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Page 153 is incorrectly numbered page 15.

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ONE DOLLAR A YEAR

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All communications, books for review, and matters relating to this publication should be addressed to the Saskatchewan Medical Journal, Box 1106, Regina, Saskatchewan, Canada.

THE SASKATCHEWAN MEDICAL JOURNAL

VOL. 2 MAY, 1910 No. 5

Original Memoirs

"A LESSON IN DIAGNOSIS" *

By C. N. Cobbett, M.D. (Edin.), Edmonton

Anyone who has seen much abdominal surgery will admit that however carefully a case may be studied, however typical the clinical features may be, errors in diagnosis are common. It is inevitable that this should be, more especially in mistaking one serious condition for another, but to the careful practitioner it is no less certain that his mistakes will diminish in number in direct ratio to the degree of development of his power of clinical observation and his increasing experience. Within this obvious and transparent truth there lies concealed a curious paradox, for to any one looking back over a long period of study of abdominal diseases it will sometimes appear as if with increasing experience there were more mistakes. This fallacy may be explained in this way, namely, that a more competent observation and a wider experience result in a greater number of cases being diagnosed, before, instead of after, making an exploratory incision, and so the mistakes become more apparent. However, it remains a fact that no matter how conscientiously and carefully a diagnosis is made, many surprises await the surgeon operating for the relief of abdominal diseases. The

* Read before "The Central Alberta Medical Association," May 10th, 1910.

difficulty of accurate diagnosis and the kind of surprises referred to are well illustrated in the following cases, each of which simulated a condition other than that actually present and led to a wrong diagnosis.

The three cases all occurred recently in my own practice and are somewhat out of the common.

Case I. A married woman, act. 25, six months pregnant. Seen at half past twelve on the night of October 11, 1909.

She complained of very severe pains in the right lower abdomen which began suddenly at four o'clock and had become worse. Vomiting was incessant. The expression of face was anxious. The temperature was 99°, the pulse 96. There was localized tenderness and well marked rigidity of the right rectus muscle.

Diagnosis. Acute appendicitis.

The patient was removed to the General Hospital as soon as practicable.

Operation about 3 a.m., October 12,—within 12 hours of the onset of symptoms. Present, Dr. Biggar, anaesthetist; Dr. Farquharson, assistant. Vertical incision through right rectus, splitting the muscle.

On opening the peritoneal cavity a small quantity of clear serous fluid escaped. The appendix was found to be perfectly normal and healthy. A little search revealed an ovarian cyst about the size of a foetal skull at birth, with a tightly twisted pedicle. It was twisted twice from right to left. The pedicle was untwisted, ligatured, and the tumour removed. Wound closed in layers.

The patient recovered and went to full term and was safely delivered of a fine boy. It is fair to state that at the time the persistence of the vomiting did cause a doubt in my mind that there might be some condition other than appendicitis present, since in this disease vomiting is an early symptom and only twice or thrice repeated as a rule, but I dismissed the idea on the supposition that the pregnant uterus would account for the persistence of the vomiting.

Case II. A married woman, aet. 34, seen on March 21, 1910. Two pregnancies, the last labour 11 months ago, when she gave birth to twins. Menses regular, not profuse, not painful. Last period March 7th. Had only weaned the babies about two weeks. She complained of a hard, tender swelling in the lower abdomen and general feeling of illness. Ten weeks ago, while straining at stool, she felt a sensation of "something giving way inside." She felt ill and went to bed. Two days later there was profuse uterine flooding with clots, and she then noticed the swelling. She did not observe any shreds of tissue (decidua.) Since then has felt very ill and has suffered from constant dragging pain. No fever. Right ilio hypogastric region occupied by a firm, solid mass, tender to touch and dull on percussion. Per vaginam the hardness seemed to be chiefly on the right side shading off behind and to the left into a softer, more boggy-like, mass. The uterus was movable, but could not be differentiated from the mass.

Diagnosis. A pelvic haematoma on the right side from ruptured tubal gestation. The patient is also subject of ventral hernia.

Operation March 22nd. Present, Dr. Farquharson, anaesthetist; Dr. Ternan, assistant. Abdomen opened by an incision through inner edge of right rectus from umbilicus to pubis.

The tumour proved to be a myoma of the uterus involving the right side and back of the organ and within the uterine cavity was a four months dead and macerated foetus. The uterus was removed leaving the lowest third of the cervix. Both ovaries were left. In closing the wound the ventral hernia was remedied. The patient made a good recovery.

The diagnosis in this case was certainly as far removed from the actual state of things as it could well be. You will observe that the history was typical of a pelvic extra peritoneal haematocele with strong presumption of ectopic gestation as the cause. The circumstance of the woman being a nursing mother served to obscure the case, but the history was so very suggestive that no doubt it led to my being only too ready to find it confirmed by physical examination. The uterine flooding preceded by a

sensation of "giving way," was, of course, coincident with the death of the foetus in utero. The absence of collapse at the time pointed to the supposed rupture being extra peritoneal, *i.e.*, between the layers of the broad ligament and the situation of the tumour on the right side seemed to confirm this hypothesis. There are two points difficult to account for, first, that the patient was unconscious of any swelling till after the haemorrhage, and second, the failure of the uterus to make any attempt to expel the dead foetus.

Case III. A powerfully built man aet. 37, seen March 25, 1910. He stated that for many years he had suffered from catarrh of the stomach; pain and distension; no vomiting. Eighteen months ago he had an attack of very severe pain in the right lumbar region radiating round the back and across the belly. There was no vomiting and no fever. A similar pain has been produced ever since by any hard muscular work. That illness was followed by slight jaundice, and he passed on one occasion a tarry stool, and on washing out the stomach, which he was in the habit of doing frequently, the stuff was black. He had never been addicted to alcohol. A week ago engaged in pitching hay he suffered very severe pain in the right lumbar region radiating across the belly and into the groin. He had to give up work and go to bed. There was no vomiting, and he stated no fever. I have since heard, however, that there was on that occasion a well marked chill followed by a rise of temperature. On examination the tongue was furred, the pulse 68, the temperature normal. No abdominal tenderness, no muscular rigidity. Liver dulness normal. Tenderness and sense of resistance in the region of the right kidney but no distinct mass to be made out. The urine was free from albumin, blood, pus and bile. He had never passed bloody or smoky urine. Two physicians who had examined him in consultation during the attack a week ago had diagnosed a dislocated kidney with perinephretic inflammation and possibly abscess.

Diagnosis. In my notes, made at the time, it is stated as indefinite. That it might be *i*, gall bladder trouble; *ii*, malignant disease of ascending colon; *iii*, it is conceivable that it

is some obscure form of appendicitis. The last hypothesis was that which I least expected to be realized. I thought that most probably it was a case of cholecystitis with gall stones, and advised the patient to submit to an exploratory operation.

Operation. March 26th, 10 a.m. Dr. Biggar, anaesthetist; Dr. Farquharson, assistant; Dr. Harwood and Dr. Ternan, visitors. Abdomen opened by a four inch incision through the right rectus splitting the muscle. A mass was felt in the right loin consisting of omentum and intestines tied up in a lump. On separating some adhesions out towards the parietes, an abscess cavity was opened. It contained about four ounces of very foetid pus. After mopping up the pus the appendix was discovered lying in a little pocket of dense adhesions high up behind the colon just beneath the liver. It was rotten and gangrenous except the root, which was densely adherent to intestines. The appendix was removed and the wound partly closed, abundant gauze packing being inserted. The gall bladder and bile ducts were normal. The patient did well on the whole for two weeks when his pulse suddenly failed, and he died on the morning of the 17th day. At the autopsy made by Dr. Farquharson and myself six hours after death, the whole of the caecum and ascending colon up to the hepatic flexure was found to be gangrenous from septic thrombosis—a backward extension from the thrombosed appendicial artery. There was no general peritonitis. The last attack of severe pain a week before operation was no doubt coincident with the death of the appendix. Possibly, had the patient come in at once, as he was advised, the prompt removal of the focus of infection might have arrested the process and saved his life. The illness 18 months previous, was presumably an attack of catarrhal appendicitis, and he was treated four years ago for right sided pleurisy, which may have been a mistaken diagnosis. The pain on exertion was caused by the dense adhesions. The tarry stool and black vomit may have been due to some drug such as iron or bismuth, or possibly to a haemorrhage from irritation of the gastric mucosa from too frequent use of the stomach tube. It is very remarkable that

on the day of operation with a gangrenous appendix and a foul abscess he should be free from pain, fever, rigidity or increased frequency of pulse.

Here, then, are three cases, one of which, with all the signs of acute appendicitis, proved to be a very different though equally urgent condition; in another, I opened the abdomen confidently expecting to have to deal with a pelvic haematoma and found instead a myomatous uterus containing a dead foetus; and the third, the exhibited features so pronounced that two careful physicians diagnosed a lesion of the kidney, whereas it turned out to be a gangrenous appendix with abscess.

To my mind, these cases are more than usually instructive. With regard to the first case—pregnancy or labour complicated by an ovarian cyst is not very uncommon, but there are very few reported cases of an ovarian cyst with twisted pedicle complicated by pregnancy. Probably in the circumstances one may conclude that an accurate diagnosis was almost impossible.

The second case—hysterectomy for myoma complicated by pregnancy—is sufficiently rare to be worth recording. In the transactions of the Obstetrical Society of London there are reported only thirteen cases in the period of nine years from the beginning of 1900 to the end of 1908. The wrong diagnosis in this case is not excusable. In spite of the deceptive history and all the circumstances which made it difficult, a correct diagnosis was undoubtedly possible and should have been made.

In the third case we have another instance of the varied and deceptive features of that deadly disease appendicitis. It is very doubtful if a positive diagnosis was at all possible. The case is interesting as demonstrating the progressive nature of a septic thrombosis. No doubt the original thrombus in the appendicial artery had extended backwards through the colic branches of the ileocolic artery. It was the most extensive result of the process which has ever come under my notice.

In conclusion, I desire to state that the title of this paper refers to what I deduce for myself from the clinical teachings of the cases, but my hope in presenting them in this form is that the experience may be of some value to others.

PATELLAR FRACTURES

By Harry Morell, M.D., Regina, Canada

It would not be wise to advocate the direct fixation of the fragments of bone by wire or otherwise in every case of fractured patella, nor is it justified. The ordinary treatment, or as named, the expectant or non-operative method, shows good results, with the exception that a certain proportion of cases leave traces of this injury through life. The symptoms generally complained of are stiff, weak joints, causing pain at change of weather; in others the after-effects are more severe. The appearance of an opened knee-joint, after a fracture of the patella, presents a disorganised mass, filled with blood, serum, synovial fluid, torn and macerated ligaments and muscular tissue, so that any union, even fibrous, is marvelous, and furnishes a good example of the reparative powers of nature.

It is accepted as good teaching, and unanimously by authorities, that unless good and well defined indications are present, the joint should not be opened for direct suture of the bones.

On looking over the literature I find opinions as follows:

"The operative method consumes less time in convalescence and an excellent result is achieved, but operation exposes to the danger of sepsis. If sepsis results, the following conditions are imminent: A stiff knee, amputation of the thigh, and possibly death from septic infection. * * * It should be undertaken only by surgeons of exceptional judgment and great skill * * *."[1]

Another says: "The risks of infective accident are, however, too great to render this method of treatment advisable for adoption by the general practitioner in recent simple fracture."[2]

Or, "The slightest error in the use of the aseptic apparatus may cause irreparable damage, and may cost the patient's life."[3]

1 Scudder, C. L. "The Treatment of Fractures." Fourth Edition. Page 354.
2 Pilcher, L. S. "International Text Book of Surgery." Page 589.
3 Gerster, A. G. "Aseptic and Antiseptic Surgery." Page 80.

The latest opinion was in 1906, at the annual meeting of the American Medical Association, when "some speakers expressed themselves against operative repair of patellar fractures."[4]

Tenney says: "If we accept the conclusion that the natural drainage of the knee is so much inferior to that of the abdomen, particularly when we follow the conventional treatment and immobilize the joint, it seems possible that we can improve results in aseptic knee-joint operations by providing for escape of the excess of joint-fluids for a few hours and by allowing as much motion as safety from bleeding and security of the sutures will permit. In septic conditions there is no longer any argument as to the desirability of opening, washing and draining freely, but I believe we should go further. There is never perfect rest in the abdomen. Walls or contents are always in motion so long as breathing lasts. Why, then, should we strive for perfect immobility and continuous contact of inflamed surfaces in septic conditions as the knee unless we are deliberately trying to get ankylosis?"[5]

Through the courtesy of Dr. J. E. Knipfel, of Broderick, Saskatchewan, the following case is narrated:

Mr. J. S——, aet. 45. Farmer. Canadian. Height 5 feet 8½ inches. Weight 225, very obese, excessive smoker and drinker, irritable temperament. Some years ago he had a severe injury to left leg, since that time complained of the knee-joint catching.

On the fifth of March, while in a wagon, the horses ran away, and he was thrown to the ground. Dr. Knipfel saw him two days after, when it was found that he had sustained a fractured patella, the left one, also the joint was badly bruised and discolored, with an enormous amount of swelling. Dr. Knipfel applied a posterior splint, with evaporating lotions and iodine, to reduce the swelling. He was brought to the Regina General Hospital where the patella was wired in this fashion: All the limb, in the vicinity of the knee-joint, within a large radius, was enveloped the night before in a green soap poultice. This was followed by a thorough scrubbing of green-soap, bi-chloride and alcohol, successively. A long vertical incision was made exposing the whole knee-joint injury. The whole area was filled with a large amount of blood in different processes of absorption, and torn and lacerated synovial membranes. The patella was broken transversely across, in the width of the bone however, the upper fragment jutted over the lower, and directly in the centre of the patella was another piece of bone separated entirely, —the latter was removed. Two holes were drilled through the two

4 Tenney, Benjamin. "Annals of Surgery" November, 1908. 5 Ibid.

fragments and closed completely together with Vienna Wire Silk of Dr. Spechtenhauser, the largest size being used. A third aperture was drilled for another suture, but in drilling this so much difficulty was experienced that the third hole was abandoned, as part of the burr, which, by the way, was hardened steel, was broken. Chromicised catgut sutures were placed in advantageous positions throughout the ruptured periosteum, and all synovial fringes with intrapatellar fat pads removed with scissors.

(These fat pads, were, no doubt, the cause of this patient complaining of trouble with this particular joint before this injury.)

The cavity of the joint was carefully cleaned up, irrigated with saline solution, dried, and incision closed with silkworm gut, with the exception of the lowest portion of the wound where a rather large strand of gauze was left in for drainage. He did remarkably well. Sutures and drainage were removed on the fifth day.

He remained in the hospital for two weeks, when I sent him home. The after treatment followed was massage to the joint, and a light dressing, but the knee-joint was not immobilized, and his doctor reports that "inside of a month he has travelled East and the movements of the joint are gradually being restored." Since his return home from the hospital, Dr. Knipfel had to cut away protruding portions of the wire. This now has been all withdrawn.

Comment. My conclusions have led me to the opinion that absorbable material should be only used, either for bone or other tissue in this locality. Some hold that it is not necessary to suture the bones, but why not insert sutures in the edges of bone?

It is reasonable to believe that a close approximation of bone tissue would prove stronger than suturing tissue in contact (periosteum).

As to the important question of drainage, my experience teaches that drainage is required in nearly all cases. I recall a case where it was necessary to remove sutures from the skin, in the dependent part of the wound as the pain was unbearable, very likely from tension. After removal of these, there was a discharge of fluid (synovial) and shortly the pain ceased, and the ultimate result was good.

The vital question of skin sterilization should not be overlooked, and when a deliberate operation on the knee-joint is contemplated, Tenney's advice shall be well considered. I quote: "I shave and scrub my knee-joints, while flexed, and then allow three days of antiseptic wet dressings before the final soap and alcohol preparation on the table. On my last three

knees I have used an exceedingly weak solution of chlorinated soda—so weak as to cause no smarting, and to give a barely perceptible odor of chlorine—with entire satisfaction."[6]

6 Tenney, Benjamin. "Annals of Surgery." November, 1908.

LABORATORY METHODS FOR THE GENERAL PRACTITIONER

FOURTH PAPER

STAINING AND DEMONSTRATION OF THE BACILLUS TUBERCULOSIS.

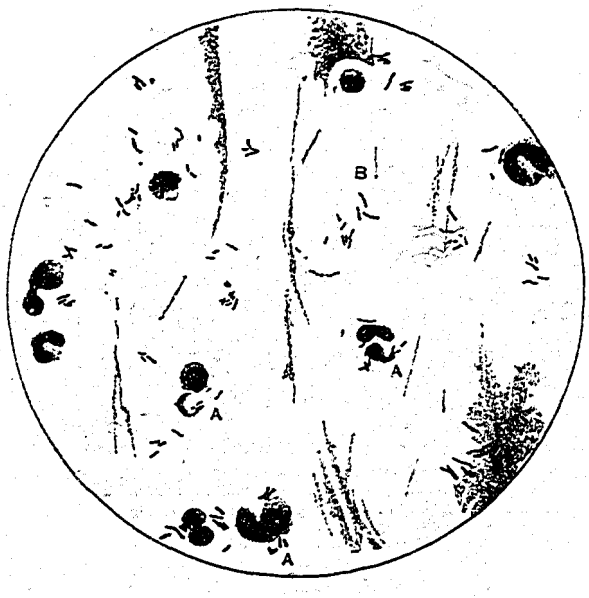
As the tubercle bacillus cannot be seen in the unstained sputum, it is necessary to stain them. As a rule, two stains are used, one to stain the bacillus, and the other to counterstain with another color.

THE COVER-GLASS, SMEAR OR FILM PREPARATION.

The Cover-glass. On the centre of a carefully cleaned cover-glass, a very small quantity of sputum is deposited with a platinum loop; this loop must, in every case, be heated to a bright red before and after it is used. The sputum is then spread over the surface of the cover-glass to form a uniform thin film. This is only possible when the cover-glass is absolutely free from dirt of any kind. (See directions for cleaning.) The cover-glass is then allowed to dry, this may accelerated by gently warming it over the flame, with the film side upwards. When the cover-glass preparation is quite dried, it now is fixed.

Fixing. The cover-glass, with the film side upwards, is held between the finger and thumb, and passed three times through the flame. After the fixing, the film is now ready for staining.

Staining. There are many methods, but we will describe two which may be depended upon, and are also the quickest. The



TUBERCLE BACILLI IN SPUTUM.

The tubercle bacilli are stained red, all other cells and tissues are counterstained with methylene blue.

—This plate has been loaned by courtesy of H. K. Mulford Co.

Sakatchewan Medical Journal
May, 1910

basic aniline dyes are used in staining bacteria. There are a large number of these, and there are several formulæ for preparing staining solutions from each. Further, as will be seen from the chapters on staining bacteria in the text-books, there are several methods of applying these stains. In an introductory course, however, it is impossible to try them all, and, consequently, those are described which seem to be the best adopted for general use.

Frankel-Gabbet's method requires two solutions:

No. 1. Carbol Fuchsin (Zeil's Solution).

Fuschin (dry)	1 grm.
Alcohol (absolute)	10 c.c.
Carbolic Acid 5% Solution	100 c.c.

Dissolve the fuchsin in the alcohol, after which add the carbolic acid solution. Instead of using the dry fuchsin and alcohol, 10 c.c. of a saturated solution of fuchsin may be used.

No. 2. *The Decolorizer or Counterstain.*

Methylene blue (powder)	2 grms.
25% Sulphuric Acid	100 c.c.

The prepared cover-glass is held, with the film side up, in a Cornet's forceps, and with a pipette, a small amount of solution No. 1 is laid over the film, just enough to cover it, and no more. Be careful, and under no circumstances must the pipette touch the specimen. Now the film is passed ten times through the flame of an alcohol lamp, wait a minute, then wash. This may be done either by a stream of water from a wash bottle or held for a short time under running water until all color has disappeared. Now the specimen is placed carefully, film side upwards, on a piece of smooth filter paper and dried. Now apply solution No. 2 in the same manner as above. It should be allowed to act for two or three minutes, washed as before, and if any red remains, wash again, or apply more No. 2. Treat the film as above with filter paper, and dry thoroughly, when it may be mounted.

Mounting. On a perfectly clean cover-slip, a drop of Canada balsam is placed on the centre, it takes a little practice to get just the required amount, and the cover-glass is placed gently

on this drop, of course, with the film side downwards. The cover will adjust itself in a minute, and if the drop of balsam is just proper, and the mounting perfect, there should be no air bubbles. Any excess of balsam may be removed by xylol.

The above is one of the many methods suggested. They all alike depend upon the remarkable property which the bacillus displays of staining with aniline dyes in alkaline solution, and (unlike the other micro-organisms, pathogenic and non-pathogenic, which occur in the sputum), of retaining the dye in spite of after-treatment with acid and alcohol.

The specimen is now to be examined with the microscope, and the tubercle bacilli will be stained red, and all other bacilli, including the background, blue. The bacillus appear, either separately, or more often in groups, as small bacilli rod-like bodies, slightly curved, very narrow, and of variable lengths (1.5—3.5 microns). They are quite motionless, and spore-formation can sometimes be seen in them.

Another Method of Staining Tubercle Bacilli.

Prepare the specimen from sputum as before, and after the cover-glass containing the specimen is fixed and stained by the carbol fuchsin. The preparation is then rinsed in water, and decolorized by treating it with a 10% solution of nitric or sulphuric acid, from one quarter to one minute. It is again rinsed in water when it is ready for examination. It can be dried and mounted permanently in balsam. The tubercle bacteria should be stained a deep reddish color. All other bacteria, or cells, in the specimen should be unstained. If desired, a counterstain, such as alkaline methylene blue can be used after decolorizing. That is, the preparation can be again stained for about one minute in alkaline methylene blue, rinsed in water and examined as before. In these preparations the tubercle bacteria are red and the other organisms and cells are blue.

When inspecting the specimen under the microscope, the oil-immersion lens 1-12, with eye-piece of 111 of Zeiss, or 2 in. B. & L. or Spencer open sub-stage condenser must be used.

Formula for Loeffler's Alkaline Methylene Blue.

Concentrated alcoholic Solution of Methylene Blue	30 c.c.
Caustic potash 1% solution	1 c.c.
Distilled water	100 c.c.

Formula for Chromic Acid Cleaning Mixture.

Dissolve 80 grams of potassium dichromate in 300 c.c. of warm water, when all of it is dissolved and the solution cooled, add it slowly, with constant stirring, to 460 Sulphuric acid (fort). Store the mixture in a glass-stoppered bottle.

To clean cover-glasses and slides. Drop the cover-glasses singly into a glass jar containing the cleaning mixture, and allow them to remain there for 24 hours or longer. Pour off the cleaning mixture and rinse the cover-glassess until all of the color disappears, then cover them with alcohol until needed, when they can be wiped with a soft linen cloth, or with lens paper. Treat the slides the same as the cover-glasses. They can be wiped directly out of the rinsing water. The slides can be cleaned satisfactorily by washing them in strong soap-suds, rinse in water and wipe.

THE SASKATCHEWAN MEDICAL JOURNAL

HARRY MORELL, M.D., C.M., *Chairman of Publication Committee*

All communications relating to this publication should be sent to the Saskatchewan Medical Journal, Regina, Saskatchewan, Canada.
Box 1105.

Editorial Notes

The New York Medical Journal, May 14, has this to say regarding the death of King Edward.

The King's Death

"We do not understand that at any time the physicians in attendance on his late Majesty during his last illness made public their diagnosis of the case. In this reticence, we think, they were quite justified; still, a natural curiosity will strive to ascertain the cause of death as nearly as may be. It may well be that the King's natural powers of resistance were weakened to some extent by his worrying over the political situation in his realm, and it is still more likely that his strength was undermined by his brave, though unwise, persistence in attending to public affairs when he ought to have been in bed. All this, however, leaves untouched the question of what it was that was the immediate cause of death. Press dispatches make it clear that it was some acute pulmonary affection or an acute exacerbation of a chronic lung trouble, perhaps associated with cardiac weakness."

The British Medical Journal gives the cause of the death of his Majesty as follows:

This must be accepted as authoritative—

"From a medical point of view, the case was perfectly simple, and the stopping of the machinery of life was due to causes

about which there is nothing doubtful or mysterious. We think it necessary to point this out since the appearance on the bulletins of the name "laryngologist," gave rise to a revival of unfounded rumors which were current even before the deceased monarch came to the throne. The king was subject to attacks of laryngitis, producing slight spasms of the vocal cords, but except for some inflammatory thickening of the hinder part of the glottis and chronic catarrh of the throat, there was, we are in a position to state, no trace of the disease in the upper air passages. The king, in short, had what is known as a smoker's throat, and this and the congestion and thickening due to this cause, combined with the loss of elasticity in the lungs, made it increasingly difficult for him to clear his chest. Here the strain was thrown upon the heart by an obstruction to the passage of blood through the lungs caused by the collection of secretion in the bronchial tubes, and had its natural sequel in a dilation of the right ventricle, and the actual cause of death was heart failure, due to increasing difficulty in pulmonary circulation. It was, in short, a type seen every day in thousands of elderly persons.

The Cause of the King's Death

"Could the king have been induced to spare himself more," continued the British Medical Journal, "he would possibly have lived many years longer. Although he always listened to the advice of his physicians with respect, he did not follow it, as it seemed to him to stand in the way of the discharge of his duties. Except for the conditions which have been referred to, the king had until lately been a remarkably healthy man. He lead a strenuous life, and it may be said that since he assumed the sceptre he seldom, if ever, had what his humblest subject would call a real holiday. Even his social activities, which he thoroughly enjoyed, he may be said to have looked upon as a part of his day's work. There is probably no man in these realms who worked harder or more conscientiously than Edward VII."

The Month

During the month of January, the Editorial Department of this journal was in receipt of two letters protesting strongly against the Commissioner of Health, a paid government servant, engaging in general practice. Mention was made of this in our January issue. The following was received since that time:

April 8th, 1910.

To The Editor,
Saskatchewan Medical Journal, Regina.

Sir,—

I want to protest most emphatically against the Commissioner of Health of this Province engaging in private practice. Not only this, but he inveigles another physician from Chicago to enter into competition with those who are engaged in general practice for a livelihood without any subsidy. It was thought when the new office of Commissioner of Health was created, that the incumbent would confine himself to public health work. This matter concerns every practitioner within the province and ought to be taken up at the meeting of the Provincial Medical Association.

Trusting that you will give prominence to this, I am,

Your obedient servant,

MEDICO.

The allegations made in the communication above have been investigated and we are very glad to give out this statement: The Commissioner of Health assures us that he is not engaged in work other than public health work which comes to him under his jurisdiction as Medical Health Officer of this Province, and also that Dr. Hendricks, the physician from Chicago, is now a paid official in the Department of Public Health, and will not under any circumstances engage in any way in private practice.

We hope the explanation given is satisfactory to our correspondents and readers.—Editor.

In the May issue, speaking editorially on the actions of the Ontario Medical Council, the Canada Lancet opens as follows: "We invite every medical practitioner to study the reports given them by the registrar. This study will reveal some very interesting facts.

"In the first place it will be seen that the medical council is running behind. It is spending more money than it is receiving. This must cease, and it lies with the medical practitioners of this province to insist upon more careful methods. The council should require no compulsion in this matter. It should feel the situation to be one of trusteeship and act accordingly. We have shown in former issues that the funds have decreased by several thousands of dollars.

"The next thing is that the announcement contains too many speeches but too few facts. The members of the College of Physicians and Surgeons are not told in very clear terms where the money has gone. We would like very much to see the personal account of each member of the medical council. If there be nothing wrong, why not give this? One does not like to hear rumors that there has been any overcharging for mileage or per diem. The only way the council can down these rumors is to breast the whole matter and tell the whole truth. So far as the Canada Lancet is concerned it is determined to get at the facts in some way."

The above has been copied as the article appears in the "Lancet," and it is reproduced for the purpose of showing the practitioners of Saskatchewan that this journal has also tried to show them their own council has not acted in a manner expected. In the January and February numbers we pointed out that no report of any kind was issued from the Council, also our Council have as yet issued no statement as to how our own finances are handled.

Do the practitioners of this province know that we have, or ought to have, about twenty-five to thirty thousand dollars in the treasury? Where is it? Who has it? Is it being administered properly? Is this fund placed so that it will draw a good rate of interest?

A short time ago, one of the members of our profession while conversing with a member of the Council, asked about these things and other matters of the council. In answer the member of the Council gave our friend a pamphlet labelled "Report of the Proceedings of the First Meeting of the Council of P. & S. of Saskatchewn." If this report of the proceedings is an index or an example of the work done by our Council, we shall be in a much worse position than the Ontario Council. The report is certainly gotten up in a slovenly and slothful manner, and it is no wonder they are not distributed to the profession at large.

We shall abstain from comments on this report, but we will ask that at the meeting of the Saskatchewan Medical Association that this question be taken up fully.

If the Council of the College of Physicians do not show a disposition to furnish a detailed statement of receipts and disbursements to a cent, resort will have to be taken as provided in cap. 28, sec. 72, which reads: "The Registrar whenever required by the Lieutenant Governor in Council shall transmit to the Provincial Secretary a certified return under the seal of the Council setting forth all such information and particulars relating to the college as may from time to time be asked for."

It is our intention later to take up the question of antivivisection, in the meantime we copy the following from the "New York Medical Record No. 2055":

NEW ANTIVIVISECTION TACTICS.

During the past four sessions of the Legislature of this State, bills have been introduced for the purpose of placing severe restrictions upon the practice of animal experimentation. Fortunately all such bills have been defeated by the sensible arguments of the medical profession. Foiled in these attempts, the antivivisectionists now seek by another method to insert their entering wedge. This consists in a bill which has been introduced into the Senate by Mr. Bayne and into the assembly by Mr. Goodspeed, "To establish a commission to inquire into the extent and nature of the practice in this state of experimentation on living animals.

Some of our readers may be inclined to welcome such an investigation on the ground that when once the full details about laboratory procedure are told the antivivisectionists will no longer have reason to continue their occupation. This is a plausible but, we believe, a specious attitude. The example of England is here, as throughout the antivivisectionist movement, illuminating. The movement originated in England, and its adherents in this country are closely following the methods and spirit of their prototypes across the ocean. There they have twice resorted to an investigation of the laboratories. As a result of violent agitation, the first Royal Commission was appointed by Queen Victoria in 1875. After taking elaborate testimony, much of which came from members of the medical profession, who at that time did not appreciate the importance of animal experimentation, the commission advised the enactment of a restrictive law. This was largely for the purpose of preventing imagined abuses in the future since the testimony showed that there existed at the time no serious abuses warranting such a drastic measure. It was expected by many people that the new law would put a stop to the unpleasant agitation. Such expectations were never realized. The agitation has raged more fiercely ever since, more and more restriction being demanded. There exist now in Great Britain no less than fifteen antivivisection societies.

In 1906 these societies again demanded the investigation of laboratories and King Edward yielded to their demand. After a year and a half a second Royal Commission sat and took elaborate testimony. This has been printed in full and again overwhelmingly demonstrates the absence of abuse. The commission has not yet made its final report, but in view of the violent discussion that has raged for two years over the details of the printed testimony, there is no reason to believe that the report will prove to be a palliative in any degree.

In case the legislature deems it wise to pass the present bill the medical profession will give every opportunity to the commission to learn details of laboratory procedure, for, as every informed physician knows, nothing goes on in any of the labora-

tories which needs to be concealed from well intentioned and mentally poised persons, whether professional or lay. Indeed, the details of such experiments are constantly being published in medical books and journals, and are seized upon and distorted by the hysterical or dishonest as evidence of the cruelty of animal experimentation, although they prove the direct contrary. And so it will be with the report of this commission, if the bills are passed. The Coleridges and the Belaises, the *Heralds,* and the *Lifes* will go on just the same; they will scream out that a dog's leg was amputated or its thoracic cavity was opened and will cry for the cruelty of it, all the time ignoring the fact, which they cannot possibly fail to know is a fact, that the animals were anesthetized and felt absolutely no pain. In all this agitation, it should be clearly understood that the antivivisection movement is due rather to a peculiar psychological state in its adherents rather than to present experimental methods.

Personals

Dr. C. A. Hogetts, Provincial Health Officer for Ontario, has been appointed medical adviser to the National Conservation Commission.

The following having passed the examinations required were recently admitted as members of the Royal College of Surgeons: S. J. Elkin, Manitoba, C. S. Gideon, A. Moir and A. H. Rolph, of Toronto.

Dr. Hutchison, of Davidson, Sask., has finished his new business block, which is a credit to the city.

Dr. Hill has returned to Lloydminster, after an absence of a couple of months.

MARRIED—On 25th of May at London, Ont., Anna Elizabeth Martin to John Nisbet Gunn, M.D., Calgary.

The following are the newly elected officers of the Manitoba Medical Association: Dr. F. S. Keele, president; Dr. H. W. Speechley, 1st vice-president; Dr. F. Schaffner, 2nd vice-presi-

dent; Dr. J. Halpenny, hon. secretary; Dr. R. F. Rorke, hon. treasurer; Dr. J. Matheson, Dr. G. G. Ross, Dr. H. Montgomery, executive committee; Dr. G. Blanchard and Dr. J. Moodie, auditors.

Obituary

Elizabeth Blackwell, widely known in the practice of medicine, both in England, where she was born, and in the United States, where she practiced several years, died at her home in Hastings, May 30. She was born at Bristol, Feb. 3, 1821. Dr. Blackwell's parents emigrated to America in 1832. In early life she taught school in Kentucky and South Carolina, later studying medicine in Geneva University, in Paris and London. In 1851 she began to practice in New York City, where she founded a hospital and medical school for women.

Returning to her native land she was placed on the English register in 1859 and subsequently practiced in London and Hastings. She founded the National Health Society, of London, and assisted in founding the London School of Medicine for Women. Dr. Blackwell was the author of several medical books.

"Le roi est mort—Vive le roi"

6th May, 1910.

11:50 p.m.

His Majesty the King breathed his last at 11:45 to-night in the presence of Her Majesty Queen Alexandra, the Prince and Princess of Wales, the Princess Royal (Duchess of Fife), the Princess Victoria and Princess Louise (Duchess of Argyll).

(Signed) F. H. Laking, M.D.
R. Douglas Powell, M.D.
Bertrand Dawson, M.D.

THE KING'S PHYSICIANS

"The King was attended in his last illness by his three Physicians-in-Ordinary—Sir James Reid, Sir Francis Laking, and Sir R. Douglas Powell, and by one of the Physicians Extraordinary, Dr. Bertrand Dawson. In the absence of Sir Felix Semon, the throat specialist, Dr. St. Clair Thomson's services were also requisitioned.

"Sir Richard Douglas Powell represents at the present time the greatest medical opinion obtainable in the country. He is but one year younger than his royal patient, and has filled the highest positions in the profession, culminating in the Presidency of the Royal College of Physicians. He has devoted himself particularly to the study of diseases of the chest, and has had a vast experience in his long connection with Brompton Hospital, of which he is one of the consulting physicians. He was created baronet in 1897, and was Physician-in-Ordinary to Queen Victoria.

"Sir James Reid, Bart., was born the son of a country doctor in Ellon, Aberdeenshire, in 1849, and after a distinguished student career qualified at Aberdeen University in 1872. From 1877 to 1881 he practised in Scotland, and was then appointed Resident Physician to Queen Victoria, ultimately attaining the rank of Physician-in-Ordinary, a post which was continued under King Edward. He was created baronet in 1897. For thirty years he has been the trusted medical adviser of our Royal Family, and has carried out all his manifold duties with distinction.

"Sir Francis Laking, Bart., is a graduate of Heidelberg University, and has for some years been closely associated with the medical destinies of the Royal Family.

"Dr. Bertrand Dawson, whose name is now prominently before the public for the first time, was educated at the London Hospital, of which he is physician. He has a successful career before him.

"Dr. St. Clair Thomson is physician for diseases of the throat in King's College Hospital, and lecturer on laryngology in the Royal Army Medical College."

DIAGNOSTIC INJECTIONS OF TUBERCULIN

"Whatever may be the value of tuberculin injections given with therapeutic intent, many question the propriety of using them for diagnostic purposes. Our own views on this point have already been expressed (New York Medical Journal, July 11, 1908). The ophthalmic test of Wolf-Eissner and Calmette and the skin tests of Von Pirquet and Moro have in a measure supplanted the old style Koch injections, and certainly appear, when positive, to afford strong presumptive evidence of the existence of tuberculous infection. Quite recently, however, two new aids to diagnosis have been brought forward. Yamananchi (Wiener Klinische Wochenschrift, November 19, 1908) obtains two or three cubic centimetres of blood serum or blister serum from the suspected individual and injects it into a rabbit, and a few days later injects tuberculin into the rabbit. If the serum was from a tuberculous subject the rabbit experiences a severe and even fatal reaction. If the original subject was free from tuberculous disease there will be no reaction in the rabbit.

"That tubercle bacilli have occasionally been found in circulating blood is well known, but that they are constantly present in all forms of tuberculous infection has recently been rendered probable. Dr. Randle C. Rosenberger, assistant professor of bacteriology in the Jefferson Medical College, of Philadelphia, in a paper read before the Pathological Society of Philadelphia on December 10th, published in the American Journal of the Medical Sciences for February, explained his technique in detail. Briefly, he draws five cubic centimetres of blood from the arm and immediately introduces it into a test tube already containing an equal amount of a two per cent. solution of sodium citrate in normal salt solution. The tube is then placed at rest in a cool place to deposit sediment for twenty-four hours. Smears of the sediment are then made and fixed and stained with carbol fuchsin in the usual manner. Rosenberger has found the bacilli in every case where the disease had been diagnosticated, clinically, and in some in which it had not been suspected. We await with interest the reports of other investigators who may follow this method." —(New York Medical Journal No. 1575.)

CHRONIC LARYNGITIS.*

BY THOMAS J. HARRIS, M.D.

Adjunct Professor of Diseases of the Nose and Throat, New York Post-Graduate Medical School and Hospital; Junior Surgeon Manhattan Eye, Ear and Throat Hospital (Throat Department).

The chairman has been kind enough to invite me to take part in the Section meeting and has suggested as a topic the subject of chronic laryngitis. This I am glad to do and thank him for his suggestion, for this subject has always interested me. At the same time I hesitate to bring it forward because it is one of such venerable antiquity. We are, in recent years, too much inclined to devote our thoughts to the consideration of rare and unusual conditions to the exclusion of those which we meet day after day. *Chronic laryngitis* is one of the latter. The text-books contain many excellent articles on it. Among the best of these are several by our American confreres, notably one by our fellow members, Dr. D. Braden Kyle. Certain subjects should not be dismissed with the statement that the essays on them contain "nothing new." Their importance is such that they are deserving of repeated discussion at frequent intervals. This applies with particular fitness to the subject of chronic laryngitis. We propose to discuss briefly some of the usual teachings in the light of our own clinical experience.

Chronic laryngitis, also spoken of as chronic hypertrophic laryngitis by Ballenger and chronic hyperplastic laryngitis by Parker, may be divided into:

Simple laryngitis.

Laryngitis nodosa or singers' nodes.

Laryngitis pachydermia, and

Laryngitis subglottica.

In addition to this we occasionally meet with laryngitis atrophica or laryngitis sicca. Several authorities speak of a laryngitis hemorrhagica. This we have never encountered. Parker adds chronic arthritis and chronic perichondritis. It has been our fortune to see but a single case of laryngitis subglottica. It is particularly of simple chronic laryngitis which we wish to speak.

* From Post-Graduate, May, 1910.

Etiology. The causes of simple chronic laryngitis are local and general. Much emphasis is wont to be placed by most writers upon conditions of the nose and throat as causative factors. Our observation has not tended to confirm this. There is a class of cases which would properly fall under the heading of pachydermic laryngitis where the relationship of nose and naso-pharynx is clearly evidenced. This is true also of cases of laryngitis sicca.

But simple laryngitis in adults can rarely be traced directly to affections of the upper air passages, although in children the removal of adenoids and enlarged tonsils is of the highest importance. Instead of putting the relation between the nose and the throat and larynx as cause and effect, it is our opinion that where we recognize an inflammatory disturbance of the nose and throat and larynx, we should ascribe it to a systemic condition affecting both. As we urged in a previous paper, in considering the relation of diseases of the nose to diseases of the ear, that operative work upon the nose should for the most part be governed by the question: "Does the nose require it independent of all question of the ear?" so now we would maintain that treatment to the nose where chronic laryngitis is present, should be in the first instance directed to the inflammation of the nose *per se*.

Among the *general* causes upon which emphasis has been placed are disturbances of the gastrointestinal canal and rheumatism and gout. While we have invariably inquired into the presence of such conditions and have, as a routine measure, put the patient upon an eliminative treatment, we must confess that we have not satisfied ourselves of the intimate relation of the digestive tract to chronic laryngitis. This, of course, does not refer to gross errors in regard to food and drink, such as we meet in alcoholics.

What then in our experience have been the most common causes of chronic laryngitis? We would say repeated attacks of acute laryngitis, occurring especially in people who are professional voice users, such as singers, public speakers, etc. As distinguished from what we have just said about the non-existence of any pronounced disorder of the stomach, there is, in all cases to which we now refer, evidence of trouble in this locality. The patients are often given to excesses in food and

drink. Constipation is not infrequently present; baths and exercises are rarely practiced.

Finally, there is a group of chronic laryngitis cases in children which should be noted. This often is the result of yelling and screaming as well as of obstructive lesions of the upper respiratory tract just referred to.

Diagnosis. No one who has an opportunity of seeing many cases of chronic laryngitis has failed to recognize the fact that the amount of disturbance is entirely out of proportion to the laryngoscopic picture. The beginner is wont to think that in a chronic laryngitis we meet with the chords uniformly reddened; he soon learns his mistake. The inflammatory reddening varies greatly. In some cases, by no means the majority, the entire chords are injected. This is no guide as to the impairment of the voice, as is shown by the fact that the chords of many singers and smokers who have no voice difficulty show a general blushing. Just as occasionally we meet with colored children with white skins, so we see at times cases of chronic laryngitis where the cords are entirely white. Rather upon the amount of thickening and muscular disturbance should the prognosis be placed. We have recently had under our care a girl of fifteen who illustrates how deceiving the laryngeal picture may be. The patient has been hoarse for a number of months, yet the vocal chords are perfectly white and close normally upon phonation. There are no other stigmata of hysteria.

Prognosis. It is particularly in regard to the prognosis that we desire to speak. Our experience may have been at variance with that of most men, but we frankly confess that where pronounced alterations have occurred in the chords we have discovered no remedy to effect a cure. So long as the patient refrains from using the voice all goes well. But, unfortunately, most of our cases are found in singers and speakers and as soon as they resume the use of their voices the trouble recurs.

Treatment. We attach much importance to the removal of all possible errors in the method of the use of the singing or speaking voice. The acquiring of a proper "method" will more satisfactorily relieve the difficulty, if not too far advanced, than any amount of topical or general treatment. We recall a case in point of a theological student who had had a spur removed

from his nose without relief. Proper training how to use his voice promptly effected a cure.

Before speaking of the tropical applications we would refer to the method of administering them. For many years we used nothing except the laryngeal applicator; latterly we have come to feel that where the drug is properly introduced by means of a spray the result is more satisfactory, in many cases especially where the throat is very irritable. We are satisfied that not infrequently we have made a thorough application to the esophagus, in a gagging patient, instead of to the larynx.

The text-books are filled with a long array of drugs to be employed. Up to a short time ago it was our routine practice to use various strengths of nitrate of silver. We have come to doubt the value of strong astringents in many cases of chronic laryngitis; with chloride of zinc, in from 2 to 4% solution, better results are obtained than with silver nitrate. We recognize that this is at variance with the teaching that over-stimulation of the mucous membrane of the larynx is desirable. Indeed, we doubt the wisdom of the indiscriminate application of astringents to the vocal chord. We have been particularly impressed in recent years with the result of intra-laryngeal injections and propose to employ them more frequently in the future. We have used for this purpose the formula of Dr. O. B. Douglas containing thymol, eucalyphthol, menthol, oil of cubeb, oil of roses and benzoinol. We have also attached considerable importance to thorough removal of any hypertrophy of the lingual tonsil.

In addition to suitable topical applications we have felt that we have obtained benefit from the regular employment of vibrassage to the larynx externally.

We have been in the habit of giving our patients some preparation of benzoinol with menthol and eucalyphthol to use at home in an atomizer or inhalation. We question how much real good is done by this, but certain temporary benefit is secured. We have also found temporary relief from the use of lozenges. The preparations put up by Hancock & Sons disturb the stomach less than any other that we know of. We have never used electricity in the form of the faradic or galvanic current, cold water by compress or otherwise, though these measures have been strongly recommended.

Efforts are being made to have a hospital erected in Melville, Sask., this summer and to further the movement the ladies have formed a Hospital Guild. Mrs. Dr. Livingston is president, Mrs. J. W. Dawsey, vice-president; Mrs. R. B. Taylor, recording secretary, and Mrs. Ed. Miller, treasurer.

Book Notices

SURGICAL TREATMENT OF TUBERCULOUS PLEURISY, LUNG ABSCESS AND EMPYEMA. By *Emil G. Beck, M.D.* Reprint from the J.A.M.A. Included are numerous stereoscopic radiographs. The latter are the latest modern method of illustrating certain lesions and are truly wonderful.

THE DIAGNOSTIC VALUE AND THERAPEUTIC EFFECTS OF THE BISMUTH PASTE IN CHRONIC SUPPURATION. By *Emil G. Beck, M.D.*, Chicago. Reprinted from International Clinics, Vol. I, Twentieth Series.

ON THE RELATIONSHIP BETWEEN THE THYROID AND PARATHYROIDS. By *J. Halpenny, M.D.*, and *F. D. Thompson*, Winnipeg, Canada. Reprint from "Anatomischen Anzeiger, Jena, Austria.

THE SPECTRUM. May Number. Issued by The Sherwin-Williams Co., Cleveland, Ohio. This is one of the most artistic booklets which comes to our desk.

THE TRAIL. No. 2, May. If this magazine keeps up the standard set, we soon shall see this periodical in the front rank of the Canadian monthlies. Published at Regina, Sask. Price $2.00 per year. H. M.

MEDICAL DIAGNOSIS. A manual for students and practitioners. By *Charles Lyman Greene, M.D.,* of St. Paul, Professor of medicine and chief of the department in the college of medicine, university of Minnesota. New third edition, revised, with seven colored plates and 248 other illustrations. P. Blakiston's Son & Co., 1012 Walnut Street, Philadelphia. Pa. Price $3.50.

The fact that this book has reached a new third edition in a short period speaks for itself. The one element which appeals to the reviewer is its practicability, also, that it contains an enormous amount of reliable and accurate information. The arrangement of matter is first-class. The two hundred and fifty illustrations, though small, are quite clear, and we like very much the marginal references which are useful in gaining desired information quickly. In the special diagnosis the technique of blood, urine and microscopical is given in detail. The book is well made in every particular and is strongly recommended to students and general practitioners as a safe and concise guide in "everyday practice."

News Items

The Saskatchewan Medical Association meeting will be held at Yorkton this year, under the presidency of Dr. Henry. The exact date has not been decided on, but it will be during the first part of July.

Professor Robert Koch, the famous bacteriologist, died at Baden-Baden on May 27th. The cause of death given out is heart disease.

Dr. Gordon Stables, M.D., C.M., R.N., the well-known writer of boys' books, aged 69, died in London, Eng., recently. Many of us in our younger days will remember the pleasure given by this gifted writer. Dr. Stables has done his share in writing for and upholding the humane treatment of the lower animals, especially dogs and horses.

During the month of May two celebrated men of science have died, viz., Dr. Heinrich Curschmann, Professor of Patho-

logy and Therapeutics at Leipzig University, aged 65; and Major K. M. Cameron, M.B., Operating Surgeon at the Cambridge Hospital, Aldershot, late of the Army Headquarters, India; served under Sir G. White and Sir Redvers Buller in South Africa; aged 70.

King Edward's annual subscription of ten guineas to the Royal Westminster Ophthalmic Hospital was posted the day before his death, and the bank has informed the hospital that the cheque will be duly honored. This was probably His Majesty's last gift to a public institution.

That the automobile is an asset of considerable value to a medical man, aside from its actual monetary worth, is the opinion of doctors who own motor cars—one such, in speaking of the services his automobile has rendered him, said: "During the first year after I bought my runabout, my practice increased over $700; during the following year over $1,500, and during the third year it was nearly $3,000 greater than when I bought the car."

We feel justified in making a special mention of the advertisment which appears in this issue, of Glaxo, an English imported infants' food, which has now been pretty thoroughly tested in Regina.

We have made some enquiries in connection with the results that are being gained by the use of this food in Winnipeg, where it is most generally known, and we find that it is giving all-round satisfaction to such of the doctors as have taken it up in their practice.

A special claim is made for Glaxo, which is that with its use a great deal of the trouble experienced in the feeding of infants during the hot weather will be avoided, as one of its principal merits is the extreme ease with which it may be assimilated by the weakest digestion.

Physicians now have the right of way with their motor cars on all the thoroughfares of Baltimore, the same as fire apparatus, police patrols, and ambulances. They are allowed to speed to sick bed calls, to the aid of injured workmen and the like without being halted by the police, while street cars and wagons

must make room for them. In order to distinguish a doctor's car from those of other individuals, the police department has provided each physician with a sign about 5 inches square, bearing a red cross on a white field. These signs are put in a conspicuous place on the front of the machine and to the left.

Unsolicited testimonials regarding a certain product speaks well For instance, Coca Cola, one of the various drinks for summer, is being used by many prominent physicians. This is not merely a beverage but a tonic, and a good one.

McGill's projected reunion of all graduates of the faculty of medicine throughout the continent has been postponed for a year owing to the death of King Edward. It was to have taken place at the convocation of June 6 and 7, and already over a hundred graduates had accepted to attend, while invitations had been sent broadcast and considerable expense incurred.

The license of the Elite theatre has been transferred from the name of H. J. Templehill to Dr. W. R. Coles, who recently purchased the show.