and those of the abdominal parietes, thus affording by nature's own efforts such a relief to the blood pressure in the portal veins, that transudation in excess of what can be absorbed by the lymph channels of the peritoneum does not take place. This collateral circulation consists, in the majority of cases, not in a new development of vessels through the formation of adhesions, but in a dilatation and amplification of the normal communications which were described by Sappey as existing between the portal and systemic veins, namely, through the esophageal plexus, and round ligament of the liver, the hepatic ligaments, and the communications of the inferior mesenteric vein with the iliac veins. Talma has reported a case in which a vein in the round ligament connecting the left branch of the portal with the epigastric in the abdominal wall, was as large as the finger, and in my second case I found two veins each as large as a lead pencil running towards the heart in the base of the suspensory ligament, thus pointing to nature's attempts to relieve the portal circulation by opening sluices in this situation.

The initiation of nature's method of preventing the occurrence of ascites by the creation of an efficient collateral circulation through these channels is of course not within the compass of the surgeon. But Talma, and later, Drummond, observed in the study of a series of cases of hepatic cirrhosis *without ascites*, that there

were numerous vascular adhesions between the parietes of the abdomen and the viscera—notably the liver, spleen, and more especially the omentum. To the communication between the portal and systemic circulations thus established it seemed fair to ascribe the absence of ascites, and it is the *imitation* of this condition that the surgeon attempts by the operative procedures which

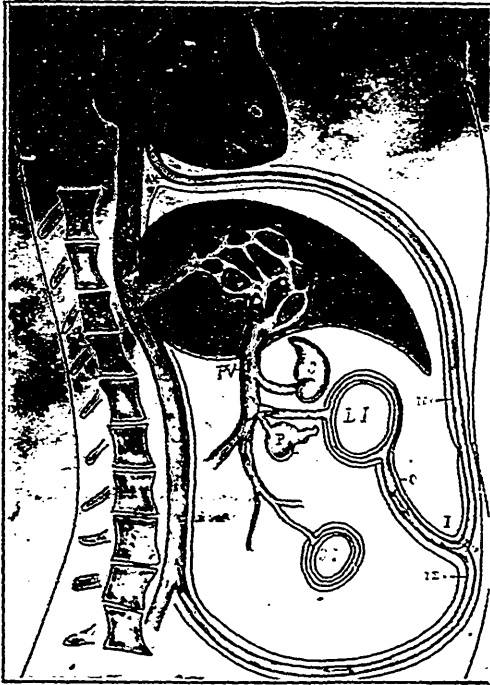


FIG. 1.

Diagrammatic scheme to show the collateral circulation the operation seeks to establish. The arrows show the direction of the current. The viscera drained by the portal vein are sufficiently indicated by the letters on the diagram. *I*, the point of implantation of the omentum into the abdominal wall. (This should have been shown above the umbilicus.) The veins from the omentum (*O*) empty (1) into the intercostal veins (*I.C.V.*), which reach the superior vena cava through the azygos veins (*A.Z.V.*), and (2) into the deep epigastric and lumbar veins (*D.E.V.*), which empty into the inferior vena cava through the lumbar, ilio-lumbar, and common iliac veins, thus avoiding the obstructed passage through the liver.

have been practised. It will of course be observed that such operations are based solely upon the theory that the occurrence of ascites in cirrhosis is due to a purely mechanical cause, viz., the obstruction offered by the diseased liver to the flow through the portal vein. This theory appears to be extremely well founded, and is, I believe, universally accepted to the pointed exclusion

of the toxic theory, which has in the past been greatly favored by some authorities.

CASE 1.—The patient, Mr. J. McG., a man aged 46 years, who furnishes the subject for this paper, was referred to me by Dr. Bowles, of Woodhill, in early part of July, 1901. At time of his admission to General Hospital the following history was obtained. He was a carpenter by trade in the early years of his life, but during the last five years he has been a hotelkeeper. There is some tuberculosis in the family history, but the patient himself has never suffered any severe illness until the present attack came on, and is certainly free at present from tuberculosis in the peritoneum as well as elsewhere. He is a man of splendid physique, about six feet in height and weighing, in health, about 190 pounds. He has always been a moderate drinker principally of malt liquors, but otherwise his habits and manner of life are good. There is no history of syphilis. The ascites first began to be apparent in February, 1901, after a mild attack of la grippe. The fluid in the abdomen increased with great rapidity, and the increase was accompanied by distressing symptoms of shortness of breath, palpitation, and a great sense of weight and fulness in abdomen. The girth of abdomen on June 5th, 1901, was 64 inches (Fig. 2), and on that date Dr. Bowles removed by tapping three patent pails full (estimated at 1,100 ounces). This was followed by great temporary relief, but the fluid reaccumulated so rapidly that on June 24th (18 days later) Dr. Bowles repeated the tapping, removing on that occasion 50 pints (1,000 oz). He was admitted to the General Hospital under my care on July 16th, 1901, with such marked distention that 35 pints (700 oz.) were withdrawn at once. The withdrawal of this amount gave relief, but did not clearly empty the abdomen. The legs were markedly edematous, and pitted deeply on pressure. There was no albumen in the urine. The venules of the conjunctivæ, face, and trunk were deeply congested and blue, giving the man the dusky, mottled appearance of one in the deep stage of ether anesthesia. The pulse was very weak, and the heart's action greatly labored. There was marked shortness of breath, but no edema of the lungs. The abdomen presented a full, tense, rounded appearance, covered with stretched, shiny skin, and appeared to be on the point of bursting. The umbilicus protruded more than an inch, and was so thin that one could readily detect the translucency of the fluid within it. On percussion it was found that the liver was larger than normal, a condition which was verified at the time of operation. As free purgation and the exhibition of diuretics seemed to have no effect whatever upon the reaccumulation of fluid, the operation about to be described was advised, though the prognosis given to the patient was extremely guarded, both as to immediate and ultimate results.

The Operation.—An incision four or five inches long

(Fig. 3, A) is made in the median line above the umbilicus, care being taken to keep a trifle to the left, so as not to injure any of the vessels in the base of the suspensory ligament of the liver (Fig. 3, S. Lig.). This incision permits of a thorough exploration of the surfaces of the liver, spleen and other viscera, and also renders it certain that the omentum will be easily within reach, even though it should prove to be matted together and rolled up, as sometimes occurs, particularly if chronic peritonitis is present. Although most operators advocate local anesthesia, in my opinion the operation should be done under general narcosis, chloroform being used by preference. After the skin incision is made, the anesthetic need not be pushed to the full surgical extent. The operative incision, in my experience, amply serves to empty the fluid from the abdominal cavity, for which purpose the patient may be rolled to the side, if found desirable. This obviates the necessity for an additional incision above the pubes for drainage purposes, as is advocated by some writers, and lessens the danger of sepsis and of subsequent ventral hernia. It does not seem to me that it is necessary, or even advisable, to completely evacuate the fluid from the cavity at the time of operation. When one remembers the enormous amount of fluid which may be present, as in the case reported, one must recognize that its total removal must at the same time remove a very potent extra-vascular support to the thin-walled abdominal veins, and thus there might occur sub-peritoneal hemorrhages, or perhaps syncope, from accumulation of the blood in these vessels, since the abdominal walls from prolonged and excessive distention have largely lost their resiliency. In the case now reported, and in the majority of recorded cases, aspiration had to be practised repeatedly after operation before the newly-formed vessels offered any appreciable relief to the obstructed portal circulation, and I consider this method of getting rid of the fluid distinctly better and safer than continuous drainage.

After evacuation of the fluid through the wound, it will be found that the abdominal walls are so lax, that by everting the edge of the wound, and at the same time making pressure upon the lateral portion of the epigastric region, the parietal layer of peritoneum is made easily accessible for a considerable distance around the abdominal incision. The operation of engrafting the omentum into the anterior abdominal wall (*epiploexy*) was in this case then carried out as follows. (Talma made a pocket in the abdominal wall for the lower end of the spleen in one case, and other operators have stitched the omentum between the detached peritoneum and the remainder of the abdominal parietes, but I have not been able to find their exact methods. At all events, I submit the method below described as an easy and efficient one.)

Avoiding the suspensory ligament of the liver, a longitudinal

incision about 1 1-2 inches in length is made through the parietal peritoneum and sub-peritoneal tissue as far laterally as can conveniently be reached. With the handle of the scalpel, or a pair of blunt-pointed scissors, a flap consisting of peritoneum and sub-peritoneal areolar tissue, is raised, and the peritoneum again cut through in a longitudinal direction at a point about 1 1-2 inches from the first incision. Thus is raised a flap or strap of peritoneum attached at both ends (Fig. 3, B1, B2). A pair of long-handled forceps is made to pass under this strap and seize a portion of the omentum, taking care to select a part in which there are veins of considerable size. This is now gently drawn through under the strap and held in position by a single catgut suture (Fig. 3, B1, B2). This process is again repeated at a point somewhat nearer the margin of the wound on the right side, and again in two or



FIG. 2.

Showing great distention of abdomen before operation. Girth, 64 inches. Note also the edema of the feet and legs.

three places on the left side. Thus the omentum may be easily and rapidly implanted into the abdominal parietes in four or five places. In addition to these grafts, however, another very large graft should be made into the suspensory ligament of the liver (Fig. 3, D). This may be very easily done by incising the ligament in a longitudinal direction, and drawing a large portion of the flocculent omentum—not necessarily its terminal portion—through this slit, and stitching it in place by one or two catgut sutures. In view of the fact that Talma found a vein as large as the finger in the free border of this ligament, and from my own experience, in my second case cited, I regard this as a very likely route for relieving the portal circulation.

The abdominal wound is then closed without drainage.

Post-Operative History.—The patient stood the operation wonderfully well, and recovered from its immediate effects very

promptly. In fact, the complete evacuation of the fluid relieved his circulation so completely that the benefit seemed to far outweigh the shock of the operation. The wound healed perfectly by first intention, and the patient was permitted to sit up in the third week. The fluid, however, rapidly re-accumulated, and tapping was required again before the patient left the hospital on the 26th day after operation. On his return home Dr. Bowles found it necessary to repeat the tapping at intervals, and the skin at the umbilicus gave way, so that constant leakage occurred from that point for about two weeks, but the sinus ultimately healed soundly. The actual dates of tapping after operation are August 27th, 32 pints; Sept. 10th, 24 pints; Sept. 29th, 20 pints. In October the patient began to improve, but fluid, in progressively decreasing quantities, was withdrawn on October 8th and 22nd, Nov. 2nd and 13th. Since the latter date the fluid has ceased to accumulate. At present (eleven months after operation) there is a small amount of fluid in the peritoneal cavity, but there is no edema of the legs, no shortness of breath, but little obstruction to the heart's circulation, and the patient enjoys a good measure of health, and is able to pursue his occupation with comfort. He is still a corpulent man, the circumference of the abdomen at present being 43 inches. The flesh is firm and free from edema, and altogether he presents the appearance of a man in fair health. The liver still maintains its condition of hypertrophic cirrhosis.

(Because it has a bearing in certain important points upon the subject under discussion, I wish to interpolate here a brief preliminary note of a second case upon which I have operated since reading the above paper before the Ontario Medical Association. This case was referred to me by Dr. H. H. Moorehouse, who assisted at the operation.)

CASE 2.—The patient, Mr. Q., is a man of good physique, aged fifty-four. He has always been a moderate drinker of malt and ardent spirits, but enjoyed good health until about June, 1901, when he began to complain of aching pains in the back. No ascites, however, was observed until October, 1901. At that time he noticed that the fluid increased rapidly in quantity, and the abdomen became greatly distended. On June 17th, 1902, Dr. Moorehouse removed by tapping 1040 ounces of fluid; and on July 7th, two days before the operation, we repeated the tapping, removing 960 ounces. On July 9th, 1902, we operated on this patient precisely as described above in Case 1. On making the incision in the middle line above the umbilicus, two veins, each as large as a lead-pencil, were found to lie in the base of the suspensory ligament, slightly to the right of the linea alba. These we carefully protected from injury by causing the line of incision to deviate slightly to the left. The round ligament itself, in the free border of the suspensory ligament, was very greatly enlarged,

being as thick as one's thumb. It appeared from palpation to be full of veins, as it could be readily compressed; but the peritoneum over it was so thickened, that the size of its contained vessels could not be estimated. I have no doubt that these were the veins described by Talma as communicating with the left portal vein before its entrance into the liver; and I have no doubt also that the blood from these veins poured into those I have already described

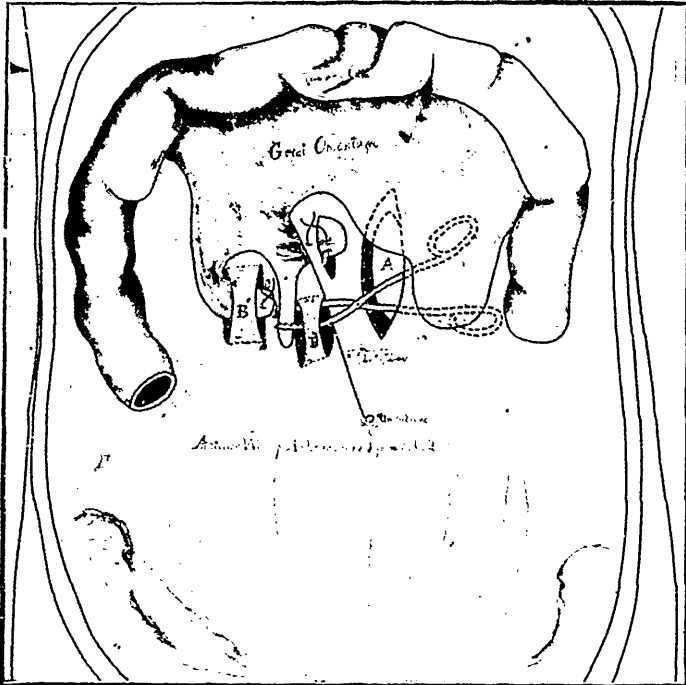


FIG. 3.

Diagram to indicate the method of implanting the omentum. The diagram represents the anterior wall of the abdomen, the transverse colon, suspensory ligament of the liver, and the omentum as seen from behind or within the abdomen. *A*, the incision in the anterior wall of the abdomen above the umbilicus. *B*¹, *B*², the straps of peritoneum raised to allow of portions of the omentum being drawn through. *C*, the implanted omentum stitched into position by a catgut suture. *D*, large graft into the suspensory ligament of the liver.

as running just under the linea alba, as the direction of the current in these latter veins was clearly upwards from the umbilicus towards the heart. In this case, also, I found the whole of the parietal peritoneum in a state of chronic inflammation. It presented a purplish congested color, and was very considerably thickened. A few flakes of lymph also were found upon its surface, but there was no indication whatever of tubercular disease. The

liver was somewhat enlarged, with rounded borders and slightly roughened surfaces, presenting, in fact, the appearance found in hypertrophic cirrhosis. The spleen also was very considerably enlarged, so much so, in fact, that after the second tapping, in which 960 ounces were removed, the notched shape of its anterior border could be seen plainly through the thin abdominal wall. The patient stood the operation very well indeed, and exhibited scarcely any signs of depression or shock. He has, moreover, no symptoms of the auto-intoxication leading to nervousness, delirium, etc., which have been described in other cases. It is now 21 days since the operation. The wound has healed throughout by first intention, but it is clear that ascitic fluid is again gradually accumulating, and doubtless he will require to be tapped repeatedly as in my first case before the benefits of the operation become established. I hope to make a further report on this case, as to the ultimate result obtained.

Remarks.—It will be observed that in my operations I did not irritate or scrub the surfaces of the liver or spleen, or the parietal peritoneum, to any extent whatever. I am aware that this is distinctly in want of conformity to the procedure originally advocated by Talma, and afterwards practised by Morison and almost all subsequent operators, and therefore the departure seems to demand reasons for its justification.

That the operation as described is efficient and adequate, is attested by the satisfactory condition of the patient (Case 1), whom I now present to the Association eleven months after the operation was performed. I may state that when I began the operation I had no definite plan differing from the methods advocated by the originators of the operation, but on opening the abdomen the liver presented itself as a very large organ with thick, rounded borders, and showed a degree of turgidity and congestion which led me to fear that even a slight irritation of its surfaces might lead to very extensive, if not dangerous, venous oozing. It seems to me also that an extensive scrubbing of this and adjacent surfaces in the sensitive and irritable splanchnic region must be productive of a very considerable degree of shock; and I felt that my patient's condition would not support such an assault. In fact, I submit that a moment's thought will substantiate the view that in the method of treatment above described there is really less traumatism inflicted, and consequently less shock produced, than in the scrubbing method, in which I consider that the shock is very much greater than would appear on a superficial view of the subject. Moreover, the large size of the veins in the omentum seemed to invite one's attention, and almost to suggest that if these were pocketed into the abdominal wall, communication with the systemic veins would speedily become established. Again, I would point out that the blood which first passes through the collateral circula-

tion thus established is that derived from the large intestine, which I surmise is much less charged with toxic substances than that which would be diverted from the venules on the surface of the congested liver. That this is not of trivial importance has been abundantly shown by the experiments of Hahn, Tilmann, Eck, and others. These authors have demonstrated that certain nervous phenomena, such as delirium and excitement, resulting apparently from a species of auto-intoxication, occur when the blood from the mesenteric areas, unmodified by being filtered through the liver, is suddenly allowed to enter the systemic circulation. These observations are further fortified by the clinical symptoms observed in Morison's third case, in Narath's case, in Le Conte's first case, and in several other reported cases. In my two cases, although both subjects were to some extent alcoholic, no such symptoms whatever were observed, and though this may be looked upon as a *post hoc* argument, the fact is stated for what it is worth. As to the outlook for this operation, one cannot but be encouraged by the results which have followed in many of the published cases. In the first case just narrated, also, the patient was certainly rapidly approaching a fatal issue. One might say that at the time of operation his span of life could be measured by weeks. He has now survived eleven months, and is in a very fair state of health. How long he may live is, of course, a problem, but his condition at present is one of progressive improvement. I am disposed to think that the cases in which the cirrhosis is of the hypertrophic type are the most favorable for operation, because in them the amount of liver tissue available for carrying on the hepatic functions is sufficient for the purposes of a healthy life when relieved from the embarrassment of circulation by the establishment of collateral venous channels.

102 College Street, Toronto.

CEREBRO-SPINAL MENINGITIS.

BY ALEXANDER MCPHEDRAN, M.B.,
Professor of Medicine, etc., University of Toronto.

DURING the past year cases of cerebro-spinal meningitis have been met with from time to time in Toronto. In February there was, what may be termed, a slight epidemic, there being seven cases in the Hospital for Sick Children at one time. Probably the first cases were two children, brother and sister, whom I had the opportunity of seeing with Dr. C. M. Foster, in April, 1901. They had just arrived from Winnipeg. They were very severe cases; the boy died in a few days and the nature of the disease was demonstrated by autopsy. The sister was sent to the Hospital for Sick Children. She was very ill for three weeks, the typical symptoms, as herpes, which was very extensive, retraction of the head, hyperæsthesia, emaciation, delirium, etc., being unusually marked. Although desperately ill she made a complete recovery and was discharged in June.

An occasional case was admitted during the summer and autumn. Late in the winter it assumed an epidemic character. I have notes of twelve cases, of whom six died and six recovered. Of the latter one boy was discharged apparently well, but a month afterwards became suddenly ill with pain in the head, and died two days later, no doubt due to a recurrence of the disease. The recoveries were all complete, none of them suffering from such permanent injuries as loss of hearing or sight. Often resulting from this disease.

The symptoms were characteristic in eleven of the cases; one was comatose when first seen and died in a few hours.

The onset of the disease was sudden in nine; doubtful in two; and in one a history could not be obtained.

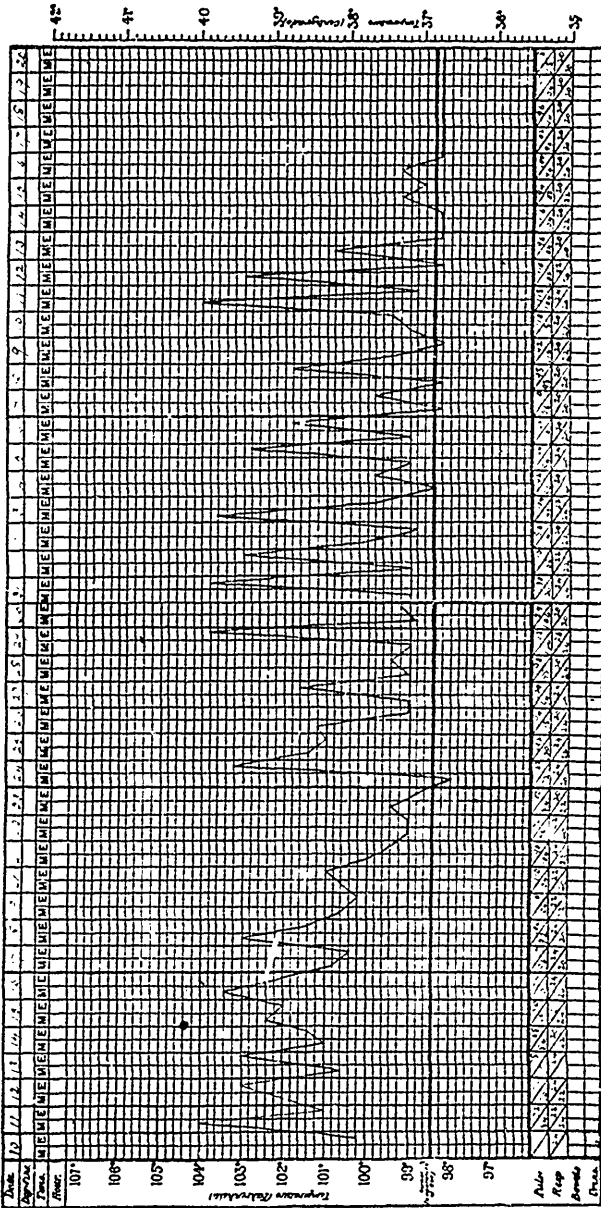
Headache was an early and severe symptom in all the cases.

Spasms of the muscles of the neck and back occurred in all, causing retraction of the head in seven, in three of which it was very marked.

General hyperæsthesia was marked in ten, affecting both skin and muscles. It was most easily demonstrated in the thigh, probably because the femur forms a good basis against which pressure can be easily made.

Rash was present in five cases. It was *petechial*, but small and scanty, and disappeared early.

Herpes facialis occurred in six, but was marked in three only. When present it is almost sufficient of itself to exclude tuberculous meningitis.



Under the care of
 Dr. Seaver

Name Bell
Beary

Age 7 1/2

Date of Admission August 12 1913

No. 100

Location Rehmann

(The record on this chart
 is from the 12 day of
August 1913 to the
26 day of December
 1913.

Pulse
 Resp
 Blood
 Urine

The *temperature* was very variable in all the cases, reaching 104 degs. F. in most of them. It was markedly remittent in some, as shown in the charts here presented.

Kernig's Sign was marked in nine cases; slightly developed in two; and in one it was not noted, as the child was comatose when first seen, and died shortly after, but it was doubtless present, as there was general tremor—an almost constant sign in bad cases.

Lumbar puncture was done in four cases. In three clear sterile fluid was obtained, but none in the fourth. In one of these three cases autopsy demonstrated the existence of cerebro-spinal meningitis.

Leucocytosis was present in two cases, there being over 20,000 leucocytes per c.mm. Unfortunately a blood examination was not made in the other cases.

Vomiting was not common, occurring in five cases, and troublesome in two only. In one it was very hysterical in character.

The *bowels* were usually constipated. The stools were very offensive in four cases, but diarrhea occurred in none.

The *spleen* was palpable in three cases; could not be felt in two; its condition was not noted in the others.

Convulsions occurred in none, but there were marked general tremors in three of the cases.

Photophobia was observed in all but the child that was comatose when first seen. The pupils were inactive in eight cases.

Active delirium occurred in one only; in eight stupor was marked.

Otitis Media occurred in one case. Streptococci were obtained from the discharge so that the case may have been one of septic meningitis, yet the course was too protracted for that disease.

A few of these cases merit more special notice. The following case, seen with Dr. Harley Smith, to whom I am indebted for the history, is very interesting, in view of the markedly remittent temperature.

CASE 1.—B.G., boy, aged 8; family history good: previous history normal; had scarlet fever two or three years ago; in excellent health up to Sunday, March 9th, 1902. After coming from church in morning complained of headache. Vomiting and delirium set in within a few hours. He was seen first on the afternoon of May 10th, when he was delirious. T. 100, P. 104, R. 24. There was present universal hyperæsthesia—no convulsions, no opisthotonos. There was muscular spasm in upper and lower extremities. There were also present about a dozen purpuric spots on the chest and abdomen, which disappeared in the course of ten days. The most troublesome symptoms during the first week were the vomiting, insomnia and pains in the head and

back of the neck. The pulse at first 104, became 72 on the second day and remained slow for three or four days, then became more frequent and remained so until convalescence. Morphia hypodermically gave him relief on the third day and again on the sixth day. A third hypodermic on the eighth day was ineffectual. After consultation with Dr. McPhedran, hot baths (T. 100, lasting ten minutes) took the place of the morphia and produced excellent results both in relief of pain and in procuring sleep.

During the third week the paroxysms of pain, accompanied by fever, vomiting and mild delirium, assumed an intermittent character, coming on every other day with more or less regularity. This peculiarity continued till convalescence. During the sixth week he became entirely free of paroxysms.



SHOWING KERNIG'S SIGN.

There have been no sequela. Intellect, vision and hearing are quite normal. Rapid action of the heart continued for two or three weeks, but gradually disappeared.

The notes of the two following cases are kindly furnished by Dr. J. W. Rowan, with whom I saw the second one.

CASE 2.—Mabel J., aged 3 1-2 years, had mild attack of mumps in latter part of February. She was well after with the exception of fairly severe conjunctivitis in the right eye. On the evening of March 10th she had pain in the head and complained of being chilly. Next morning she was seen by her mother at 4 o'clock, and again at 7 o'clock; she was then sleeping quietly. At 8.30 a.m. her elder sister, who slept with her, called her mother, who found her (Mabel) unconscious. On picking her up she noticed that her whole body was in a state of general tremor. There were no

convulsions, but the coma continued until her death at 2 o'clock the same day.

CASE 3.—Tommy I., aged 5, became sick on March 11th, the day of his sister's death. He complained of headache. He would put his hand to his head, saying, "Oh ! my head." Nose bled freely at night and he was delirious. There was nausea and some vomiting. Temperature 102 degs. F. The headache gradually lessened, temperature became lower, and in a week he was apparently well, though the temperature was slightly elevated. On March 21st and 22nd he was out playing all day and ate heartily. Early on morning of Sunday, March 23rd, commenced to cry, complaining of headache and nausea. When seen a little later by Dr. Rowan his temperature was 102.5 degs. F. He was very restless; muscular tremors were marked. On Monday, 24th, he lay with his eyes closed and head turned from the light. Though apparently in stupor he could be roused. There was spasm of the muscles of the neck and back, but no retraction; any movement caused much pain. The pupils were moderate in size and quite inactive. There was decided hyperæsthesia of the body generally. Kernig's sign was easily demonstrated as it was very marked.

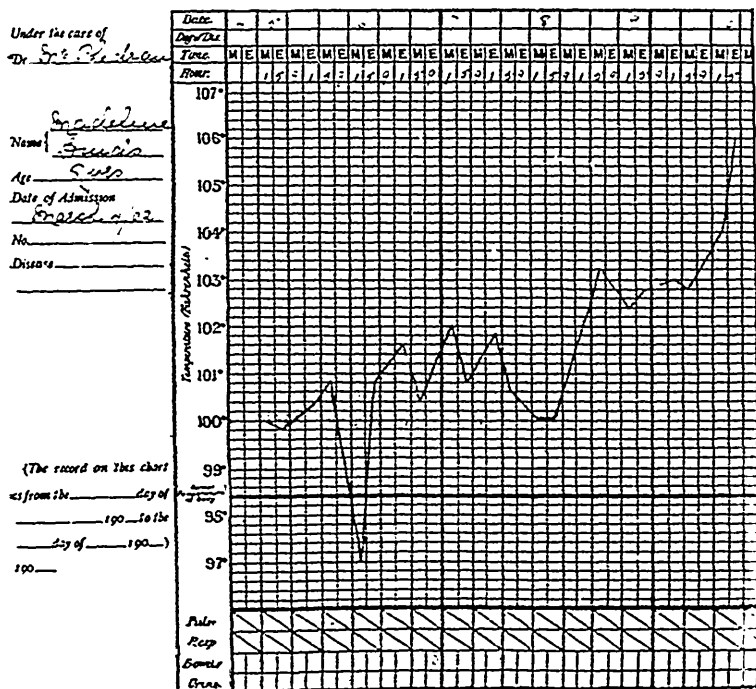
The temperature, which varied from 98 to 104 degs. F., became normal a week later. The pulse was generally about 100, but was irregular and had been up to 160 per minute. He improved rapidly and made a complete recovery.

In this case the symptoms were typical, and there is no doubt as to the diagnosis of cerebro-spinal meningitis. This confirms the diagnosis in the little sister's case. In her the muscular spasm and coma indicated disease of both brain and cord, and there can be no reasonable doubt as to the nature of the infection. It is the most rapidly fatal case that I have met with.

CASE 4.—The following case, an Italian boy, aged 4 1-2 years, had otitis media a year previously. The condition in the interval is uncertain. He became suddenly ill on March 15th, 1902, with severe headache and vomiting. He was admitted to the Hospital for Sick Children on March 18th. There was a good deal of stupor, much headache, general hyperæsthesia, much restlessness, marked rigidity of the muscles, especially of the neck and back, and Kernig's sign and great retraction, as shown in the accompanying photograph. The bowels were constipated, and when acted on the discharge was extremely offensive. On the 20th, two days after admission, the right ear discharged offensive pus, due to streptococcic infection. Lumbar puncture was done in the 3rd and in the 5th lumbar interspaces, but no fluid was obtained. The temperature was irregular, reaching 105.4 degs. F. two hours before death. There was considerable delirium but no convulsions. Warm baths (100 degs. F.) for ten minutes were always followed by an hour's relief and usually by sleep. Large doses of morphine subcutaneously did not affect

the pain. He died on the 23rd, the ninth day of his illness. The occurrence of this case when there were so many others, and the early incidence of the spinal symptoms indicate that it was one of cerebro-spinal fever, notwithstanding that there was a streptococccic discharge from the ear.

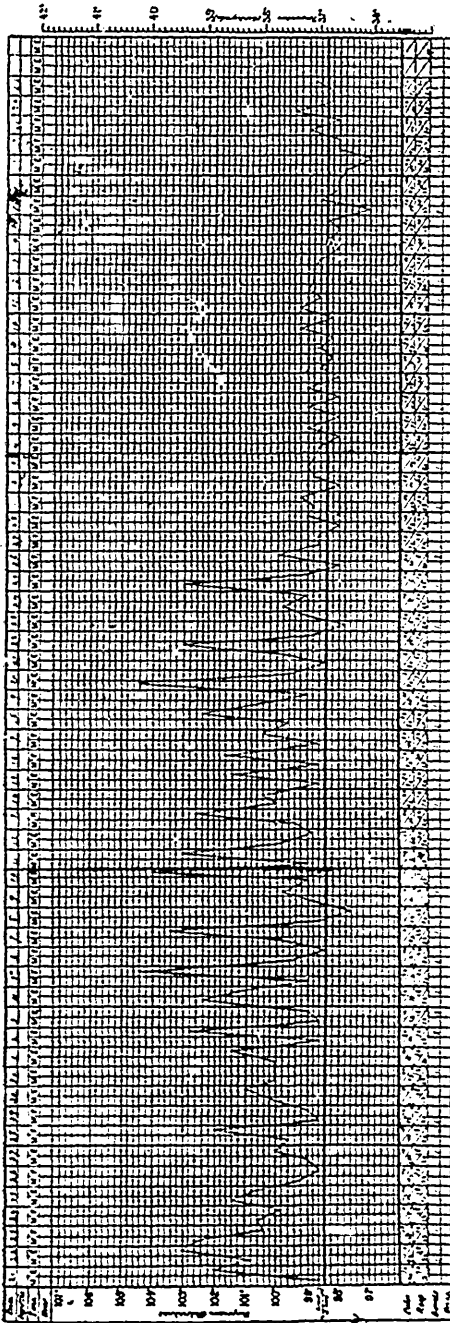
CASE 5.—M. H., aged 8, entered the Hospital for Sick Children on March 4th, with a history of illness for four weeks supposed to be bronchitis and typhoid fever. She was emaciated and showed marked stupor, but could be roused. She had a large foul ulcer on the inner surface of the lower lip. The spleen could not be



felt, and the blood did not give the Widal reaction for typhoid fever. She complained from time to time of severe headache and showed delirium when roused. The temperature was moderately elevated and irregular; the pulse was feeble, rapid and irregular.

The head was slightly retracted, the muscles of the neck and back rigid, and any movement gave her pain. Kernig's sign was fairly well marked.

Lumbar puncture was done and one and one-half ounces of clear, pale fluid obtained, which was sterile. She died on March



Date Recd. of
 Dr. Wm. G. B. G.
 Name of
 Patient Wm. G. B. G.
 Age 28 Sex M
 Date of Admission 1/10/10
 No. of Case 111
 Name Wm. G. B. G.

(The record on this card
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10th, six days after admission, temperature having risen to 106 degs. F. and pulse to over 160 per minute before death.

On *post-mortem* examination there was found meningitis, chiefly of the base of the brain and of the spinal cord, and the infecting organism was the diplococcus intercellularis of Weichselbaum. There was also found a small tuberculous nodule in the right lung, and some of the bronchial glands were caseous.

CASE 6.—The following case is interesting chiefly on account of the protracted course, the apparent convalescence and the relapse with the marked neurotic symptoms that occurred.

Olive T., aged 12, admitted to the Hospital for Sick Children January 17th, 1902, with the typical symptoms of cerebrospinal meningitis. There was pain in the head and back; irregular fever; slight petechial rash, which faded in three or four days; general hyperæsthesia; herpes on lips and cheeks; Kernig's sign; retraction of the head; sluggish bowels, with very offensive evacuation, etc. On February 18th she became very hysterical and tried to vomit whatever she did not wish to take. She lost flesh and strength rapidly and on the 28th the pulse became very irregular, falling as low as 50 per minute. She appeared comatose, but could be roused.

Improvement then set in, and by March 8th she sat up in bed. She improved uninterruptedly until March 20th, when vomiting and headache recurred. The headache became severe, and the pulse slow and feeble. On the 23rd March she sat up in bed, became suddenly cyanosed and died in a few minutes. No *post-mortem* examination was permitted.

This short series of cases calls for little by way of further comment. They are all fairly typical cases of the disease.

The only treatment found of use was the hot bath. It quieted the extreme restlessness, eased the headache, and caused sleep, lasting for an hour or more. Several fell asleep in the bath. Even large doses of morphine hypodermically had little effect on either pain or restlessness.

I am indebted to the kindness of Dr. A. Rutherford, House Physician, for the histories of the hospital cases.

151 Bloor Street W. Toronto.

TREATMENT OF PAINFUL GROWTHS, MALIGNANT AND
NON-MALIGNANT, BY THE HYPODERMIC
USE OF THIOSINAMIN.

BY J. F. MACDONALD, M.D., HOPEWELL, N.S.

THE remedies proposed, used, and experimented with for the cure of cancer are many; in some cases results are encouraging. From clinical study and research now in progress the outlook brightens, and in the near future it is hoped that this disease that has so far baffled the skill and resources of our profession will be amenable to treatment. Is it contagious? is a question yet to be settled.

Among the remedies used, one of which little has been heard is thiosinamin. Its medicinal use was first reported about ten years ago by Hebra. It has been used in glandular enlargement, for absorption of cicatricial tissues, in skin diseases, in adenoid growths, malignant and non-malignant, with varying results. For the absorption of adventitious tissues, cicatricial tissues and neoplasms its use has given good results.

The best results are gotten from it when used hypodermically. Given by this method its absorption is rapid. Patients often find a garlicky taste in from two to five minutes after administration. Elimination is not so rapid. When given by the mouth very little benefit seems to be gotten from it, and much larger doses are needed.

I have used it since 1896, and have never found ill effects from its use when not pushed too far by large or too frequent doses. In painful growths, even where it does not cure, pain is readily relieved. In painful diseases of the alimentary canal, including nose and throat, its use is remarkably beneficial. In external growths I have not found its use satisfactory.

I submit a few cases which may be interesting :

CASE 1.—Mrs. M., aged 62, married, never had children. Was a strong, healthy woman until about ten years ago, when she began to have dyspeptic attacks; five years ago had a severe attack, with pain and persistent vomiting, from which she recovered; has never been so well since; has been subject to attacks of pain and vomiting. Family history not good; two brothers and one sister died from cancer of stomach. The pain in her stomach gradually became more frequent. A year before beginning treatment by thiosinamin the pain was so severe that morphine had to be taken daily and in increasing quantities. Vomiting was so frequent that little or no food was retained. She

became emaciated, anemic and cachectic. On palpation of stomach, found a hard, painful tumor about the size of the closed hand in the median line, which could be plainly seen on inspection. Diagnosis, cancer of stomach.

Treatment.—September 18th, 1896, began treatment by hypodermic injections of thiosinamin, gr. 1-3; about two minutes after, while arranging my syringe, she said she had "a queer taste in her stomach," the garlicky taste often experienced after taking a dose of the drug. On the 22nd the pain had been less since first injection; gave second dose, gr. 2-3. On the 26th vomiting had ceased; no pain, and can take a little liquid food. Tenderness on pressure unchanged; said she felt much better and able to sit up; gave third dose, gr. 2-3. October 1st, called at my office on her way home from church and received fourth dose, gr. 2-3. Said she felt well and took food freely without giving pain. No vomiting. From this date the dose was increased to gr. 1 1-4, and was given very irregularly until January 16th, 1897, four months from beginning treatment. The tumor has decreased in size—almost disappeared; there is neither pain nor vomiting and she has gained in weight and strength. Considers herself well and discontinued treatment. June 30th, 1898, she called at my office, reporting herself as well. The tumor has disappeared entirely. Five and a half years have passed and there is no return of disease. She is well.

CASE 2.—Female, aged 50, married; has had eight children. Family history good, except that one brother and one sister died of tuberculosis.

October 26th, 1896, is suffering from pain in the stomach and vomiting; anemia and cachexia marked. Has had frequent attacks of pain in her stomach and vomiting for the last year, dyspepsia attacks extending further back; has lost flesh rapidly lately. Pain is now almost constant, severe, "cutting and darting," vomiting frequent, so that very little nourishment is taken or retained. No blood vomited. On palpation, found tender, uneven induration near and to left of pylorus. These symptoms strongly suggest a suspicion of malignant disease. Gave gr. i. thiosinamin hypodermically. October 31st, no improvement; gave second dose; experienced no effects in any way from the drug. November 4th, found her a little better, pains not so severe; gave third dose. November 7th, gave fourth dose. She is much improved, pain almost gone, no vomiting; takes a little food with but little inconvenience, is out of bed and feels comfortable. The treatment was continued, giving gr. iss. to gr. ii. twice a week. November 30th, much improved; tenderness on pressure much less. Twenty-three injections were given extending over a period of four months, at the end of which time she was apparently well and has had no return of disease to this date.

CASE 3.—Male, aged 45. Clinical history much like the preceding, but of longer duration and apparently severe. Palpation of stomach reveals a hard, flat, nodulated tumor at and to left of pylorus, which is very tender to touch; he is anemic and greatly emaciated. Diagnosis, probably malignant disease of stomach. The treatment was the same as the preceding cases, extending over a period of three months, taking twenty-two doses, at the end of which time he appeared well, and has remained so to this date.

CASE 4.—Male, aged 64. One sister died of cancer of uterus. He has been a chronic dyspeptic for twenty years. May 11th, 1898—For six months pain in the stomach has been constant and increasing in severity, vomiting every day. For four weeks previous to my seeing him the pain had been very severe and vomiting frequent. Says he vomits everything he swallows; vomiting occurs ten or fifteen minutes after ingesta; no blood vomited. On examining the stomach found tenderness on pressure, especially near the pylorus, where there was a hard, rough enlargement. He was greatly emaciated, cachexia very pronounced. Diagnosis, stenosis of pylorus, caused by malignant disease.

Treatment.—Gave thiosinamin, gr. iss. every third day. The pain and vomiting relieved after the third dose. He received ten doses of gr. iss.; the pain and vomiting ceased and he was able to take food; gained in flesh and strength and was able to attend to business. The enlargement at pylorus almost disappeared. He then refused to continue the treatment. After a year's immunity from suffering the disease gradually returned; he was treated by another physician, but died before the end of the second year from the time the thiosinamin was discontinued. Had he continued the treatment as I urged him to do his cure would probably have been as complete as the others.

In the four cases here briefly reported the most remarkable feature is the rapidity of relief from pain, no narcotic being given after the first injection of thiosinamin. The severity of the symptoms and clinical history leave little doubt as to their malignant character. Nos. 1, 2 and 3 at nearly the end of six years are well and are cured.

In a case of tumor of the pancreas of one year's growth—the pain and tenderness existed six months before the tumor was recognized—the relief was as prompt and results as satisfactory as in the other cases. Treatment was followed for three months, at the end of which time the tumor had disappeared, and with it the pain and soreness. In two cases of chronic disease of the throat of a year's standing there was pain, with tenderness on handling, and a little enlargement of glands; the results of the treatment by thiosinamin were satisfactory. No return of disease after four years.

In a case of cancer of the breast of about a year's standing,

I used the thiosinamin treatment, but after giving fourteen doses, there being no improvement except that the pain was not so severe, it was discontinued.

In treatment of skin diseases most favorable results have been obtained wherever I have used it. In treatment of enlarged prostate its use will be found most beneficial.

It is not claimed that malignant, internal growth may or can be cured by hypodermic use of thiosinamin. The number of cases are too few and my experience in the use of the drug too limited, although I have been studying its use and action for the past six years. Yet the cases here given, which I believe to have been malignant, with a few others treated, have been cured.

TECHNIQUE OF THE REMOVAL OF TUBERCULAR CERVICAL GLANDS.

BY L. W. COCKBURN, M.D., HAMILTON.

In dealing with the subject of removing tubercular cervical glands, I wish to be understood to refer to the deep-set only. The removal of the superficial glands being comparatively easy, and lying within the "canons" of every-day surgery. I propose first to briefly outline the procedure experience has taught me to adopt in all these cases, and will then touch on a few points in the technique of the operation.

I make a straight incision, the whole length of the neck lying just posterior to the anterior edge of the sterno-mastoid. I pay no attention whatever to any structures lying between the skin and the muscle. The external jugular vein being clamped, cut and tied, and any nerves severed as they are met. The anterior edge of the sterno-mastoid is then defined from end to end of the incision, and the muscle "cleaned up" from the underlying parts, keeping close to it and using considerable traction. Towards the upper part of the incision this tension on the muscles causes the spinal accessory nerve to stand out plainly, and it is easily identified. I now clean the nerve, in order that being clearly seen it may not be injured in the subsequent manipulations. I now turn to the lower end of my incision and identify the internal jugular vein; having clearly made it out, the next step is to define the boundaries of the glandular mass by carefully peeling the surrounding parts off on all sides till the whole enlargement stands out plainly, though still, of course, adherent by its base. I now select the largest and best-defined gland and carefully incise its capsule, taking care not to enter the gland substance. The cut edges are clamped and very gently retracted, then with the point of a small sharp knife I sever the numerous trabeculae which dip into the substance of the gland from the capsule. I now, by means of a pair of mouse-toothed forceps, make gentle traction on the gland, and at the same time roll it over so as to bring fresh trabeculae into view. It is surprising how easily and quickly a large gland can be removed in this way. After all the glands have been so treated all that remains of the large glandular mass is a collapsed empty frame work of capsule vessels and thickened connective tissue. I now direct my assistant to compress the jugular at the root of the neck. This throws the vein and its tributaries into prominence, when the whole framework just mentioned can be easily and safely cut away with a pair of scissors curved on the flat.

I have more than once in this way cleaned away large masses of matted glands right up to the jugular foramen easily and quickly. Before closing the wound I go carefully over it, keeping the vein distended and pairing away any fragments that remain. The wound is then closed in the ordinary way without drainage.

Comments.—Any one who starts out to clean the triangles of the neck under the guidance of the descriptions in the text-books on surgery, will, if his experience tallies with my own, often find himself in a tight place. Most of the written descriptions of this procedure which I have read deal in vague generalities. No definite plan is advised, and the operator, especially if a beginner, after making his incision, which he usually does in the long axis of the swelling (a great mistake), finds himself groping over the wound area trying to find the easiest looking gland in the bunch for the purpose of removing it by that abominable procedure called "blunt dissection." He is further mystified by a multitude of fancy incisions—S-shaped, angular, curved, crossed, and crooked. In the *International Text-Book of Surgery*, Vol. II., page 124, Fig. 79, is shown three incisions for the removal of tubercular glands. Woe betide the unlucky neophyte who attempts to clean the triangles of the neck through such incisions! Yet this work is, I believe, looked on as one of the best, as it certainly is one of the most modern, of the standard works on surgery. Authorities talk glibly of dissecting up flaps of skin, subcutaneous tissue, platysma and fascia, as if the procedure were taking place on the neck of a cadaver in the dissecting room, instead of upon the neck of a living patient, with the parts matted, distorted, and oozing with blood. I must respectfully demur to all this and a great deal more. In my humble opinion, to talk of turning back flaps composed of certain definite structures is ridiculous. The parts are usually so matted that all such land-marks are obliterated. Again, the stock advice to keep close to the capsule of the gland sounds very soothing in print, to an inexperienced operator, but when face to face with his patient he will find it anything but soothing in practice. Even if he does succeed in digging out a gland, it will only be to reveal a dense matted adherent mass below and around. There are three points in the technique of the operation to which I wish especially to allude. Section of the sterno-mastoid, blunt dissection, and removal of parts of the internal jugular vein. First, with regard to division of the sterno-mastoid. I have seen it done. I have never done it. I never intend to do it. I believe it is unnecessary in any case, and should anything go wrong with the healing of the wound it may cause a serious deformity. With regard to blunt dissection, I most strongly deprecate its use. It appears to me thoroughly unsurgical and clumsy. To take a pair of blunt-pointed scissors, as I have seen advised, and proceed to enucleate deep cervical glands by alternately gouging and snip-

ping, keeping meanwhile traction on the growth, appears to me about as dangerous to the patient's neck as the proverbial bull would be to the china shop. As to the necessity for excising part of the jugular vein, which several good authorities advise, I believe it is never called for. If the suggestion I have made is followed, the vein is easily cleaned throughout its whole length. I have never removed part of the jugular vein, but I have seen it done, and as with section of the sterno-mastoid, I can emphatically say I will never do it. The deep veins are extremely fragile and easily torn. They will not stand anything like the hauling and pulling that the superficial veins will, and to strip up the internal jugular and tie it off as it enters the jugular foramen, in my opinion, exposes the patient to far more peril than ever his cervical glands could do. There is another grave objection to cutting the deep jugular vein. Tubercular glands are common, and may return on one side after having been removed on the other. Should the first operator be an enterprising man, and remove a piece of the jugular on one side, and the patient subsequently falls into the hands of another surgeon for the purpose of having the other side of the neck cleaned, and should the second operator also remove a piece of the internal jugular on his side, the result to the patient would be startling, to say the least of it.

I think the instructions frequently given to save this or that branch of the superficial cervical plexus is a mistake, so is the advice to try and save the external jugular vein. No harm comes from the division of these structures, and the operator has quite enough to think about without bothering his head over unimportant vessels and nerves. For all practical purposes, the only structures that need be thought about are the internal jugular vein and the spinal accessory nerve.

I quite expect what I have said will be subjected to a good deal of criticism. I shall be told that I am smearing a fresh wound with armies of tubercle bacilli from the infected glands by opening the capsules. I can only say I have done it repeatedly and seen no ill-effect follow, and furthermore, it must be borne in mind that all surgery is a choice of evils, and on this principle, speaking for myself, I would much prefer the risk of infection from a broken down gland than the risk of having my internal jugular tied off close to the foramen.

I am conscious of having dealt with this subject in a very imperfect way, but my experience has been small, smaller, I feel sure, than that of many of my hearers, and I shall await with interest expressions of opinion on the points I have raised which may fall from those present better qualified to speak than I am.

NOTES FROM THE OPERATING THEATRES OF LONDON.

BY F. WINNETT, M.R.C.S.(ENG.), TORONTO.

FOURTEEN years had passed since my student days in London, and I was prepared to see perfection in technique and radical changes in keeping with modern surgery, but in many instances it was disappointing to find work decidedly mediocre being done. While most of the hospitals have built operating rooms with due regard to asepsis, students have met with little consideration. They seldom accommodate more than twenty-five or fifty, usually standing; and of those not more than a dozen can see the operation.

Following are a few scattered notes of operations which are fairly representative:

1. Mr. Godlee, University College Hospital. Operation—nephrectomy. The previous day he operated for stone, but incision revealed sarcoma. The incision was enlarged and the twelfth rib removed. Double sets of ligatures were used for the pedicle, the second being tied after the kidney was removed. He spoke of once having had the ghastly experience of seeing the usual ligatures slip off the pedicle as soon as it was divided.

The cystoscope or X-rays had not been used, although the latter has revealed calculi weighing from 12 grs. up. No suspicions were likely entertained of the necessity to remove the kidney, or else permission to do so would have been obtained.

2. Appendicitis suspected. The patient was a middle-aged man. To clear up the diagnosis he made a median incision, and found a hard mass the size of a finger towards the right side. Judging it to be the appendix the wound was closed and the usual lateral incision made. Finding several lumps he suspected tubercle, took a particle for the microscope, and closed the wound. The specimen having been mounted pus was found, and his suspicions reverted to the appendix.

His first suspicions should have led him to make the exploratory incision over the appendix. Both incisions were exceedingly small, and the appendix was not seen, and possibly not felt. In fact, although quite close, I doubted if the thickened and adherent peritoneum was opened.

3. Nephrectomy—female; cyst of kidney; urine 30 oz. No bacillus tuberculosis nor pus. Was in doubt as to the cause, and spoke of the possibility of stricture of the ureter. Did not catheterize ureter, or prove the second kidney was healthy. On removal it proved to be tubercular.

4. Recurrent cancer of tongue. Some time previously he had removed half of the tongue. Tongue was loosened and drawn out,

the base compressed with curved forceps, and amputated. An attempt was made to catch the artery, and the compressing forceps was removed. The artery bled long and furiously before it was successfully tied.

Mr. Pearce Gould, Middlesex Hospital. Diagnosis—Cystic tumor of breast, with hematoma, in a woman aged 40. Incision revealed simple hematoma, with masses of fibrin. Mr. Gould said he was misled by its lobulated appearance and its attachment to the skin. The dressing consisted of a pad of double cyanide gauze, and over this, bichloride absorbent cotton. He said he was not aware Lister taught that these two salts formed a compound without antiseptic action.

Dr. Spencer, University College Hospital. Diagnosis—Carcinoma of uterus. Some time previously curettings were diagnosed as cancerous, but he still believed it to be innocent, and contented himself with curetting. As the disease returned he decided to remove the uterus. The vagina was very small, and the uterus quite immovable, yet the vaginal method was chosen.

The perineum was freely divided, and the thermocautery used in place of the knife. Antiseptics were used and rubber gloves worn, yet feces were allowed to constantly escape. The cervix and body were affected, and so soft that most of it came away in bits when drawn on by the forceps. Six pairs of forceps were left applied to the broad ligaments. It was a tedious and dirty operation. The early microscopic diagnosis should have been followed by removal, and few at home would for a moment consider the vaginal route at such an advanced stage, not to speak of the other contra-indications.

Mr. Butlin, St. Bart's Hospital. Excision of head of humerus for caries. Frequent attempts to pass curved needle around neck for chain saw, and also aneurismal needle failed. A straight saw was tried repeatedly, in combination with forceps, before it was successful.

2. Patient brought into theatre anesthetized was cyanosed, due to a tight bandage over the dressings about the neck. It was so tight that difficulty was experienced in cutting it.

Mr. Walsham, St. Bart's Hospital. Cancer of breast in a fleshy woman. The oval skin removed was four inches broad. Incisions went down to muscle, axillary vessels were cleaned with the knife, incision was carried up to clavicle, pectoralis major was divided, fascia from pectoralis was removed by itself. As skin would not cover wound it was freely loosened, an incision carried down from the inner extremity of oval, and the pectoralis major removed. Many silk-worm gut sutures were inserted and drawn with such force that several broke, and the skin was left blanched. Wound was reduced to two inches square. Time occupied, sixty-five minutes. The tension was excessive, and must assuredly have caused sloughing.

J. Hutchinson, jun., London Hospital. Patient, a woman, had a small tumor of the breast, which had been tapped. He

diagnosed it as adeno-cystoma, but operation revealed a condition resembling melanotic sarcoma or nevus.

Mr. Bland Sutton, Chelsea Hospital, had operated on this patient six months previously, and removed ovaries. Recovery uneventful. Diagnosis—Pain in one side. Cause not known.

At 3.28 began operation; 3.30, finger in peritoneal cavity; 3.35, finds abscess of stump. Although he believes the pus is sterile yet he drains. Operation completed at 3.45.

2. Hysterectomy. Diagnosis—Fibroid.

At 2.32 operation begun; 2.33, tumor size of fetal head exposed on abdomen; makes some remarks to visitors; 2.35, tumor and body removed, forceps left applied to arteries, uterine artery spurted; 2.40, peritoneum dissected back and cervix removed; 2.55, ligatures and sutures applied. Peritoneum, aponeurosis and skin sutured separately. Operation completed at 3.03; dressed at 3.05.

3. Hysterectomy.

At 3.13½ operation begun; 3.14½, uterus and tumor, size of large fist, exposed on abdominal wall; 3.15, catches right ovarian artery in forceps, and with knife divides it on uterine side. Right uterine follows. Makes transverse incision of peritoneum. Left side done, and cervix divided; 3.16, uterus removed; 3.35, ligatures and sutures applied. Operation completed at 3.45.

This method of compression, division, and then applying ligatures is in keeping with general surgery.

4. Extra-uterine pregnancy or tumor.

At 3.48 operation begun; 4.04, finds cyst of ovary and nevus of broad ligament; 4.24, tumor removed. Operation completed at 4.25.

For coolness and rapidity without hurry or excitement, Sutton cannot be equaled, and this is also the opinion of my friend, Dr. Wishart, of London, Ontario, who suggested keeping time.

INDICATIONS FOR, AND TECHNIQUE OF, OPERATION FOR NEPHROPTOSIS.*

BY AUGUSTIN H. GOELET, M.D., NEW YORK.

(Abstract.)

THE importance of nephroptosis as a factor in producing renal disease, and also disease of the female pelvic organs, was emphasized by the author, who thinks this is not generally appreciated, or the utility of nephropexy would be more universally recognized.

Nephropexy may be regarded as a fad of the surgeon by those who have not investigated the subject carefully, but he thought the surgeon the better judge of the necessity for operation because he saw these kidneys exposed on the operating table, and could observe the structural change that resulted in consequence of prolonged congestion or obstruction of the ureter due to prolapse.

In a contribution to the Gynecological Section of the American Medical Association, he had shown that nephroptosis causes disease of the female pelvic organs by compressing the ovarian vein and interfering with the return circulation from the pelvis. In this alone he thought was to be found justification for considering this a grave condition, entitled to be placed beyond the pale of palliative treatment.

Such diseases of the kidney as would result from prolonged congestion of the organ or obstruction of the ureter, were to be found in prolapse of the third or fourth degree. Hence in nephroptosis, when long neglected, the kidney may be affected by nephritis, perinephritis, pyelo-nephritis, hydro-nephrosis, pyo-nephrosis, and atrophy. Extravasations under the fibrous capsule, and between it and the fatty capsule, are also met with in cases of long standing.

Operation was not advised for prolapse of the first or second degree, except when the left kidney was found to be in the second degree of prolapse at the time of operation on the right kidney; then the left kidney should be fixed at the same time to obviate the necessity for a second operation later, which would surely be required, because prolapse of that degree is inevitably progressive.

For nephroptosis of the third degree or beyond, operation is necessary because of liability to disease of the kidney resulting at any time, and because of its influence upon the female pelvic organs.

* Read at the first annual meeting of the American Urological Association, at Saratoga, N. Y., June 13th, 1902.

He thought it unnecessary and unwise to deprive the kidney of its protecting fibrous capsule, or to transfix its structure with sutures or muscular bands. Firm adhesion of the kidney with its fibrous capsule intact could be secured, if it is held for a sufficient length of time immovably in contact with the exposed muscles of the back. This can be accomplished by inserting the sustaining sutures under the fibrous capsule only in such manner that its resisting power is utilized to the best advantage.

Two sutures of silk-worm gut are employed, one having three insertions under the fibrous capsule of a half inch in length each, and the other two insertions of the same length. They are brought out through the structures of the back at the upper angle of the wound, just below the last rib, and are tied over a small, flat pad of gauze to prevent cutting and loosening of the suture loop, which would permit the kidney to sag and destroy the chance of adhesion. These sutures are not removed until just as the patient is ready to get out of bed, three weeks after operation.

The author has operated upon 109 cases by this method, in 27 of which both kidneys were fixed at the same time, making a total of 136 nephropexies without a death and without any complications following. So far as he has been able to ascertain, there have been no relapses in any of his cases.

Gynecology and Obstetrics.

... IN CHARGE OF ...

GEO. T. McKEOUGH, M.D., M.R.C.S.(ENG.), AND J. H. LOWE, M.D.

CANCER OF THE UTERUS.

T. WILSON, F.R.C.S., Birmingham, England, has the following paper in the *Journal of Obstetrics and Gynecology of the British Empire*, and which is of much practical interest:

The improved results that have been obtained by Halsted's method of operation in the treatment of cancer of the breast is stimulating gynecologists to the endeavor to find a safe operation that shall be attended by similarly improved results in cancer of the uterus. Mackenrodt (*Zeitsch. für Geburts. und Gynak*, Bd. xlvi., No. 1, 1901) states that at the Giessen Congress it was shown that by vaginal hysterectomy a definite cure can be obtained in about 32 to 40 per cent. of operable cases, and in 10 to 12 per cent. of all patients seeking advice for carcinoma of the uterus. These results, as regards cancer, must be considered relatively favorable, but they do not appear satisfactory to many gynecologists. A more radical operation must be based upon ascertained anatomical and pathological facts. As regards the pathology of uterine cancer, it is important to note that the pelvic connective tissue is early implicated, and that often there is early infection of the pelvic glands. The paravaginal connective tissue can be almost completely removed through the vagina with the help in certain cases of a vagino-perineal incision, or of a paravaginal incision, as in Schuchardt's method. By the latter method, Schuchardt has obtained, in a material showing 62 per cent. of operable cases, a definite cure in 24.5 per cent. Mackenrodt states that Schuchardt, in his operations, has paid no attention to the danger of infection of the fresh vaginal wound by cancer, and claims that he himself has obviated this danger by the use of the actual cautery in making the incisions. Igniextirpation of the uterus through the vagina has given, in Mackenrodt's hands, 42.8 per cent. of lasting cures in a material showing an operable ratio of 92.9 per cent. The difference of 18 per cent. of radical cures between his figures and those of Schuchardt Mackenrodt ascribes to the avoidance of implantation metastasis in his method. Preparatory cauterization of the central portion of the mass does not suffice to prevent cancer infection of the operation wound.

because there is an equal likelihood of infection by pieces derived from the peripheral portions of the growth.

Mackenrodt believes that the complete removal of the pelvic connective tissue through the vagina is a practical impossibility, but he further asserts that in all the cases that have been sufficiently investigated by him a complete operation was anatomically possible and recurrence avoidable. The removal of the whole of the glands, and not only of those that are already obviously diseased, is necessary. Mackenrodt thinks that there is a possibility of obtaining radical cures in more than 50 per cent. of cases of cancer of the uterus, and as in cancer there is everything to gain, and very little to lose by operating, the end to be aimed at is not good statistics, but the definite cure of as many patients as possible.

Influenced by the above considerations, and being assured that a complete removal of the pelvic glands is from their anatomical relations feasible, Mackenrodt has sought for a suitable operative method. He found that the removal of the glands was not possible through a median lower abdominal incision, and the method he has arrived at after careful trial is a subperitoneal one carried out through a horseshoe-shaped incision. The cancerous growth is prepared two days beforehand by curetting and packing with gauze soaked in 10 per cent. formalin solution. The operation is briefly as follows: A vertical incision is made on each side along the lower part of the outer border of the rectus muscle. The lower ends of these incisions are joined by a transverse cut just above the pubes. The attachments of the recti to the pubes are divided. The peritoneum is pushed off unopened from the large abdominal flap, and is cut across above the bladder. The uterus is then drawn up through the opening, and its peritoneal attachment divided all round. The peritoneum separated from the anterior abdominal wall is next sutured to the peritoneum on the posterior pelvic wall from one side to the other. The peritoneal cavity is thus shut off above, while below the pelvis, with its contents, lies widely open. The peritoneum is now pushed off the lateral pelvic wall, and the glands are removed retroperitoneally as high as the bifurcation of the aorta. Finally, the uterus, and as much of the vagina as seems desirable, are removed. If the ureters are implicated in the growth, it is claimed that portions of them can be easily removed, and the ends implanted in the bladder. As regards the treatment of the wound left after removal of the uterus, in the first five patients operated upon in this way the whole enormous cavity was stuffed with iodoform gauze, and the parietal wound closed by sutures. Four out of the five cases died from septic infection that undoubtedly arose from the vagina and the injured rectum. In several other cases the wound was divided into four, the bladder being first sutured to the stump of the sacro-uterine ligaments, and the lower compartment of the wound thus

formed being drained into the vagina. The upper compartment was then divided into three by suturing a fold of peritoneum to each lateral border of the abdominal flap, and these three cavities were separately drained through the abdominal incision by tubes with gauze. After this method of treatment of the wound, healing proceeded smoothly in six cases. One avoidable death took place, being caused by hemorrhage from a cut epigastric artery.

Mackenrodt thinks that, with the above operation, not only can a larger percentage than usual of radical cures be obtained, but the indications for operation can be greatly extended

J. H. L.

“VIVE LA FEMME.”

THE following was written by a lady patient of a well-known surgeon in Toronto last winter and handed to him one morning when making his daily call :

Tell me not in rhythmic numbers
Life is but a surgeon's play,
The body is not dead that slumbers
Under anesthetic sway.

Life is pain and life is sorrow,
Operations are no joke,
But 'tis the remedy assigned
To all the ailing woman-folk.

Headache, backache, both remind us
We may live this life sublime,
And departing leave behind us
Daughters suffering for all time.

Daughters whom perhaps another
Surgeon on life's stormy main,
Clever as his elder brother,
Seeing, operate again.

Let us then be up and doing,
Bearing daughters—woman's fate—
Pain enduring, health pursuing,
Learn to labor and to wait.

Speed the time when little kidlets,
Shall grow on sour apple trees,
Hasten on, ye incubators,
Women wait for such as these.

Our anatomy has been altered
“Woman's ailments” all are past
Do off your hat, O man, our master,
The “New Woman's” found at last!
Alas and alack!

Selected Articles.

THE INTRAVENOUS INJECTION OF COLLARGOLUM (ARGENTUM COLLOIDALE CREDE) IN SEPTIC DISEASES.

BY DR. JOH. MULLER, BUTOW, POMERANIA.

THE author says that the employment of Argentum Colloidale Crede (Collargolum), which has been used with such excellent effects in maladies which we were otherwise hopeless of combating, has long excited his vivid interest. With the exception of Crede's and Wenckebach's articles, comparatively little has as yet appeared in literature. His own observations now include thirty cases; and the results of treatment have been so uniform, and often so striking, that he feels impelled to report them briefly. In almost all cases he administered the remedy as a 1 per cent. intravenous injection. In his large country practice he was not able to observe the cases with the closeness which might be desirable; but after all the chief things were the results.

The first case was that of a woman forty-seven years old, who came under treatment on June 25th, 1901, suffering from a severe bullous erysipelas dependent upon an abscess of the left side of the neck. The entire left side of the neck and face were affected. Twenty-four hours later the right side of the face and the right ear were involved. Not long before Dr. Muller had had a fatal case of erysipelas, and he therefore instituted the Collargolum treatment, injecting 5 grams (1 1/4 drams) into a superficial vein of the left arm. The temperature at the time (noon) was 39.9 degrees C. (103.8 degrees F.); in the evening it was 37.7 degrees C. (99.9 degrees F.), and the next morning 36.7 degrees C. (98.1 degrees F.). The general condition had become good; the erysipelas stopped spreading, and was cured in a few days.

Encouraged by this, Dr. Muller, on July 22nd, injected a boy of five, suffering from a severe pneumonia, in which the crisis had not occurred on the twelfth day, with 2 1/2 grams (37 1/2 grains) of the Collargolum solution in the forenoon. In the evening the boy felt better, was interested in his playthings, and the temperature had fallen. Next day there was renewed pyrexia; another injection was given; the temperature fell to normal, and remained so. There was a rapid recovery.

On July 28th, a girl of twelve suddenly fell sick with headache, chills, vomiting, stiffness of the neck, and somnolence. Next day there was opisthotonus and such rigidity of the spine that the patient had to lay upon her abdomen, spasm of the facial muscles, contractions of the extremities, etc., so that the diagnosis of epidemic cerebrospinal meningitis was made. On the afternoon of July 31st, 4 grams (1 dram) of Collargolum solution were injected. The patient was quieter during the night following, and recognized her parents in the morning. A second injection was given. In the evening the sensorium was free, the temperature was normal, and the opisthotonus was relaxing, so that the patient could lie upon her back again. Rapid progressive improvement. But the paralysis of the muscles of deglutition lasted for eight days longer so that tube nourishment was required. In this case, which appeared perfectly hopeless, both the physician and the parents were delighted with the results of the treatment.

The next case was a phlegmonous erysipelas, occurring in a seventeen year old apprentice, starting from a wound of the leg, and involving the entire limb up to the inguinal region (August 5th). The process stopped even after the first injection, and two further ones caused it to retrogress completely. Only two small incisions of the skin first affected were required for the evacuation of pus.

Another more recent case was that of a woman of twenty-eight, who had a perimetritis with high fever and violent pain fourteen days *post-partum*. The exudation reached the height of the navel in a few days. The general condition was bad. On October 1st, the fourth day of the disease, she was given a Collargolum injection. The next night was a better one, the morning temperature was 37.7 degrees C. (99.3 degrees F.), and the general condition was markedly improved. Nevertheless, on account of the excessive sensitiveness of the patient, and her distrust of the remedy, another injection was refused. A gynecologist was called in consultation, who did not know Collargolum, and did not approve of its use; so that it was only by October 8th, when the exudation had extended to two finger-breadths above the navel, that Muller was allowed even to employ the silver salve. He personally injected twice daily 3 grams (45 grains) of the Unguentum Crede exactly according to rule; and after the fifth inunction there was a fall of temperature to the normal. In about a week and a half the exudation disappeared entirely.

All the other cases ran an almost similar course.

The Collargolum injections were employed in two other cases of perimetric exudation, one of parametric infiltration and in four of beginning mastitis in which the fever disappeared four to eight hours after the first injection, and suppuration did not occur in any case. They were also used in an obstinate lymphangitis of

the forearm, for which one injection sufficed; two panaritiums, in which one and two injections, respectively, were enough; and three phlegmons of the extremities, in which one or two injections were sufficient to prevent extension of the destructive process. Of course incisions were requisite in these as in the advanced panaritiums; but surgical interference is no longer our only means of coping with these affections. The injections were employed once in acute articular rheumatism; salicylic treatment for fourteen days gave no results, and two injections sufficed to cause the disease to disappear; in two pleurisies with effusion, where they caused defervescence of the fever and rapid disappearance of the exudate; and one facial erysipelas, in which one injection gave the desired result. There was one appendicitis, injected on the fourth day, with disappearance of the fever at once, and the exudation in a few days; one severe general peritonitis, and one suppurative meningitis, in which the parents sent me word two days after the injection that the child, which was thirteen years old, had recovered consciousness. One appendicitis case received an injection on the fourth day, causing marked lowering of the temperature and improvement of the general condition; on the four following days because the temperature did not entirely disappear, especially at night, there was given a daily injection, which entirely removed the vomiting and meteorism, and greatly diminished the local tenderness; an abscess formed in Douglas's cul-de-sac, which broke spontaneously into the rectum on the ninth day. There were also two cases of phlegmonous angina.

Muller also used the Collargolum injections in two cases after resection of the ribs in consequence of empyema, and found that the offensive odor rapidly disappeared, and recovery occurred much quicker than is usual. He employed it five times in a girl nine years old, who had had resection of the joints and various sequestrotomies done in consequence of a severe tuberculosis of both knees. This patient was emaciated almost to a skeleton, and had persistent fever; after the injections she recovered rapidly, and the wounds healed visibly under his eyes. In febrile (septic) tuberculosis of the lungs also Muller has twice employed the injections with thoroughly satisfactory benefit to the patient; the fever and night-sweats stopped, the appetite improved, and the body weight increased.

With the exception of the chill, which almost regularly occurs from one to four hours after the injection, Muller has seen no trouble occur from this method of employing the Collargolum, though his dosage, especially in children, has been very large.

On the basis of his very favorable experiences, which certainly cannot all have been due to accident, Muller has no doubt that the action of the Collargolum in septic processes is a specific one. He injects it in these diseases with the same confidence with which he

employs antitoxin in diphtheria, and most earnestly recommends the further employment of the soluble silver by intravenous injection to his colleagues.—Abstracted from the *Deutsche Medicinische Wochenschrift* of March 13th, 1902.

CONTRACT MEDICAL ATTENDANCE UPON SICK CLUBS.

BY H. LANGLEY BROWNE, M.B., B.Ch. BIRM., F.R.C.S. EDIN.,

West Bromwich.

At the present time it may be of interest to many readers of the *British Medical Journal* if some suggestions were made as to how far the profession should go in its support of or opposition to the present very widely adopted system of contract medical attendance. Most of us will admit that it is perfectly legitimate and fair that the working classes should make some provision to ensure not only sick pay but also medical attendance in times when they are prevented by illness from following their usual employment. Living, as such vast numbers of them do, from hand to mouth, and spending each week the amount of their weekly wages, when illness comes they must run into debt for the necessaries of life and for their medical attendance unless they have previously made provision by joining some form of provident society.

The large Friendly Societies, such as the Foresters, Oddfellows, and others, registered and working under definite rules, have very little of the objectionable element in their constitution. They seldom, if ever, employ canvassers, and they are recruited by the efforts of the individual members of the different lodges into which they are divided. They seem to require reform in two ways: First, the sum paid per head for medical attendance is often too small; and secondly, they admit members who are to a certain extent above the class the society was originally intended to benefit, and who are able to pay ordinary medical fees for their attendance. The sums paid per head per annum for medical attendance are generally settled by the local lodge, and are not fixed by the central governing body, and they vary in amount from 3s. to 6s. At the last conference of the Friendly Societies it was admitted that these fees were in many places inadequate, and there seemed to be a general disposition to favor a minimum payment of 5s. per head per annum for adults. If medical men resolved to take no less payment than this not only for adults but for all members of the juvenile department they would probably soon succeed in getting the Friendly Societies to grant it. On the second point, the admission or retention of members who are able to pay better fees, the only suggested remedy has been that of a wage limit, and this the Friendly So-

cieties distinctly decline to discuss. A wage limit is by no means so easy a matter to fix as it looks.

The wages earned, perhaps, for many months of a year might exceed the limit, but in all trades there are large variations, and periods during which full time is made are followed by periods of depression, during which the men are only working two or three days in each week, so that to arrive at the rate of weekly wage the amount earned during the whole year would have to be taken into account and averaged. As the Friendly Societies are determined not to entertain the principle of a wage limit, it seems useless for the members of the medical profession to insist upon it. A compromise in the shape of a sliding scale, whereby the minimum rate of 5s. a year paid for medical attendance should be increased to men earning more than a fixed amount of wage, and in proportion to their wages might possibly have a chance of being accepted, as such a plan would only affect the medical fees, and not interfere with the admission to the society and the insurance of payments during illness.

Another form of provident society is often seen, where the employees of some large firm, either by themselves or aided by their employers, unite to form a club for relief in sickness and for providing medical aid. To these clubs no legitimate objection can be taken. There is no canvassing, the finances are controlled by a duly-appointed committee of workmen, and the management of them by this committee is generally excellent. There again arises the question of the capitation fees paid to the medical officer, and here also the minimum fee should not be less than 5s. a year for all employed—men, women, and juveniles. The custom of paying less for females and young persons is quite a wrong one, and unjust to the medical profession, as it is generally these who require the most medical attendance. The appointment of medical officer to these clubs is generally eagerly sought after. If the medical officer is paid entirely by the employers, they, of course, have the right to appoint whom they please, and if the medical officer is paid entirely from the contributions of the men, the same right should be conceded to them, and the appointment should be an annual one. As the men are seldom unanimous in their choice of a doctor, by far the best method is that a list of medical men should be agreed upon every year, and each workman should then make his selection of the doctor he wished to be under for that year. By this method much trouble would be saved to the profession, as such appointments are often the source of disputes between rival medical men.

Another class of clubs are the various provident dispensaries. These are either entirely self-supporting, maintained by charitable subscriptions, or composed of both these elements. They are the means by which medical attendance could be obtained, not only for

men but for women and children of all ages. Properly managed, they are not open to any serious objection, and as they do not exist for any object except for the one of providing medical attendance, they should certainly be restricted to those members of the working classes who are not able to pay ordinary medical fees. Unfortunately this is not always done, and the chief abuse in connection with these dispensaries is the fact that the admission of all classes of patients is permitted, and care is not taken to eliminate unsuitable cases. Admission should always be made subject to the approval of the medical staff. There should be no collectors or canvassers attached to these dispensaries, and the whole of the proceeds after the payment of expenses, provision of drugs, etc., should be allotted to the medical officers.

Insurance societies often have attached to their usual business a medical aid department; but as these societies employ canvassers and collectors, they should not be countenanced by the medical profession. Medical aid associations are open to the same objection, and to a further one, in that they generally pay their medical officers by salary, and retain their profits for their own use, or else they make such deductions from the capitation fees as will ensure a good profit. This practice may be defined as farming or exploiting medical men, and sometimes a very good income is made by doing it.

Private medical clubs are now very numerous, and they are in most cases absolutely unjustifiable on the ground that the worst form of canvassing is there made use of. If a doctor starts or maintains a practice by engaging a collector to canvass for patients for his private club, he is guilty in a far greater degree than is a medical aid association, because the doctor must know that such canvassing is unethical, whereas the question of ethics is never known or thought of by the associations referred to. Such clubs will undoubtedly soon be condemned by the General Medical Council, and it would be well if they were discontinued before any action is taken. A private medical club in which the contributions are paid at the surgery in a district where there is an unopposed practice, and where, therefore, the club can do no harm to any other medical man, is, of course, legitimate.

In conclusion, one may point out that there is no part of one's professional work which gives rise to so much worry as club practice, because of the fact that it is contract work; and however conscientious a doctor may be in his attendance, there will always be some grumbler who will believe that he is not getting the best of it. The glaring evils of club practice may be removed by combination and co-operation between the members of the profession; and there is ample evidence of the growth of a spirit of concord and a regard for ethics in the ranks of our profession which must in time be attended with good results.—*British Med. Journal.*

AGES AT WHICH DIFFERENT DISEASES STOP THE HUMAN MACHINERY.

CHANCES 6 TO 4 THAT CONSUMPTIVES WILL DIE BEFORE AGE FORTY-FIVE—56 CHANCES TO 44 THAT SUFFERERS FROM HEART DISEASE WILL REACH SIXTY—ODDS IN OTHER CASES—CURIOUS FACTS FROM THE MORTALITY RECORDS OF THE LARGEST LIFE INSURANCE COMPANY IN THE WORLD.

No records of "the natural shocks that flesh is heir to" are kept more scientifically than the data which the life insurance companies accumulate from their own experience. The cause of every death among policyholders is investigated with the utmost care by the medical directors of the company interested. Thousands of physicians, selected for their skill, are attached to the medical departments of the great American life insurance offices. In every community of consequence the companies have physicians on guard to examine into the physical condition of applicants for insurance and to investigate causes of death when called upon to do so.

The Mutual Life Insurance Company of New York, the oldest and largest of the American companies, in fact the largest life insurance company in the world, has prepared some interesting statistics showing the causes of the deaths among its policyholders from the commencement of its business in 1843 to the end of the year 1898, a period of 56 years. The first year only three policyholders died; in 1898 the deaths numbered 3,421. In the 56 years, 46,525 deaths passed under review, from a total of more than 1,000,000 individuals on whom insurance had been written.

As might be expected, the mortality experience of the Mutual Life is a vast storehouse of scientific as well as curious facts. The scientific things may be left for the scientists to study. Popular interest will centre in the things that everybody can understand.

For example, at what ages do certain diseases carry off their victims? That is something that the good citizen who has "sympoms" would like to know.

The Mutual Life's figures can tell nothing of individual cases, of course, but of average or typical cases they tell everything, and here are some of the revelations as interpreted by *The Insurance Press*.

If a person is to die of consumption, the Mutual Life's records show the chances are about 6 to 4 that he will die under age forty-five. Deaths from consumption are divided as follows, by ages: Under forty-five, 59 per cent.; forty-five to sixty, 29 per cent.; above 60, 12 per cent.

If a person is to die of other general diseases, smallpox, measles, diphtheria, erysipelas, cancer, diabetes, etc. (which cause in the aggregate nearly one-eighth of all the deaths), the chances that he will die under age forty-five, between forty-five and sixty, or above sixty, do not differ widely. Thirty per cent. of the deaths from these diseases occur under age forty-five, 36 per cent. between forty-five and sixty, and 34 per cent. above sixty.

If a person is to die of apoplexy, softening of the brain, paralysis, etc., the chances are 55 to 45 that he will live to be sixty or more. Only 12 per cent. of the deaths from these diseases occur under forty-five years; 33 per cent. occur between ages forty-five and sixty; 55 per cent. occur above age sixty.

If a person is to die from some other nervous disease besides apoplexy, paralysis, etc., he will probably pass away before he is sixty. Thirty-five per cent. of the deaths from these causes take place under age forty-five; 38 per cent. between ages forty-five and sixty; 27 per cent. above age sixty.

If a person is to die of heart disease the chances are 56 to 44 that his heart will perform its allotted task until he is sixty. Thus, according to the Mutual Life Insurance Company, he may expect to live to become gray-headed or bald-headed. Not more than 11 per cent. of the deaths from heart disease occur under age forty-five; 33 per cent. between forty-five and sixty; 56 per cent. above sixty.

If a person is to die of pneumonia the chances are 64 to 36 that he will not reach sixty. Twenty-nine per cent. of the deaths from pneumonia occur under forty-five; 35 per cent. between forty-five and sixty, and 36 per cent. above sixty. Other respiratory diseases, such as bronchitis, pleurisy, etc., grant a little longer lease of life. From such causes the deaths under forty-five are 24 per cent.; between forty-five and sixty, 30 per cent.; above sixty, 46 per cent.

If a person is to die of some derangement of the digestive system, the chances are more than two to one that he will not live to be sixty. Thirty per cent. of the deaths from diseases of this class occur during age forty-five; 38 per cent. between ages forty-five and sixty, and 32 per cent. above age sixty.

If a person is to die of Bright's disease he has a fair chance of reaching sixty. Only 16 in 100 of the victims of Bright's disease die under forty-five; 37 in 100 die between forty-five and sixty; the remaining 47 per cent. die after completing threescore years. Other complaints, classified as genito-urinary, are old-age diseases, 77 per cent. of the deaths from such causes occurring at ages above sixty.

If a person is to die from accidental or violent causes, the chances are 86 to 14 that he will not see sixty. Fifty per cent. of the deaths from violent causes occur under forty-five.

If a person is to die from some obscure, ill-defined or unclassified disease, he has 62 chances in 100 of reaching sixty. Human bodies that have been subjected to the wear and tear of threescore years or more are most subject to the kind of break-downs that puzzle the doctors.

If a person is to die of typhoid fever, his summons will probably come before he reaches forty-five. Fully 68 per cent. of the typhoid fever deaths occur under forty-five; another 23 per cent. between ages forty-five and sixty, the remaining 9 per cent. at higher ages.

PERCENTAGE OF DEATHS, BY AGES FROM FAMILIAR DISEASES, AS SHOWN BY FIFTY-SIX YEARS' EXPERIENCE OF THE MUTUAL LIFE INSURANCE COMPANY OF NEW YORK.

	Per cent. Under 45.	Per cent. 45 to 60.	Per cent. Above 60.
Consumption.....	59	29	12
Other general diseases.....	30	36	34
Apoplexy, paralysis, softening of brain, etc.	12	33	55
Other nervous diseases.....	35	38	27
Heart disease.....	11	33	56
Pneumonia	29	35	36
Other respiratory diseases.....	24	30	46
Digestive diseases	30	38	32
Bright's disease.....	16	37	47
Other genito-urinary diseases	77
Unclassified and ill-defined.....	14	23½	62½
Typhoid fever.....	68	23	9

The data given above relate to all lives, without regard to sex. The essential differences between the sexes in the mortality tables result from the accidents and diseases due to the function of maternity.

Among causes of mortality common to both sexes the widest differences are found in the number of deaths from cancer and from violent causes. The latter causes are far more fatal among males than females. On the other hand, the cancer death-rate among females is much greater than among males.—*Insurance Press*, New York.

A NEW METHOD TO FURTHER THE FLOW OF THE BILE.

BY DR. BLUM, FRANKFORT O. M.

ON a former occasion I gave an account of the various results of my investigations respecting the influence of sebacie salts (soaps) on the secretion of the bile, and I also mentioned that of all soaps oleate of sodium has the greatest effect on the action of the liver. I will not here go into details comparing the results of my various trials made in the course of my researches respecting the in-

fluence of oils and fats on the gall secretion. I wish, however, to state that with dogs oleate of sodium is able to produce bile-flow, and to increase it fourfold in cases of complete or incomplete fistula growing outward from the gall-bladder, if introduced into the stomach in doses of 32 to 80 grains either dissolved or undissolved, and with or without ligature of the ductus choledochus. This result is not caused by any irritation of the mucous membrane of the intestinal canal, and the thereby increased peristaltic action, as even a subcutaneous application of 16 to 32 grs. of oleate of sodium dissolved in water increases the flow of the bile.

Under these circumstances we are justified in the conclusion that the soap in reaching the liver produces a heightened activity of this organ. As a further conclusion we may presume that the oleate of sodium is partly absorbed back into the gall, and with the latter flows into the bowels; there is, however, so far no analytical confirmation of this assumption.

I have not been able to notice any irritations of the urethral organs or the bowels either on administration by the mouth or by subcutaneous injections; there was only an increase of the bile-flow.

Under these circumstances I thought a therapeutic use of oleate of sodium as a cholagogue quite possible and well worth a trial.

Oleate of sodium, as sold in the ordinary trade, and as used for technical purposes, is a most impure preparation; even the so-called pure oleate of sodium does not answer as a medicament. I therefore applied to Messrs. Zimmer & Co., of Frankfort O. M., and induced them to prepare me a chemically pure oleate of sodium. This product, a white substance, melting at a low temperature, has no longer the unpleasant rancid taste; it is easy to take and causes no disturbing after-effects.

To this new preparation Messrs. Zimmer & Co. have given the name of Eumatrol to distinguish it from those already in use; it is made into pills of 4 grains of Eumatrol with a chocolate coating.

I used to give the oleate of sodium in gelatine capsules but now prescribe the pills. There is no doubt as to the indications of cholagogues in a great many bilious complaints; of these medicines there is, however, great scarcity.

Stadelmann, in a lecture at the Berlin Medical Society (*vide Berliner Klinische Wochenschrift*, 8196, No. 9 u. 10) was only able to cite salicylate of sodium and the choleinates as certain cholagogues. Oleate of sodium has, however, decided advantages over these; it influences the bile-flow rather more strongly, and can, in the form of Eumatrol pills, be taken for months without the slightest injurious or unpleasant effect on the intestinal canal or the general condition of the patient. I have had very satis-

factory results with persons with whom an increased secretion of the gall had to be produced, by administration of two doses of 16 grains of Eumatrol per day. All these were people taken ill with cholelithiasis; I prescribed the pills, partly immediately after an attack of colic and partly after the diagnosis had been positively established. I need not mention that the treatment with morphia, proper diet, and the regulation of the stool, were not at the same time neglected. To promote the alvine discharge I generally combined an oil clyster treatment with the administration of the pills; from the clyster one may always expect a certain beneficial effect in cases of gall-stone colic, an effect produced on one hand by the removal of the constipation, on the other, very probably, by the presence of oleate of sodium in the intestinal canal, caused by the saponification of the oil.

I will not enter into the question whether and in how far cholagogues are indicated in cases of gall-stone complaints; a difference would also have to be made between a single acute increase of the bile-flow and a heightened secretion extending over a period of some duration. I have only endeavored to attain the last-mentioned form of influencing the liver, by a continued administration of Eumatrol, and there has never been ill-success so far as no patient ever felt worse after the treatment with Eumatrol than he did before; by far the greater number benefited greatly by it; the attacks become less vigorous and less frequent, the dull pain in intervals grew less acute or disappeared altogether.

Naturally, from observations extending over a period not longer than twelve months, it is not possible to speak of a definite cure of so changeable a complaint as cholelithiasis; when, however, the application of a medicine causes the cessation of attacks, which used to set in with a certain regularity, and, furthermore, a freedom from all the symptoms to which the patient had been subjected, there is no doubt as to the capability of the medicament to produce a beneficial effect. Personally I have obtained good results with Eumatrol, and I consider the medicine well worth a trial in cases of cholelithiasis. No disappointment need be feared as regards the power of Eumatrol to further bile flow. I have also often observed the excretion of fairly large quantities of gravel and small stones.

The pills are best taken : four in the morning, four at night, after meals.

Gift of Osborne House.—King Edward has signalized his coronation by the gift to the nation of Osborne House, one of the favorite residences of Queen Victoria. In the letter announcing the gift the King expresses the hope that the palace may be devoted to national purposes and be converted into a convalescent home for Officers of the navy and army whose health has been impaired in rendering service to their country.

The Canadian Journal of Medicine and Surgery

J. J. CASSIDY, M.D.,

Editor,

69 BLOOR STREET EAST, TORONTO.

W. A. YOUNG, M.D., L.R.C.P.Lond.,

GENERAL MANAGER,

145 COLLEGE STREET, TORONTO.

Surgery—FRUCE L. BORDAN, M.D., C.M., McGill University, M.D., University of Toronto; Surgeon Toronto General Hospital; Surgeon Grand Trunk R.R.; Consulting Surgeon Toronto Home for Incurables; Pension Examiner United States Government; and F. N. G. STARR, M.D., Toronto, Associate Professor of Clinical Surgery, Lecturer and Demonstrator in Anatomy, Toronto University; Surgeon to the Out-Patient Department Toronto General Hospital and Hospital for Sick Children.

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Medicine—J. J. CASSIDY, M.D., Toronto, Member Ontario Provincial Board of Health; Consulting Surgeon, Toronto General Hospital; and W. J. WILSON, M.D., Toronto, Physician Toronto Western Hospital.

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Mental Diseases—EZRA H. STAFFORD, M.D., Toronto, and N. H. BEEMER, M.D., Mimlen Insane Asylum.

Public Health and Hygiene—J. J. CASSIDY, M.D., Toronto Member Ontario Provincial Board of Health; Consulting Surgeon Toronto General Hospital; and E. H. ADAMS, M.D., Toronto.

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Pediatrics—AUGUSTA STOWE GULLEN, M.D., Toronto, Professor of Diseases of Children Woman's Medical College, Toronto.

Pathology—W. H. PEPLER, M.D., C.M., Trinity University; Pathologist Hospital for Sick Children, Toronto; Demonstrator of Pathology Trinity Medical College; Physician to Out-door Department Toronto General Hospital; Surgeon Canadian Pacific R.R., Toronto; and J. J. MACKENZIE, B.A., M.B., Professor of Pathology and Bacteriology, Toronto University Medical Faculty.

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Laryngology and Rhinology—J. D. THORBURN, M.D., Toronto, Laryngologist and Rhinologist, Toronto General Hospital.

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Advertisements, to insure insertion in the issue of any month, should be sent not later than the tenth of the preceding month.

VOL. XII.

TORONTO, SEPTEMBER, 1902.

NO. 3.

Editorials.

ABNORMAL MEMORY IN DELIRIUM.

In the *Lancet*, London, July 14th, 1902, Dr. Henry Freeborn recounts a case of abnormal memory in delirium. The patient was a woman of seventy years who had broncho-pneumonia. "Becoming delirious, on the night of March 13th and on the 14th, 1902, she was found to be speaking in a language unknown to those about her. It sounded as if she was repeating some poetry sometimes, or carrying on a conversation at others. She repeated the same poem time after time. The language was found to be Hindustani. On the 14th, in the evening, the Hindustani began to be mixed with English,

and she spoke to, and of, friends of a later date in English, French and German. The patient was born in India, which country she left at the age of three years, and landed in England, after a five months' voyage, before she was four years old. Up to the time she landed she had been under the care of Indian servants, and spoke no English at all, her only language being Hindustani. On her coming to England the ayah was sent back, and she then began to learn English, and from that time had never spoken Hindustani. She apparently, on the 13th, went back in her delirium to her very earliest days, when she spoke again the first language she ever heard. The poem was found to be something which the ayahs are in the habit of repeating to their children, and the conversations were apparently with the native servants, one being recognized as a request that she might be taken to the bazaar to buy sweets. Through the whole delirium there could be recognized a sequence. 'As time went on, the friends she spoke of were of later date, and she took events in their proper order. She apparently began at the beginning of her life, and went through it, until on March 16th she had reached the time when she was married and had her children growing up—boy and girl.'

Dr. C. A. Mercier, who comments on this case in the same number of the *Lancet*, finds that the delirium from which this patient suffered, produced in her memory a condition similar to that which obtains in certain cases of senile insanity. Her whole personality was transported back to her early years, and she lived over again the life of her childhood. She spoke of, and to, friends and relatives of her girlhood; she asked that she might be taken to the bazaar to buy sweets.

In senile insanity Dr. Mercier says the memory of recent events is lacking, but there is an excess of memories derived from long-past experience. It seems, he says, as if structural memories were laid down in the nervous system in strata, the memory of each successive experience overlying the memories of previous experiences; and as if in senile loss of memory, the removal of the upper layers allowed of an over-activity of those that remain. Dr. Mercier says that this hypothesis of the stratification of memories is not put forward as an illuminating one, but simply for what it is worth, as in this very obscure region even a glimmer of light is grateful.

That an old person should recall circumstances which occurred in her life at four years of age is not an unusual occurrence.

Many conscious persons can recollect, by an effort of the will, events or conversations, not always of importance, which occurred in their early childhood. Such a person may also be blessed with a fairly good recollection of more recent events, and as long as the nexus remains intact, applying to the recent as well as the more distant events in life's history, the identity of the individual is recognized by himself. As Reid says, "I cannot remember a thing that happened a year ago without a conviction . . . that I, the same identical person who now remember that event, did then exist." And this personal sense of identity is, doubtless, a strong proof of an individual's sanity—that his mind is *totus teres atque rotundus*. It must be acknowledged, however, that conscious recollections of long-past events tend to become imperfect as age advances, resembling pictures that have become dim with age.

It is said, also, that persons threatened with imminent death experience a search-light illumination of the past, and it is quite likely that much of the incapacity of the memory in ordinary persons may be due to mental sluggishness. Perhaps, also, in the struggle for existence, the conscious, sane individual concentrates his mental powers on the questions cropping out of his every-day life, making but scant effort to recall his past. It would seem, in fact, that all minds—ordinary and extraordinary—receive an excess of images, sounds and other sense impressions, and that while some of these remain adherent to the tablets of memory, to be recalled by efforts of the will, the greater number are allowed to pass into seeming oblivion. The interesting part of the story is that, though forgotten, they are not dead.

One difference between Dr. Freeborn's patient and a senile dement is that the former reviewed the stages of her life (strata of memory) in orderly succession, emerging from her delirium into sanity at a stage of her history corresponding to her real age and actual state.

A senile dement, however, retains his identity as far as certain events in the distant past of his history go, but whole sheets are worn out of the book of his adult and senile life; or, if they remain available (and they may), he lacks the power to throw them on the canvas. Moreover, in the delirious patient the brief time devoted to the operation necessarily prevented an extensive dramatization of her child life. She doubtless reproduced some sense impressions as faithfully as though they had been given back from a phonograph; but in fulness of detail and in the number of the incidents

recorded, a senile dement's efforts are greater, inasmuch as he can devote years to the work which the delirious patient had to compress into a few days.

A third difference is that the delirious patient merely acted as a phonograph in reproducing the nursery songs and chit-chat of sixty-six years ago. A senile dement can do more—he can live in the same house with his nearest relatives, and by his conversation show that he fails to recognize the ties of relationship, all of which is logical on his part, inasmuch as he is mentally living amid the scenes which he inhabited eighty years before, when he had neither wife nor child.

J. J. C.

THE ELECTRIC ENEMA.

THE treatment of patients suffering from atonic stasis of feces by electrical currents (faradic or galvanic) is, if we are to judge by the literature of this subject, very satisfactory. Cases of obstinate constipation are recorded by Erb, showing that when purgatives and ordinary enemata had proved of no avail, the use of the faradic current to the patient's abdomen resulted in the production of copious fecal evacuation. In very difficult cases Erb used an olive-shaped metallic electrode, insulated to the tip, which he introduced two or three inches into the rectum of the patient. This is said to give rise to no sensation, or, at the most, to a slight feeling of pricking and burning, if the cathode is introduced. He says, further, "it is advisable to change the direction of the current several times, in order to allow the cathode which is the more vigorous excitant, to act occasionally upon the rectum. The active contraction of the abdominal muscles should be the measure of the strength of the current; the duration of the sitting varies from three to ten minutes."

In an article which appeared in *La Presse Medicale*, July 5th, 1902, A. Zimmern gives a brief historical review of the applications of electricity in the treatment of obstinate constipation and ileus, and also a detailed account of the electric enema. In explanation of the meaning of this term it may be stated that the galvanic current has been successfully applied in the treatment of cases of constipation, in which the faradic current had failed to give relief. But the galvanic method is not without its perils. As an indication of the inconveniences and even dangers met with in

using the galvanic current in the rectum, Erb says: "If the galvanic current is employed (in the rectum) prolonged closure of the circuit should be avoided, in order to prevent the formation of eschars; repeated changes of polarity should be made with a very short period of closure of the circuit." The caution given by Erb will go to show the motives which induced Boudet, of Paris, who, in cases of intestinal occlusion preferred the galvanic to the faradic current, to introduce an original method of treating such cases, possessing the advantages of the continued current without the risk of causing eschars in the patient's rectum. This method he called "the electric enema." The instruments required in giving the electric enema are: 1, an irrigator large enough to hold two or three quarts of water; 2, a galvanic battery capable of giving a current of at least forty milliamperes; 3, two conducting cords to connect the battery with the patient; 4, an abdominal electrode made of copper or block tin, covered with felt, spongopiline, or, more simply, with several thicknesses of absorbent cotton retained by fine muslin; 5, Boudet's rectal electrode. The latter instrument consists of a hollow metal tube slightly flexible, of about $7\frac{3}{4}$ to $9\frac{3}{4}$ inches in length, covered with hard rubber or ebonite. The hard rubber cover should extend about a half-inch beyond the intra-rectal opening in the metal tube, so that when in use the latter may not come in contact with the rectal mucous membrane. The intra-rectal end of the metal tube is pierced with a hole, so that when connected with the irrigator, it allows water to flow into the rectum. The outer end of the electrode is connected, by a piece of rubber tubing armed with a tap, to the irrigator, and also carries a binding post on the outside for the insertion of a conducting cord to the battery (The Krouse rectal electrode which appears in the catalogues of American instrument makers, resembles the Boudet electrode and is used for a similar purpose.)

The patient is placed on a sofa or bed, in the dorsal position, with the head unsupported by a pillow and the pelvis slightly raised. The irrigator filled with lukewarm, boiled water, saturated with common salt, is placed at a height of about 2 ft. 6 in. above the level of the patient. The Boudet electrode, previously asepticated, is connected with the irrigator, the tap from which is turned off. The operator introduces the Boudet electrode as deeply as possible into the patient's rectum, carefully following its curves.

Obstacles are occasionally met with in passing the electrode.

For instance, the rectal ampulla may be abnormally dilated, and the true route through it may be hard to find, or a protruding portion of gut, forced there by the pressure of the intestinal mass which is distended with gases, may offer resistance. When the electrode has been introduced, it should be held with one hand. With the other hand the tap on the rubber tube of the irrigator is gently turned on so as to allow the salt water to penetrate very slowly into the intestine. A too rapid flow might irritate the rectum and cause the expulsion of the electrode and the water.

When from 8 to 16 oz. of water have entered the patient's intestine, an abdominal electrode 8 inches in diameter is placed over the abdomen.

The second step in the operation consists in starting the electrical current. The positive pole is connected with the rectal electrode, and the negative pole with the abdominal electrode.

The current should be raised progressively to 10, 20, 30, 40 and 50 milliamperes. During the whole sitting the tap of the irrigator should remain half open, so that the water may enter slowly into the patient's rectum. The perforated end of the rectal electrode is thus immersed in a fluid; the electrical current passes out through the hole in the intra-rectal end of the electrode with the water, and thereby reaches the rectal mucous membrane. The advantages of this electrode are, first, that the metal end does not come into direct contact with the gut, and, therefore, cannot injure its mucous membrane by the electrolytic action, and, second, a much more powerful current may be used without fear of injury as there is always a layer of water between the electrode and the gut. The instrument can also be taken apart and cleaned.

Regarding the question of diagnosis in cases of intestinal occlusion, Erb's opinion is worthy of note. He shows that it is difficult to differentiate occlusion of the intestines by atonic stasis of feces from other varieties of occlusion of the intestines (from invagination, internal strangulation, volvulus, etc.); but thinks that the previous constipation, the demonstration of large masses of feces, the prolonged absence of fever, perhaps previous similar conditions, may render the diagnosis easier.

He adds: "Moreover, electrical excitation of the intestines in the other forms of occlusion would not produce any notably bad effects, and need be omitted only when peritonitis is distinctly developed; indeed, Curci recommends electricity as a differential diagnostic measure in occlusion of the intestines from obscure

causes. If improvement does not occur after one or two sittings, we may assume a mechanical obstruction."

At the present time the galvanic current, applied as Zimmern directs, is the classical method of treating intestinal occlusions when electrical methods suffice.

J. J. C.

CANADIAN MEDICAL ASSOCIATION.

INTENDING delegates to the thirty-fifth annual meeting of the Canadian Medical Association, to be held in Montreal on the 16th, 17th and 18th of September, should take note of the following additional information issued from the Transportation Department. Owing to a clerical error relating to points east of Montreal, the announcement should have read:—If ten (10) or more delegates are in attendance from Quebec City, Megantic and east thereof, holding Standard Convention Certificates, delegates from such points will be issued tickets (free) for return.

A side trip *via* the Richelieu and Ontario Navigation Co. has been arranged for to Quebec City from Montreal, at \$4 for the round trip.

The time limit for delegates attending from points west of Fort William has been extended to the 12th of October, permitting delegates from the West to arrive home by that date.

Delegates may go and return by the Richelieu and Ontario steamers, in the usual way, by asking for that route, and obtaining a Standard Convention Certificate.

The Entertainment Committee, of which Dr. H. S. Birkett is chairman, has arranged the following programme:—Tuesday, a garden party; Wednesday, the Grand Trunk Railway has invited the members of the Association to inspect the Victoria Bridge, and will take them to Lachine, where a lunch will be served; in the evening there will be a smoking concert in the Victoria Rifles' Armoury.

PROVISIONAL PROGRAMME.

The General Meetings and Evening Addresses will be held in No. 111 Lecture Room, Medical Faculty, McGill University. The sections will meet in other lecture rooms of the same building.

FIRST DAY.

- 9.30 a.m.—General Meeting: Proposal of Members, Notices of Motions etc., Striking of Committees.
10.30 a.m.—Meetings of Sections.

SURGICAL SECTION.

- Paper by A. Primrose, Toronto—Filariasis cured by operation.
 “ Dr. Perry Goldsmith, Belleville—Hemorrhage in Removal of Adenoids and Tonsils.
 “ H. D. Hamilton, Montreal—Complete Occlusion of Posterior Naris.

MEDICAL SECTION.

- Paper by John Hunter, Toronto—Pleurisy as associated with Tuberculosis.
 “ A. E. Orr, Montreal—On Blood Pressure.
 “ G. A. Charlton, Montreal—Anemia due to Toxins.
 “ Dr. J. R. Clouston, Huntingdon—The Country Doctor of To-day.
 2.00 p.m.—General Meeting: Proposal of Members, etc. followed at
 3.00 p.m.—by Address in Surgery by John Stewart, of Halifax, N.S.
 5.00 p.m.—Garden Party at the Residence of Mr. Jas. Ross, Peel St.
 8.15 p.m.—President's Address, followed by Lantern Demonstration on the Exanthemata, by Dr. Corlett, of Cleveland, Ohio.

SECOND DAY.

- 8.00 a.m.—Exhibition of Cases at the different hospitals.
 Montreal General Hospital: Surgical Cases.
 Royal Victoria Hospital: Medical Cases.
 Hotel Dieu: Medical Cases.
 Notre Dame Hospital: Surgical Cases.
 9.30 a.m.—General Meeting: followed by a discussion on “Diseases of the Gall Bladder and Bile Ducts”
 (a) Medical Diagnosis—Introduced by Dr. A. McPhedran, Toronto.
 (b) Medical Treatment—Introduced by Dr. A. D. Blackader, Montreal.
 (c) Surgical Diagnosis—Introduced by Dr. Jas. Bell, Montreal.
 (d) Surgical Treatment—Introduced by Dr. J. F. W. Ross, Toronto, followed by Dr. G. E. Armstrong, Montreal.

2.00 p.m. MEDICAL SECTION.

- Paper by Dr. J. F. Macdonald, Hopewell, N.S.—On Tuberculosis.
 “ Drs. Starr and McKenzie, Toronto—Multiple Sarcoma.
 “ Dr. Maude E. Abbott, Montreal—Methods of Classification in Medical Museums.
 “ A. D. Shirres, Montreal—Degeneration of Spinal Cord in Anemias, etc.

SURGICAL SECTION.

- Paper by G. A. Peters, Toronto—A New Symptom of Intestinal Paralysis in Peritonitis
 “ Dr. Ferguson, Chicago—Removal of Prostate by Perineal Incision.
 “ G. E. Armstrong, Montreal—Treatment of Prostatic Hypertrophy by Suprapubic Incision.
 “ Dr. J. O. Orr, Toronto—Artificial Astigmatism.
 “ Dr. Burnham, Toronto—Sympathetic Ophthalmia.
 “ Dr. Monod, Montreal.
 “ Dr. A. E. Garrow, Montreal.

OBSTETRIC AND GYNECOLOGIC SECTION.

Paper by Dr. Robinson, Ottawa—Normal Labor.

“ Dr. Laphorn Smith, Montreal.

“ Dr. Lockhart, Montreal.

“ Dr. Chipman, Montreal.

8.15 p m.—Address in Medicine by Dr. Wm. Osler, Baltimore, followed by Reception in Engineering Building at 9 o'clock.

THIRD DAY.

8.00 a.m.—Exhibition of Cases at the different hospitals :

Montreal General Hospital : Medical Cases.

Royal Victoria Hospital : Surgical Cases.

Hotel Dieu : Surgical Cases.

Notre Dame Hospital : Medical Cases.

9.30 a.m.—General Meeting : Reception of Reports from Committees.

General Business.

10.30 a.m.

Paper by Dr. Robinson, New York—X-Ray Treatment of Cancer.

“ Dr. Girdwood, Montreal—X-Ray as Diagnostic and Curative.

“ W. F. Hamilton, Montreal—X-Ray as Diagnostic Agent in Thoracic Diseases.

“ S. F. Wilson, Montreal—On the Use of High Potentials in X-Ray Work.

The afternoon will be given over to an excursion by rail over Victoria Bridge and thence to Lachine (through the courtesy of the Grand Trunk Railway). From here the Steamer *Duchess of York* will make the trip up Lake St. Louis and run the Lachine Rapids, arriving in the city about 5.30 p.m. (Lunch on board Steamer.) At 8.30 a “Smoker” will be given in the Victoria Rifles' Armoury, Cathcart Street.

Any further information may be secured by applying to the Local Secretary, Dr. C. F. Martin, 33 Durocher St.; Dr. J. Alex. Hutchison, Chairman of the Transportation Committee, 70 McKay St., Montreal; or to George Elliott, General Secretary, 129 John St., Toronto.

EDITORIAL NOTES.

Treatment of Thrush (Muguet) by Applications of Strong Solutions of Nitrate of Silver.—Certain cases of thrush in babies resist the employment of alkaline lotions, and the glycerine of borax. Dr. G. E. Vladimirov, a member of the extern consulting staff of St. Vladimir's Hospital for Sick Children, Moscow, Russia, after failing to cure severe thrush with the usual remedies, has been prescribing, for the last two years, the application of

2 per cent. solutions of nitrate of silver in such cases. The surgeon first detaches the milk-white elevations of thrush from the tongue and the mucous surface of the cheeks of the patient, by means of pieces of dry cotton wool, or lint. As these elevations are occasionally very adherent, their removal may cause a little hemorrhage, which should be checked by pressure with a plug of cotton wool. After all the milk-white elevations have been removed, the infant is placed on its side and a solution of chloride of sodium is applied to its buccal cavity, in order to neutralize the excess of the silver salt, which is next applied. To prevent movements of suction on the part of the infant, its jaws are separated by the fingers of an assistant, or by the use of a tongue depressor. After the solution of nitrate of silver has been used, the buccal cavity of the infant assumes a whitish color, which enables the surgeon to discover if all the diseased surfaces have been touched. One application a day of this treatment is sufficient. In Dr. Vladimirov's experience, from one to three treatments of this sort suffice to effect a complete cure of thrush.

The Causes of Death in Diphtheria.—In a paper read before the Society of Pediatrics, Paris, June 17th, 1902, Drs. Barbier and Alquier reported on causes of death in diphtheria from autopsies which they had made on the bodies of forty-five children, who succumbed at different stages of the disease. The most frequent cause of death was cardiac thrombosis, which was found in 50 per cent. of the cases, the thrombus almost always being in the right side of the heart. A bacteriological examination of the blood clot was made in twelve cases, and yielded a negative result in four cases; the bacillus diphtheriæ was found in four cases; the streptococcus alone in two cases; the staphylococcus alone in one case; the streptococcus and the bacillus diphtheriæ in one case. Cardiac thrombosis appears to be frequent in severe forms of diphtheria (associated forms or simple ones). It appears during convalescence, nine to fifteen days after the disappearance of the false membranes. The patient dies suddenly, death being sometimes preceded by pallor of the face, cyanosis, agitation and great distress. A remarkable find in the *post-mortems* was the high percentage of latent tuberculosis. Tubercular lesions were found in eighteen cases (40 per cent.). In 25 per cent. there were recent tubercular attacks developed under the influence of diphtheria. But although the tuberculosis got worse under the influence of

diphtheria, it did not originate cardiac thrombosis, for the latter coexisted with tuberculosis in only four cases.

A Contribution to the Study of Gonorrhoea in Women.—Dr. Etesse, in a recently published thesis, studies the effects of the infection of Skene's glands with the gonococcus in causing chronicity of gonorrhoea in the female patient. These glands, which are regarded as homologues of the seminal vesicles, are found on each side of and below the vulvar segment of the female urethra, their orifices opening right and left, one-tenth to two-tenths of an inch inside the free border of the meatus urinarius. They are almost as frequently infected with the gonorrhoeal virus as the glands of Bartholin. The infection of these glands may happen primarily, but generally it is caused by the gonorrhoeal discharge bathing the parts around the meatus urinarius in cases of urethritis in the female. The disease is generally chronic, rarely acute, and causes no subjective symptoms, so that the surgeon must seek for it as his attention will not be called to it by the patient. Once ensconced in Skene's glands the gonococcus may cause repeated infections of the patient's urethra, as well as proving the occasion of numerous attacks of gonorrhoea among her male visitors. In Dr. Etesse's opinion the only efficacious treatment is destruction of the glands of Skene in the patient by the use of the galvano-cautery, as ordinary topical treatment yields only uncertain results.

Intestinal Obstruction successfully treated by the Administration of a large Dose of Metallic Mercury.—McKean Harrison reports in the *British Medical Journal*, April 26th, 1902, two cases of acute intestinal obstruction treated by the administration of half a pound of metallic mercury. His first patient was a man of sixty, who had been suffering from intestinal obstruction for eight days. A few hours after he had swallowed the mercury a considerable improvement was noticed in his general condition, and twenty-four hours afterwards he passed a large stool. In his second case, a man of eighty, a similar result was obtained, only that the symptoms were more alarming and the effect of the mercury more rapid, the first stool being voided a few hours after the mercury had been taken. No signs of ptyalism or pain were observed in either case. The mercury was passed per rectum nine or ten days after it had been taken. Watson (*Practice of Physic*) mentions that in a case in which half a pound of quicksilver had been administered, two ounces and a half of the metal were voided

unchanged five weeks afterwards. He does not favor this procedure, however, giving as reasons that the obstacle may be in an ascending coil of intestine, and that it has often done mischief and seldom or never done any good.

Estimation of the Capillary Circulation of the Skin.—Drs. Hallion and Laignel-Lavastine have presented to the Society of Biology, Paris, June 21st, a report embodying their observations on the production of the white spot—mechanical anemia of the skin—by the use of slight pressure. Their subjects were examined when in the recumbent posture, the temperature of the atmosphere being $62\frac{3}{4}$ degs. F., and the pressure applied with the thumb for three seconds in the first interosseous space, dorsal surface. In aged subjects, those having arterio-sclerosis, Raynaud's disease, malignant asthenia, the duration of the white spot was considerably lengthened. In others having fevers, pneumonia, typhoid fever, Basedow's disease, erythromelalgia, its duration was shortened. The pulse in the fingers was studied comparatively by the use of Halion-Comte's digital plethysphygmograph. The authors state that the results obtained by the latter method were such as, for theoretical reasons, might have been expected, and coincided with the activity of the capillary circulation.

Value of Alcohol in the Disinfection of the Hands.—In an article which appears in *Berlin. Klin. Wochenschr.*, Schaeffer recommends the following method of disinfecting the hands: Energetic washing and rubbing of the hands for five minutes with soft soap, in water as hot as can be borne; scrubbing of the nails; drying of the hands with a hot, sterile compress, vigorously applied to the epiderm; washing and brushing from three to five minutes in strong alcohol; rinsing in an aseptic liquid (sterilized water, or better, a 1 per cent. aqueous solution of mercuric chloride).

Mortality among German Military and Naval Officers.—The military life insurance company, in which all the officers of the German army and navy are insured, has just published an interesting table, showing the mortality among these classes. In 1901, the mean age at death was 46 years and 6 months. Of 297 deaths among officers, 42 died a violent death, 29 suicided, 4 were assassinated, 9 died from accidents. The greater part of the remaining deaths were due to nervous diseases or to tuberculosis. J. J. C.

The Weather.—The newspapers certainly seem to have kept in type this season, under the caption of weather probabilities, the

word "thunderstorms." To the peculiar position in relation to each other of several of the planets, astronomers tell us, is largely due the unusual number of electrical storms by which we have been visited, in all their violence and consequent destructfulness this summer. Anxious to learn the number of deaths occasioned by lightning in Ontario during recent years, the latest information that could be obtained was a report for 1900, which shows that not a single death occurred that year (in Ontario) directly as the consequence of persons being struck by lightning. The statistics for 1901-2 are as yet incomplete. Surely we may be pardoned for referring to that forbidden subject—the weather, when the *Literary Digest* inserts in a recent issue a very amusing cartoon representing Morgan sitting in an aereobile, upon the side of which is inscribed: "Spot cash for old and second-hand industries." Below, on the roof of his house, which is floating away, so great has been the rainstorm, with his family, little Johnnie and the cat, sits the farmer, who remarks as he gazes skyward, "Pierpont, now's your chance to organize a *rain* trust and curtail production."

Attracted by Morbid Curiosity.—Would that the days of capital punishment were at an end, not that those compelled to suffer do not deserve their fate, and the ends of justice seem best served, perhaps, in this decisive and final way! Those called upon to perform the duties connected with "a hanging," the form in which capital punishment is administered at present in Canada, are certainly a class by themselves; those who form the spectators, present either out of curiosity, for scientific purposes, or reporting for the daily newspapers are surely ever after haunted by the memory of that awful sight, or are hardened and rendered a shade less finely discriminative in their taste in the selection of experiences. As for the newspapers, in the name of common decency, why print such horrors, giving to a gaping public every nauseating detail of the affair, with photo of the criminal inserted between the paragraphs? The contemplation of a human being suspended twixt heaven and earth is not an ennobling pastime. Why detain the moment?

The Passing of the Beard.—"He that hath a beard is more than a youth; he that hath no beard is less than a man," said one of Shakespeare's fair women; but in this century, when kisses are said to be microbe-transferring agents, need we marvel that the powers that be, in the shape of the German Emperor, has decreed

that those among his lieges who practice medicine and surgery shall cut off their beards? A writer in the *British Medical Journal* says: "So sweeping an order sounds rather improbable, even as coming from a potentate whose motto is *Summa lex regis voluntas*. But the German Emperor, like the Prophet Habakkuk, is capable of anything when he is bitten by an idea."

W. A. Y.

PERSONALS.

DR. D. J. GIBB WISHART spent the month of August on his island at the Madawaska Club, Go-Home Bay.

WE are authorized by Dr. A. M. Rosebrugh to state that, hereafter, he purposes devoting himself more exclusively to the medical treatment of alcoholism, and more especially to the home-treatment of the milder forms of inebriety. Dr. Rosebrugh retired from his position at St. Michael's Hospital a few months ago, so as to afford him more time for the study and treatment of alcoholism, as well as to promote the passage of the proposed Bill for the treatment of inebriates. There is surely a wide field for usefulness in this department of medicine, and the doctor has our best wishes in connection therewith. Dr. Rosebrugh's address is Room 12, Confederation Building, Toronto.

WE wish to draw the attention of our readers to the medical practices offered for sale from month to month by the "Canadian Medical Exchange," among our advertising pages. We know of no way anyone seeking a medical practice could secure the same with so much facility and certainty of fulfilling their desires as by enlisting the services of Dr. Hamill, who has made a specialty of this line of work for ten years with remarkable ability and success. This applies with equal force to those desiring to sell their practices; in fact, the "Canadian Medical Exchange," under his able management, offers a short cut to physicians to buy and sell quickly, and the choicest offers appear monthly in this journal.

Correspondence.

The Editor cannot hold himself responsible for any views expressed in this Department.

PROVISION FOR LEPERS IN THE UNITED STATES.

DEAR SIR,—I read in the report on the Lazaretto, Tracadie, New Brunswick, of your Honorable Minister of Agriculture for the Dominion of Canada, for the year ended October 31st, 1900, as quoted by Dr. Eblers, the editor of "Lepra," in Vol. II., fasc. 4, page 234: "Dr. A. C. Smith, in his Annual Report on the leper hospital at Tracadie, N.B., stated: ' . . . The citizens of the neighboring republic are awakening to the necessity of a National Leper Asylum. *Investigation which has hitherto moved in a more or less academic orbit, commandeered by pamphleteers, has entered into a definitely practical phase.*'" The lines which I have italicized are evidently Dr. Smith's for they are under quotation marks by Dr. Eblers.

Will you allow me to inform Dr. Smith that our bill for a National Leper Law (Home) now before the American Congress, is the one which I myself drafted. It is the only one, excepting that introduced by delegate Wilcox for a Hawaiian leper law. Senator Platt, of New York, introduced it. It is endorsed by the U. S. Senators of California, Oregon, Louisiana, Minnesota, West Virginia, Kansas, North Dakota, Michigan, Wisconsin, Pennsylvania, South Carolina, Iowa, etc., and by Governor Heard, of Louisiana. It has the promised support of a majority of the Senate Committee on Public Health and National Quarantine, and the House Committee on Interstate and Foreign Commerce, to which it was referred. Senator Perkins, of California, and delegate Wilcox, Hawaii, have agreed to modify the second section of their Hawaiian bill, so as not to conflict with our Platt-Wanger bill. You see, sir, that our work has every assurance of success.

A copy of this bill, as printed by the Senate, was sent some time ago to your chief quarantine officer, the distinguished Dr. Montizambert, of Ottawa. A reference to it would show the efficiency and practicability of the work commandeered by the "pamphleteers," at which some one seemed to turn up his *more or less academic* nose.

ALBERT S. ASHMEAD, M.D.

Items of Interest.

Professor Albert von Kolliker, the anatomist, has resigned from the chair of anatomy at the University of Wurzburg, which he occupied for fifty-five years.

An International Tuberculosis Congress.—An international conference on tuberculosis under the auspices of the Central International Office for the Prevention of Consumption, will be held in Berlin from October 22 to 26.

Bequests by Dr. Klock.—By the will of the late Dr. Klock, one of the foremost physicians of Ottawa, the General Protestant Hospital of that city receives his valuable x-ray apparatus. His library will be divided between the Lady Stanley Institute and the Maternity Hospital.

Laval Professors Attending the Continental Congress.—Two professors of Laval University, Montreal, sailed *en route* to Rome, August 21st, to attend the fourth international congress of the professors of gynecology and obstetrics. They are Dr. L. N. Delorme and Dr. M. T. Brennan, and both will read papers.

To Improve the Breed of Royalty.—A dispatch to a London news agency from Rome, probably manufactured for summer use, announces that the Pope has notified the Catholic reigning houses of Europe that no more dispensations for consanguineous marriages will be granted. It is the wish of the Pope, says the dispatch, that royal personages contract marriages outside of royal families in order to put a stop to the tendency to physical and mental decadency now so apparent.

A Wireless Ambulance Call.—While the *Kaiser Wilhelm der Grosse* was making her way to New York last week, one of the passengers was taken ill with symptoms of appendicitis. An operation was indicated, but as land was so near it was deemed advisable to wait until the ship arrived. Accordingly, a wireless message was sent while the boat was still fifty miles away, and in response to the call an ambulance was in waiting when the pier was reached. The patient, a son of former Prime Minister di Rudini of Italy, was taken to hospital, operated upon, and is now convalescent.—*Med. Record.*

Toronto's Health for July.—The return of vital statistics for July shows 425 births, 222 marriages and 245 deaths, compared with 352 births, 241 marriages and 303 deaths for the same month last year. The total births to date for 1902 are 2,899, an increase

of 318 over the figures for 1901. There is an increase of 144 in the total number of marriages, 1,321, compared with 1,177 last year. The deaths show a decrease, there being only 1,899 for the present year, and 2,101 last year at the same date. The deaths for the month from contagious diseases were: scarlatina 2, diphtheria 8, measles 1, typhoid 3, and tuberculosis 27.

Complaints of British Transport Service.—Captain Shields, medical officer of a transport carrying returning troops from South Africa to Melbourne, made a report in which he condemned the service in the strongest terms. He said that "the overcrowding of the ship was shameful and scandalous, and without consideration for health or loss of life. The air was poisonous and foul, and the decks were always wet, causing pleurisy and pneumonia." He said, further, that the supply of medicine on board was absurdly small, and that the condition of the ship was directly responsible for the epidemic and deaths on board.—*Med. Record.*

Appointments.—Dr. Goldwin Howland, of Toronto University, has been appointed registrar of the National Hospital for Nervous Diseases, London, England. Dr. A. J. Lomas, a recent graduate of McGill University, has been appointed surgeon on the steamship *Botanga*, which left England, July 17th, for West Africa. Dr. Telesphore Parizeau has been appointed Professor of Pathology and Surgery at Laval University, Montreal, to succeed the late Dr. J. A. S. Brunelle. Dr. Parizeau is a graduate of Laval and after receiving his degree, spent several years in the hospitals of Paris. He is a member of the visiting staff of Notre Dame Hospital.

Removing Toronto Insane Asylum.—The Hon. Mr. Stratton, the Provincial Secretary of Ontario, has in contemplation the removal of the Toronto Asylum for the Insane to a point some miles beyond the city limits. Although the present site is large it is not considered sufficient for the employment of the eight hundred inmates; and the proposal is to secure a farm of three hundred acres and erect new buildings on the cottage plan. The present property is in the centre of the western section of the city and, owing to the tendency of the city to grow westwards, has increased so much in value that the province would lose nothing and the inmates gain much by the proposed change.

An Appreciation of Lister.—The following editorial note, under the caption, "Long Live the King," which appeared in the *Sun* of August 10, needs no comment: "The coronation of Edward yesterday had a far broader significance than the crowning of a mere titular monarch. It was the coronation of modern antiseptic surgery. The Englishman on whose head the crown was placed in Westminster Abbey was really Joseph Lister—the head from which came the discoveries in the application of the antiseptic treatment by which the life of Edward and the lives of many thousands of other sufferers apparently doomed to death have been saved. Long live the King."—*Med. Record.*

Diabetes in Pregnancy: Large Fetus.—Chambreleut observed dystocia from size of the fetus in two patients where diabetes developed during pregnancy. There was no history of gigantism, and no cachexia in either case. In the first patient glycosuria appeared in the fourth, in the second during the sixth month. Appropriate medical treatment proved beneficial to the mothers, but the fetus died shortly before labor in both cases. In both cases it weighed over eleven pounds, and delivery proved very difficult, especially when the shoulders came down. The dystocia was mainly due to the increase in the diameters of the trunk.—*British Medical Journal.*

Unborn Child Heir with Other Children.—An unusual point of law, the first of its kind ever raised in Canada, and it is stated the second on record, has recently been pronounced on and decided at Toronto by Mr. Justice Lount. A farmer in the western part of Ontario died, leaving a widow and four children. A fifth child was born four months afterward. The case turned on the division of a \$2,000 insurance policy, which according to the will was to be turned over to the widow and children in equal shares. The administrators applied to the court for advice as to whether or not the infant child born after the death of her father was entitled to a share in the insurance money. His Lordship ruled that a child, although unborn, is still a child in law, and takes rank as a child living at the death of its parent.

Canadian Criminal Statistics.—A report on criminal statistics for the year ending September 30th, 1901, has been prepared by the Dominion statistician. The number of charges for indictable offences was 128 less in 1901 than in 1900, being 8,291 in the former year and 8,419 in the latter. The convictions numbered 5,638, or 130 less than in 1900. The effect of the abuse of alcohol on crime may be seen from the following: In 1899 the immoderate drinkers represented 33.5 per cent. of the convicted criminals; in 1900, 29.1 per cent.; in 1901, nearly 30 per cent. About one-third of the criminals were persons addicted to drinking liquors. Regarding juvenile crimes, while there has been a satisfactory decrease in the female sex, the male sex has increased disproportionately. This is the most serious fact of the records of crime in Canada.

Atmospheric Cleansing by Snowfall.—Snow, and probably rain, rank high among Nature's methods for the purification of the atmosphere. The air of cities is rich in germs, a certain proportion of which are pathogenic, and apart from microbes the atmosphere is more or less heavily laden with minute organic particles which irritate and otherwise damage the respiratory tract. Some experiments recently carried out by the Chicago Board of Health illustrate this cleansing action very well. Culture plates exposed on January 18th gave colonies varying in number from 630 to 1,050. On the 21st snow fell to the extent of 0.28 of an

inch, and the experiment was repeated on the 22nd, when the number of colonies obtained fell to between 66 and 180, so that the atmosphere was nearly 90 per cent. purer after the snowfall than it was before.—*Medical Press*.

Heavy Fees from Royalty.—Max O'Rell is quoted from Paris as saying: It is a good thing to be a physician, to be called to the bedside of a royal patient. For his four weeks' attendance at Sandringham, prior to the recovery of the King from typhoid fever, in 1871, Sir William Gull received \$50,000. Twice this amount was paid to Sir Morell MacKenzie for his treatment of the late Emperor Frederick. The doctors who attended Queen Victoria in her last illness received 2,000 guineas each; while Dr. Lapponi's skill in removing a cyst from the Pope's side a few years ago was recompensed with \$2,500. Dr. Dinsdale for his journey to St. Petersburg and vaccination of the Empress Catharine II., received \$50,000 as his fee—\$25,000 for travelling expenses and a life pension of \$2,500 a year. One hundred thousand dollars will not pay the bill that King Edward must settle for his late illness and operation.

St. Michael's Endorses the Inebriety Bill.—The following memorial regarding the treatment of inebriates, and regarding Dr. A. M. Rosebrugh's connection therewith, was signed by the twenty-one visiting physicians and surgeons of St. Michael's Hospital, a little over twelve months ago, on the occasion of the retirement of Dr. Rosebrugh from the visiting staff of that institution:—*Whereas*, After eight and a half years' service as one of the attending physicians of St. Michael's Hospital, Toronto, Dr. A. M. Rosebrugh feels compelled to retire therefrom to enable him to devote more time to the study and treatment of inebriety and the adoption of the proposed Bill and its economic treatment; *Therefore, Resolved*, That in view of Dr. Rosebrugh's long and faithful service at the hospital, and also in view of his devotion to the interests of the unfortunate inebriate, we, the attending staff of the hospital, desire to place on record our appreciation of those services, and to wish him every success in the line of work he has mapped out for himself. *Resolved*, secondly, That we take this opportunity of expressing our unqualified approval of the proposed Bill, now under the consideration of the Ontario Government, for the economic treatment of proper inebriates, and we would be much gratified if members of the medical profession could see their way to an endeavor to bring their personal influence to bear on behalf of this important measure, and more particularly with a view of securing the co-operation of their representatives in the Ontario Legislature.

Medical Experts in the Law Courts.—The trial of Professor Dührssen, Berlin, Germany, has directed attention to the state of the law relative to medical evidence given before courts of justice. As a general rule the medical officer of health of the district is

ex officio medical expert in the courts, but in some of the larger towns special medical officers have been appointed for this duty. In cases of considerable importance and in appeal cases, recourse is had to the provincial board which exists in each province (Provincial Medicinal-Collegium) composed of professors of the university of the province, together with Government medical officers and others, and to a central board in Berlin (Wissenschaftliche Deputation für das Medicinalwesen) composed of professors of Berlin University only. The professional opinions given by the authority last named have a great influence on the decisions of the courts, for the judges believe that no expert is more competent in medical questions than this Board, and its opinion is very seldom disregarded. Since the Duhrssen trial, however, some medical journals have pointed out that, although the Board is composed of the leading medical men of Berlin, its formally expressed opinions nevertheless do not possess the weight and importance with which they are usually credited. When in a given case the opinion of the Board is asked by a public prosecutor, or by a court of justice, the President of the Board, as a rule, entrusts the matter to a member who is a specialist in that department. If, for instance, a surgical case is under consideration, it is one of the surgeons, or if it is a gynecological case it is the gynecologist who draws up the report. There is no discussion of the matter by the whole Board; when the report is prepared it is signed by the other members, but in reality the opinion of the Board is only the opinion of one member, whose views may sometimes be out-of-date, and who is by no means superior to other specialists who may be called by the other side. Moreover, the opinion of the Board, or of the member who acts in its name, has to be based on written statements, for the patient is very seldom examined with a view to the preparation of the report. It is also quite unusual for the members of the Boards to attend a court as witnesses, or to undergo cross-examination; a member of the Provincial Board was present at the trial of Professor Duhrssen but the Central Board was not represented at all. Some medical journals now propose that this system should be altered by abolishing the Boards, and that in cases of considerable importance the opinions of the most competent men in the respective branches should be asked, as they would be required to appear in court, and after being sworn as experts might be cross-examined like other witnesses.—*Lancet*.

The Physician's Library.

BOOK REVIEWS.

The Colonials. By ALLEN FRENCH. Toronto: William Briggs. 1902.

Although this tale is deftly told, some parts of the framework do not hang well together, making, in fact, serious demands on the reader's credulity. That a girl of fifteen, who had been raised in the woods, and retained the use of her senses, could, in two years, forget the face and voice of a man who had given her the worst of insults, is simply absurd. Yet we are expected to believe that the heroine, Alice Tudor, who when in Canada in 1772 had been brutally insulted by Captain Sotheran, failed to recognize her assailant in Boston in 1774, and in fact received him as a friend and suitor. In view of the fact that Sotheran was instantly recognized by Frank Ellery, whose opportunities for seeing Sotheran had been no better than those enjoyed by Alice Tudor—this part of the tale seems very improbable. Apart from this lack of the ordinary powers of observation, Alice Tudor is a very attractive personality. Beautiful, pure-minded, true-hearted, she lives a romantic, eventful life, and meets her manifest destiny in becoming the bride of the American, Frank Ellery.

The character of the hero, Frank Ellery, shows to greatest advantage in Book I., in which he is described as a hunter battling with Indians in the forests of Canada. On his return to Boston, Ellery sides with the Whigs and, when the revolutionary war begins, fights against the British troops. The author endeavors to enhance the minor part played by Ellery as a soldier by exalting the brilliancy of his swordsmanship. One wonders how Ellery could have acquired any skill in fencing. He might, it is true, have taken lessons in fencing before he fled from Boston when a lad of eighteen. On the other hand, the author represents Ellery as sickly and almost consumptive at that period of his life, so that it would not be likely that he would spend much time in the fencing academy, and would, therefore, not be a good fencer when he left Boston. His three years of hunting life in the Canadian forests would improve his general health, develop him as an all-round athlete, make him a rifleman; skilful with the tomahawk and hunting-

knife, but would be sterile in developing any skill which he may have possessed, when a boy, with the short sword. To make him suddenly so accomplished a swordsman, so much a master of *carte* and *tierce*, as to defeat with ease and certainty a practised duellist, on two occasions, is a tremendous appeal to one's gullability, and is as far removed from reality as the Flying Dutchman's escape by swimming from Portsmouth Harbor, as recounted in "The Flying Dutchman." As a word-panorama, depicting scenes and conditions of life in Canada and the American colonies one hundred and twenty-seven years ago, before the woodman's axe had swept away the picturesque forests of the land, "The Colonials" will be read by young and old with absorbing interest.

J. J. C.

Clinical Lectures on Neurasthenia. By THOMAS D. SAVILL, M.D.
London: Henry J. Glaiser, 57 Wigmore Street West. Second edition.

This is a really good series of lectures. The author speaks from clinical experience of a very large number of cases. This experience has been very largely gained in the Paddington Infirmary, where, as the author points out, a very great number of patients in all stages of nervous disease can be studied to great advantage, as the patients are usually permanent residents and thus their various symptoms can be watched under known conditions and not, as in the case of hospital patients, only for a limited period and in the out-patient class under unknown conditions of home life; a most useful chapter is given on clinical investigation and a very helpful scheme for case-taking is given. In treating of the pathology of functional disorders a somewhat startling theory is propounded in regard to chorea. The author has long believed that chorea is due to a specific microbe and that it is communicated from one child to another not by "imitation," but by infection, and very plausible reasons are given for this theory, and a very plain and clear difference is given between hysteria and neurasthenia—two distinct conditions which are too often confounded together. The relations of the neurasthenic state and insanity are very fully gone into and the importance of early treatment thoroughly advocated. A large number of cases, illustrating the many forms of nervous disorders, are given and are most helpful to the reader. In considering the treatment advisable in the different conditions giving rise to neurasthenia it is pleasing to notice that the "soothing influence of a pipe" is highly spoken of in impending neurasthenia. The practitioner must be left to follow out the very excellent and full lines of treatment from the lectures themselves. The course of lectures ought to be read by every practitioner, as it is a branch of the art of medicine too often neglected. It is too much the case that this class of disease is treated as trivial and dismissed by the doctor as merely "nerves." It is surely the duty of

every medical man to fit himself to cope with all kinds of ailments, and in view of the suffering of the patient and his or her friends this is not a trivial complaint, and not allow patients to drift into the various forms of charlatanism which are always ready to fatten on these unfortunate and easily deluded sufferers.

J. M.

A Manual of Instruction in the Principles of Prompt Aid to the Injured. Including a chapter on Hygiene and the Drill Regulations for the Hospital Corps, U.S.A. Designed for Military and Civil use by ALVAN H. DOTY, M.D., Health Officer of the Port of New York, late Major and Surgeon, Ninth Regiment N. G. S., N. Y., late Attending Surgeon to Bellevue Dispensary, New York. Fourth edition, revised and enlarged. New York: D. Appleton & Company. London: 25 Bedford Street. 1902.

The fourth edition of this little work of 300 pages on "Prompt Aid to the Injured" presents many changes and additions. The chapter on "Disinfection" has been re-written, in order to make it in harmony with the results obtained by recent scientific investigation in this direction. The hospital corps drill regulations now used by the United States army have been introduced, and many other minor changes.

The book is well designed to instruct those desirous of knowing what course to pursue in emergencies in order that the sick or injured may be temporarily relieved. Special attention has been given to information necessary for the instruction of ambulance corps connected with the different military organizations. It is also a useful little work in minor surgery and bandaging for the use of house surgeons, dressers, junior practitioners and nurses. Considerable space has been devoted to "Anatomy and Physiology" in order to make the subject-matter better understood by non-medical persons. Lay synonyms have been introduced as far as possible for more complex medical terms.

The book is largely illustrated and is well arranged as a ready reference for use in the treatment of accidents and emergencies.

E. H. A.

Practical Dietetics, with special reference to Diet in Disease. By W. G. THOMPSON, M.D., Professor of Medicine in the Cornell University Medical College in New York City; Visiting Physician to the Presbyterian and Bellevue Hospitals. Second edition, enlarged and thoroughly revised. New York: D. Appleton & Company. 1902.

The dietetic treatment of disease is fast approaching its proper place in lectures delivered in the various medical schools at the present time. Some teachers give a series of lectures on "diet in

disease" which cannot but be of inestimable value to the student, and we hope soon to see this subject more fully dilated upon by the teaching staff of every medical school. Dr. Thompson has thoroughly revised the present edition, and rewritten it in part, adding also over thirty pages of new matter. The sections on Diet in Disease have also been enlarged, and as in the previous edition developed with special reference to their practical application for the sick. The author, besides giving the usual hospital diet tables, gives a description of the various cures, as the Fruit Cure, the Grape Cure, the Meat and Hot Water Cure, the Dry Cure, Athletes' Diet, Brain Workers' Diet, etc. The chapter on Infants' Diet is especially interesting, as is also that on School Children's Diet. The work concludes with an appendix, containing a long list of preparations of milk, meat, and eggs, which are very useful to the general practitioner. This is undoubtedly as good a work on dietetics as has ever been published. A. J. H.

A System of Physiologic Therapeutics. A Practical Exposition of the Methods, other than Drug Giving, Useful in the Prevention of Disease and in the Treatment of the Sick. Edited by SOLOMON SOLIS COHEN, M.D., Professor of Medicine and Therapeutics in the Philadelphia Polyclinic, etc. Vol. IX., Hydrotherapy, Thermotherapy, Heliotherapy and Phototherapy, by Dr. Wilhelm Winternitz, assisted by Dr. Alois Strasser and Dr. B. Buxbaum, of Vienna; and Balneology and Crounotherapy, by Dr. E. Heinrich Kisch, of Prague University. Translated by Augustus A. Esbner, M.D., of Philadelphia. With notes by Guy Hinsdale, A.M., M.D., and different chapters by A. C. Peale, M.D., J. H. Kellogg, M.D., and Harvey Cushing, M.D. Illustrated. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut Street. 1902. Canadian Agents: The Chandler & Massey Co., Limited, Toronto and Montreal.

Vol. IX. of this series has been delayed for some time by the publishers to permit the insertion of several supplemental chapters on important subjects, and an appendix designed to bring the material and the illustration of new methods and new instruments "right down to date." The volume is certainly in itself a most complete work on the subjects of hydrotherapy, thermotherapy, heliotherapy and phototherapy. We may say that we know of no other book which enters into such detail, or at such length on the subjects named; and we think that it will pay any physician to buy this one volume anyway (as we presume he can do), even though he may not desire to possess the entire set.

The section devoted to mineral waters and their uses is exceedingly interesting. This part of the volume goes fully into the

constitution and general effects of mineral baths, acrato-thermal baths, acid and brine baths, sea baths, sulphur baths, iron baths, gas baths, peat and mud baths, mineral steam baths and medicated baths. To the different writers the general profession owe a considerable debt of gratitude for the material placed at their disposal. The volume is certainly one of the best of the series.

Text-book of Physiological and Pathological Chemistry. By G. BUNGE, Professor of Physiological Chemistry at Bale. Second English edition. Translated from the fourth German edition by FLORENCE A. STARLING, and edited by ERNEST H. STARLING, M.D., F.R.S., Professor of Physiology in University College, London. Philadelphia: P. Blakistons Son & Co., 1012 Walnut Street. 1902. Canadian Agents: The Chandler Massey Co., Limited, Toronto and Montreal. Price, \$3.00 net.

This volume is based upon a series of lectures delivered by Professor Bunge on Physiological Chemistry. "Representing, as they do, the ideas which have produced throughout many years discoveries of fundamental importance in the school of Schmiiedeberg, they have served to spread the method of thought of that school, and to render more effective the work of men in other laboratories." Physiological Chemistry is, to most at least, fairly dry reading, so that an author upon that subject must, of necessity avoid being too flat and tiresome, and hold his reader's attention by being as lucid as possible. This Dr. and Mrs. Starling have succeeded fairly well in doing, the volume under review being full of thoroughly interesting matter, and yet not too scientific. The work of translation from the German has been very satisfactorily done, making the text readable without in any way losing its original meaning.

A Treatise on Diseases of the Skin. For the use of Advanced Students and Practitioners. By HENRY W. STELWAGON, M.D., PH. D., Clinical Professor of Dermatology, Jefferson Medical College and Woman's Medical College, Philadelphia; Dermatologist to the Howard and Philadelphia Hospitals. Handsome octavo of 1,125 pages, with 220 text-illustrations, and 26 full-page lithographic and half-tone plates. Philadelphia and London: W. B. Saunders & Co., 1902. Cloth, \$6.00 net; sheep or half mcrocco, \$7.00 net. Canadian Agents: J. A. Carveth & Co., Toronto.

We think that we are not very far astray in saying that general practitioners know far too little of diseases of the skin, their symp.

tomatology and treatment, but perhaps more especially of their diagnosis. At best, it is very often a fine point to correctly diagnose one form of skin affection from another, such requiring considerable care and knowledge of the many fine points involved in the different branches of dermatology. Dr. Stelwagon's book will undoubtedly be found to be a work that is complete and in every sense up to date and we are glad to find, in reading it, that the author has devoted most space to diagnosis. Another good point about the book is that Dr. Stelwagon, in discussing treatment, gives with emphasis what he in his own practice has found to be effectual and does not, as so many authors do, wander off into the often too shallow theories of others, of which he cannot speak with any degree of exactness.

W. A. Y.

Diseases of Children. By JAS. FREDERIC GOODHART, M.D., LL.D., Aberdeen, F.R.C.P., Consulting Physician to the Evelina Hospital for Sick Children; Consulting Physician to Guy's Hospital; late Demonstrator of Morbid Anatomy and Lecturer on Pathology in its Medical School. Seventh edition. With the assistance of George Frederic Still, M.A., M.D., F.R.C.P., Assistant Physician for Diseases of Children, King's College Hospital; Assistant Physician to the Hospital for Sick Children, St Ormond Street. Philadelphia: P. Blakiston's Son & Co. Canadian Agents: The Chandler & Massey Co., Limited, Toronto and Montreal.

It is now nearly eighteen years since the first edition of Dr Goodhart's work on Diseases of Children appeared, and the fact that he has had to publish a seventh edition alone speaks volumes for the character of his contribution to medical literature. Dr. Goodhart modestly calls his book "A Student's Guide to Diseases of Children." It is more than that, and might easily be termed a text-book without resorting to any exaggeration.

The seventh edition brings the volume in every respect up to date, the author having re-written or re-arranged it in almost its entirety. The space devoted to the feeding of infants is considerable, and wisely so, as every physician realizes how important this is, and how, if it were correctly carried out, it would in a vast number of cases entirely ward off sickness.

The Medical Treatment of Gall-Stones. By J. H. KEAY, M.A., M.D. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut Street. Canadian Agents: The Chandler & Massey Limited, Toronto and Montreal.

In this small work of 126 pages Dr. Keay has certainly put forward a very strong plea for the medical treatment of gall-

stones. He does not dispute the fact that surgery finds its place in the well selected cases, but argues that it is not the rational treatment in the great majority of cases, and that much more can be accomplished by the physician than the surgeon in this field. The grounds he takes is that the surgeon, by opening the gall-bladder or ducts, or both, and removing the stones, does little towards permanently relieving his patient; whereas, the physician who recognizes and treats, by diet, drugs, hygiene, etc., the causes of the formation, migration of the stones, with their consequent impaction and perforation of ducts, accomplishes much more.

The author quotes many cases, amongst others his own personal experience, having been a sufferer for years from gall-stones. The treatise is divided into the Formation and Migration of Gall-stones, the Morbid Conditions associated with them, their Symptoms, Diagnosis, and Treatment, and will prove to be four or five hours' useful and pleasant reading.

W. H. P.

A Text-Book of Practical Therapeutics, with Special Reference to the Application of Remedial Measures to Disease and Their Employment Upon a Rational Basis. By HOBART AMORY HARE, M.D., B.S.C, Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital; One-time Clinical Professor of Diseases of Children in the University of Pennsylvania; Laureate of the Royal Academy of Medicine in Belgium, of the Medical Society of London; Corresponding Fellow of the Sociedad Espanola de Hygiene of Madrid; Author of a "Text-Book of Practical Diagnosis," etc. Ninth edition, enlarged, thoroughly revised and largely rewritten. Illustrated with 105 engravings and four colored plates. Philadelphia and New York: Lea Brothers & Co. 1902.

This, the ninth edition revised and enlarged, practically represents the scientific and practical therapeutics of to-day. The author, whose whole life has been devoted chiefly in this direction, has compiled a work which no physician or student can do without if he wishes the most ready and up-to-date therapeutical work in his library. Dr. Hare's clear-sightedness and exactness is characterized in his work, and has enabled him to give his confreres a volume that cannot but be fully appreciated by his many admirers.

^{A. J. H.}
The Care of the Teeth. By SAMUEL A. HOPKINS, M.D., D.D.S. Professor of Theory and Practice of Dentistry in Tufts College Dental School. New York: D. Appleton & Company. 1902.

Appropriately dedicated to the mother is this little work on the care of the teeth. How much anxiety and trouble would be spared

to mothers if they were able to prevent and relieve the pain, discomfort, disfigurement, and ill health caused to their children by the defective condition of their teeth. Certainly the great field for relief in this direction consists in measures of prevention, and in the early treatment of dental caries. It is because the author is actuated by the belief that the decay of the teeth may in a great measure be prevented, that he has written this little book. It is full of suggestions of a practical nature, which will be of benefit to mothers of young children, to school teachers, nurses, physicians, and others who have the opportunity of influencing for good the lives of young children. It will also be found of interest and use to everyone desirous of taking proper esthetic, and hygienic care of the mouth and teeth.

E. H. A.

Saunders' Medical Hand-Atlases.—Atlas and Epitome of Abdominal Hernias. By PRIVATDOCENT DR. GEORGE SULTAN, of Gottingen. Edited with additions, by WILLIAM B. COLEY, M.D., Clinical Lecturer on Surgery, Columbia University (College of Physicians and Surgeons). With 119 illustrations, 33 of them in colors, and 277 pages of text. Philadelphia and London: W. B. Saunders & Co., 1902. Cloth, \$3.00 net. Canadian Agents: J. A. Carveth & Co., Toronto.

There are few situations in which a practitioner sometimes finds himself placed which demand such prompt action as when face to face with a strangulated hernia. Under such circumstances it is essential that there be no delay. The attendant doctor must recall what he may years ago have learned as to hernia and its treatment, but which knowledge he might not have had so far to make use of in practice—an atlas, such as this, can prove of incalculable benefit under those circumstances, as even a glance at the colored illustrations will prove of the greatest assistance. Dr. Sultan's Atlas is exceedingly practical and deals largely with the operative side of the subject. The illustrations are very well drawn and add materially to the value of the book.

W. A. Y.

Clinical Psychiatry. A Text-Book for Students and Physicians. Abstracted and adapted from the Sixth German Edition of Kraepelin's "Lehrbuch Der Psychiatrie." By A. ROSS DEFENDORF, M.D., Lecturer in Psychiatry in Yale University. New York: The Macmillan Company. London: Macmillan & Co., Ltd. 1902. Cloth, \$3.50.

The introductory section on general symptomatology, comprising one-sixth of the book is entertaining and instructive not only to the general practitioner but also to the experienced alienist. The author's examination of normal physiological mental manifestations

and his comparison of them with morbid psychical expressions as observed in mental disease attest at once his masterly grasp of his subject. In clear, concise and elegant diction he has most successfully accomplished in this handsome volume his object of presenting to American students and practitioners an adaptation of Professor Kraepelin's more elaborate work on psychiatry, and having done this he has added much to the interest of the study. It is however, a matter of doubt whether the same clear and definite views of the different forms of mental disease may be obtained from the classification adopted by the German Kraepelin as from that promulgated by the English Clouston.

N. H. B.

Heralds of Empire. Being the story of one Ramsay Stanhope, Lieutenant to Pierre Radasson, in the Northern fur trade. By A. C. LAUT, author of "Lords of the North." Toronto: William Briggs.

This romance is of interest in parts, but the authoress seems to have failed to grasp the exact physical geography of that wonderful country which surrounds the Hudson Bay. Her fault (I will not say failure) was the same in "Lords of the North." This same fact is the one source of beauty and attraction to Charles Kingsley's and Robert Louis Stephenson's works, and we cannot but suggest it to the authoress. Her style is very effective at times, and we must congratulate her on the masterly way she has handled his romance. Taking her characters in Boston, she transports them in ships to Hudson Bay territory, finally bringing them to the Court of King Charles. Miss Laut is a resident of Ottawa, and has succeeded in writing an attractive story, and we wish her efforts may be as much appreciated as they certainly deserve.

This book is published by William Briggs, Toronto, and is most tastefully bound in black cloth, with red and gold relief.

A. J. H.

Compend of Special Pathology. By ALFRED EDWARD THAYER, M.D., Assistant Instructor in Gross Pathology, Cornell Medical College; Pathologist to the City Hospital; formerly Fellow in Pathology Johns Hopkins University, etc. Containing 34 illustrations. Philadelphia: P. Blakistons Son & Co., 1012 Walnut Street. 1902. Canadian Agents: The Chandler Massey Limited, Toronto and Montreal.

This small work may be perhaps best described as a manual. It is divided into ten chapters, the subjects considered being: The Circulatory System, Respiratory System, Ductless Glands, Alimentary Canal, Alimentary Glands, Urinary System, Reproductive System, Locomotory System, Cutaneous System, and Death

by Violence and Poison. It will be found to be a most useful adjunct to the larger and more comprehensive works upon the subject, and convenient for hurried reference.

Diseases of the Nose, Pharynx and Ear. By HENRY GRADLE, M.D., Professor of Ophthalmology and Otology, Northwestern University Medical School, Chicago. 547 pages, illustrated. Philadelphia: W. B. Saunders. 1902. Cloth, \$3.50. Toronto: J. A. Carveth.

The author presents the diseases of the nose, pharynx and ear as he has seen them during twenty-five years' practice. Every practitioner has had anxiety about the course and outcome of disease in individual patients, anxiety due to lack of experience in such cases and because no sufficient answer to his questions was to be found in the text-books. Dr. Gradle has tried to meet just such questions. The relation of therapeutic procedures bears the stamp of personal experience. Enough, but not too much, space has been devoted to the topographical anatomy of the parts. Altogether, it is a useful text-book and a good work for reference. J. M. M.

First Report by the Canadian Red Cross Society on its Operations in the South African War, October 21st, 1899, to June 1st, 1902.

Thanks to Captain Charles A. Hodgetts, M.D., A.M.S., Toronto, we are in receipt of the first report of the Canadian Red Cross Society as to its operations in the South African War. The Report is exceedingly well gotten up, bound in a rich grey cover, bearing on the outside the Society's crest, a beautiful maple leaf with, in its centre, the red cross. The pamphlet is exceedingly interesting, especially the report of the Red Cross Commissioner, Lt.-Col. George S. Ryerson, of Toronto, and goes to show how much the work and labor of love on the part of the Society, in its different branches, is appreciated, and the comforts afforded to our brave boys when in a far-off land fighting for our dear old flag.

The Lady Paramount. By HENRY HARLAND, author of "The Cardinal's Snuff-Box." Toronto: William Briggs.

In this charmingly-told love tale, sunny Italy and old England divide honors as the scene of inaction. Day glides into night, and then again it becomes morning, and the song birds "thrill" (the author says) the blue heavens through and through with their melody, and so on till the book closes over the last chapter. Besides the loving maid and the lovely man, a sprightly, verdant, person keeps something doing in the talking line all the way

through; his sayings are as bright as "a new dollar," but less valuable to the long-suffering reader. Altogether, it's a good story for the silly season, and we prophecy for it a first place in the list of hammock books for 1902.

W. A. Y.

Some Important Practical Notes on the Technique of Skiagraphy.

By MIHRAN K. KASSABIAN, M.D., in charge of Roentgen Ray Laboratory, and Instructor in Electro-Therapeutics in the Medico-Chirurgical College and Hospital, Philadelphia, Pa., etc.

It will repay any physician, whether particularly interested in X-Ray work or not, to send a postal card to the G. Cramer Dry-Plate Co., St. Louis, Mo., and ask for a copy of this pamphlet. It is quite short, and can be read through in very little time, is full of practical information as to the cathode rays and their application to surgery, and written by a man who is able to express an opinion on the subject.

In Search of Mademoiselle. By GEORGE GIBBS. The Copp Clark Company Limited, Toronto.

This is much superior to many of the modern novels. The style is similar to that of "Lorna Doon," though less prosy in descriptive detail. The title page is kept strictly in evidence all the way through the work, while it abounds in stirring adventures from beginning to end. The brutal cruelty of Diego de Basco, the deceit and rapacity of Mendenez, the courtly honor and confidence of Ribault, and the terrible and complete revenge of De Gourgnés are all brought out in bold relief and in contrast with the modesty, honesty and strength of character of the giant hero, Killigrew. The volume contains 373 pages and four illustrations. W. J. W.

The Life of St. Luke. By EDWARD CLAPTON, M.D., L.R.C.P.; late Physician to St. Thomas' Hospital. London: J. & A. Churchill, 7 Gt. Marlborough Street. 1902.

This small book of eighty pages in length will prove of interest to many, more especially, perhaps, Biblical scholars. The life of Saint Luke is full of interest, and will be read by medical men if for no other reason than that the character throughout the volume represents the life of a physician as well as an evangelist.

The Baby's Care in Health and Disease. By EDWIN LEONARD, Jr., M.D. Jersey City, N.J.: Reed & Carnrick, Publishers.

This little pamphlet is replete with facts which cannot but be of value to nursing mothers and others who have the care of infants.

The different chapters discuss such subjects as: Our Baby, How to Feed the Baby, Symptoms of Disease, Common Diseases, Accidents and Emergencies, Local Remedies, Diet for the Older Ones, Diet for the Sick and Convalescent. Incidentally the value of Reed & Carnrick's different foods and preparations is demonstrated.

Baby's Diary. Published by Borden's Condensed Milk Co., New York, N.Y.

This pamphlet is quite unique. It is tasty in appearance, and will be prized by many mothers as useful to record their "darling's" progress in life, also weight at certain periods of the child's existence, date of christening, the date when dentition first appeared, its actions, food, health, etc., etc. The publishers will be glad to send one to any one for the asking.

Mrs. Wiggs of the Cabbage Patch. By ALICE CALDWELL HEGAN. Toronto: William Briggs. Cloth, 75 cents.

A great deal of humor, a touch of pathos, a character study of a cheery woman of the working-class in old Kentucky, a chapter here and there devoted to the "doings" of her several children, who add much to the amusement of the reader as he spends an hour in the company of the inimitable Mrs. Wiggs.

On Analgesic Methods and their Respective Limitations.—

Prof. J. V. Mikulicz, of Breslau, says: "Apart from the minor procedures, numerically important though they be in medical practice, the only local analgesic that we need consider nowadays is cocain and its surrogates, eucain, tropacocain and holocain. I refer the reader to the communications made by Gottstein in the years 1896 and 1899 in regard to the technique of local anesthesia as practised in my clinic. I shall only remark here that we employ the following solution for infiltration anesthesia:

Cocain hydrochlorate.....	0.5 gram.	(7½ grains)	~
Beta-eucain hydrochlorate	0.5 "	(7½ ")	
Chloride of sodium.....	2.0 "	(30 ")	
Distilled water	1000.0 "	(32½ ozs.)	

We do not add the morphine, as originally recommended by Schleich, for, as is well known, it has no local effect at all, and sometimes shows a very undesirable general one. When it is deemed necessary to get an additional morphine effect, we give a subcutaneous injection of 0.01 gram. (1/6 grain) of the drug half an hour before. We have employed the methods of Oberst and Hackenbruch exactly as prescribed by the authors." (Abstracted from the *Archiv für klinische Chirurgie*, Vol. LXIV., Part 4, Berlin, 1901.)