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## Original Contributions:

### PLASTIC INDURATION OF THE CORPORA CAVERNOSA PENIS.\*

BY M. J. AHERN, M.D., QUEBEC,

Professor of Clinical Surgery at Laval University, President of the Quebec Medical Society.

I WISH to report a few cases of, and make some remarks on, a somewhat rare affection of the fibrous tissues of the penis—an affection which has been variously denominated by different authors as *chronic inflammation of the erectile tissues of the penis and of its fibrous sheath*—*chronic circumscribed inflammation of the fibrous sheath of the penis* (Keyes)—*chronic circumscribed induration of the corpora cavernosa* (White)—*fibrous transformation of the pectiniform septum and sheath* (Gross)—*fibroid sclerosis of the corpora cavernosa* (Taylor)—*nœuds et ganglious des corps caverneux* (Nélatin)—*induration plastique des corps caverneux* (Reclus)—and *nœuds des corps caverneux* by most French authors. This disease with the many names is said to be one of old age by most writers; one of middle life by others, and by Gross to be most frequent between 50 and 40. Yet it has been met with in patients aged 21, 26, 27 and 28 years respectively.

It is said to occur most frequently in those who have abused of sexual intercourse. It is characterized by a localized induration of the fibrous sheath (and underlying tissue, Keyes) of the C. cavernosa and also of the pectiniform septum. When the sheath is affected the diseased part is felt as a circular or quadrangular plate, hard, smooth, resilient, immovable and not adherent to the skin which is freely movable over it. These hard plates are more frequently met with on the dorsal part of the sheath than elsewhere.

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\* Read at the Canadian Medical Association, Quebec, August, 1898.

When situated in the pectiniform septum the nodules are wedge-shaped—the base of the wedge upwards—and when the contiguous portions of the sheath on each side of the base of the wedge are affected the nodule is more or less saddle-backed. The induration rarely extends through the whole thickness of the corpus cavernosum. Two or more nodules may exist at the same time. According to Keyes a nodule may disappear and be replaced by another elsewhere. Easily discovered when the organ is flaccid, they are scarcely appreciable when it is in a state of erection during which they do not expand, thus causing the penis, at that spot, to be bent over to the affected side, producing what Ricord called penile strabismus. When the induration extends through the whole thickness of both c. c., that part of the penis situated in front of the induration remains flaccid during erection, and the male organ of generation has then the undignified appearance of a flail. Although this bending of the penis is rather awkward during sexual intercourse yet it does not altogether impede it. The semen is expelled but slowly, and sometimes it oozes away only after erection has ceased.

As a rule the bending of the penis first attracts the patient's attention and brings him to the surgeon. The nodules gradually and very slowly increase in size and number—or remain stationary—never getting very large and never disappearing and being situated generally in the posterior three-quarters of the organ. They never become large enough to permit of their discovery by simple inspection. They never suppurate. In the beginning there may be some slight pain and the hard spots may be tender under pressure. This affection was first well described by La Peyronie in 1743, later on by Kirby, and in 1874 by Keyes. The last extended account of it was given by Tuffier in 1885.

The etiology is obscure. La Peyronie ascribed the disease to syphilis and his opinion prevailed until 1850, when Kirby, supported by Verneuil, Paget and others, rejected it and declared the affection to be always due either to gout or to diabetes.

After 30 years of age, according to Tuffier, the tissues which form the c. c. begin to increase in thickness and to lose somewhat of their elasticity; these changes become gradually more pronounced with age, and under the influence of arthritism and its manifestations, gout and diabetes, become exaggerated and progress irregularly, thus producing the nodes. This explanation does not cover the cases occurring in young subjects.

At the present day gout and diabetes are looked upon as being the principal, if not the sole, etiological factors. Nevertheless, a few cases supposed to be of syphilitic origin have been reported; but the facts on which this etiology is founded are far from being conclusive. Antisyphilitic treatment has cured only one patient whose nodes disappeared after the prolonged use of KI. in large doses.

In another patient, undoubtedly syphilitic, a long course of KI.

was followed by the disappearance of an induration in one c. c., while a new node showed itself in the other. So that the treatment was not conclusive as to the etiology of the affection.

Some have thought that the affection might be the result of a traumatism. But there is no evidence in favor of such etiology unless we accept as proof the two following rather remarkable cases reported by O'Zoux, of Bordeaux: Two young men, intimate friends, Mr. O., medical student, and Mr. T., a soldier, after exposure, injected with force, as a prophylactic, a strong solution of sulphate of copper. Two months later the soldier showed the student a small hard nodule the size of a pea in his right c. c. He had discovered it by accident. He had never had either tenderness or pain. The student then examined his own penis, and to his great surprise discovered a similar lesion. Neither of these young men had ever had any venereal disease nor did they suffer from gout, diabetes or rheumatism; it is not probable that their nodes had a traumatic origin, as they never had either pain, tenderness or an ecchymosis. Their nodes did not disappear.

The histology of these tumors is not very well known. In the case of a man aged 50, from whom Tuffier removed one on account of pain, the microscopical examination showed that it contained both fibrous and cartilaginous tissues and was a chondro-fibroma.

A node removed four years ago at Bellevue Hospital, N. Y., for examination, was said by the pathologists of the Carnegie Laboratory to be a carcinoma of the c. c. (*Med. Rec., N. Y.*, 97, v. 1, p. 283.) When gummy tumors of the c. c. shrivel up, and become fibrous or calcify, they might be mistaken for the nodes of plastic induration. The former are very rare—occupy generally only the anterior third of the penis—are hard, painless swellings which have been larger, and the patients have a history of syphilis.

In plastic induration the nodes are hard, frequently tender on pressure and often painful in the beginning, increase in size very slowly, may remain stationary but never diminish, and are not affected by antisyphilitic treatment.

All observers agree in regarding the disease as incurable. In young men it is liable to bring on neurasthenia and be a cause of suicide.

I know of only two cases said to have been cured—one in a syphilitic patient already mentioned and the other a diabetic whose nodes disappeared under treatment for his diabetes. Treatment is useless—removal of the tumors, if they impede copulation and are not too numerous, is recommended by most authors.

Within the last few years I have seen the following cases:

CASE 1.—J. J., a country merchant, consulted me on the 6th May, 1893, for a hard lump in his penis. He is 46 years old—has been 21 years married—father of nine children, two of which died a few hours after birth, he knows not why; one died of diphtheria and one of diarrhoea (infantile). From some unknown cause his wife was prematurely delivered at six months and seven months at her third

fourth and fifth pregnancies. Family history presents nothing worth noting except that patient's mother had during several years oedema of the lower extremities which disappeared about seven or eight years before her death, due to strangulated bowels. Patient resembles his mother, whose family was inclined to obesity. On the 10th March, 1893, after having worked all day in a store that was very cold, J. J. felt a scalding in the urethra during micturition and found that the penis and lower belly were sensitive on pressure. Fifteen days later he discovered some hard lumps in his penis. On the right half-dorsal aspect of penis, one-half inch behind the glans, may be felt a hard, well-defined round plate, seemingly a foreign body, situated in the right c. c. and over which the skin moved freely. It had the shape and was of about the size of a ten-cent piece. A short distance behind this plate both c. c. are hard, round, nodulated and tender on pressure. This induration extends backwards to the crura. During erection penis is bent to the right. There is some scalding during micturition, but no discharge of any kind. Has never had any venereal disease. Has no stricture of the urethra nor any disease of the prostate, and does not remember having suffered any traumatism of the penis. No history of gout or diabetes. After taking KI. during some months there was less smarting on passing water and less tenderness of the indurated parts, but they had diminished neither in size nor in consistency.

CASE 2.—On July 17th, 1893, was consulted by N. L., 64 years, for deviation of the penis during erection. Married 39 years—lost his wife two months ago. One month after her death noticed that during erection penis was bent to the left. Health has been always good. Had gonorrhœa 19 years ago. Family history uninteresting.

*Examination.*—On the dorsal aspect of the penis, close to its root, may be felt a hard, wedge-shaped nodule in the left c. c., entirely independent of the skin, which is freely movable over it. Behind this hard mass are several smaller ones of the same consistency. These indurated spots have never been painful nor have they been sensitive under pressure. Patient has had no discharge during last 19 years—has no stricture—micturition is normal—no disease of the prostate. Has never had syphilis, gout, rheumatism or diabetes. Pot: Iod. had no effect on his disease.

CASE 3.—On October 17th, 1896, saw Mr. T., a lawyer, 50 years. Had been married seven years, then fifteen years a widower; and now married for the second time nineteen months ago. Nothing worthy of mention in his family history. His previous health has been good. Has never had syphilis, gout or rheumatism; but has headaches before bad weather and was rather fond of his drop at one time. Has had gonorrhœa several times. In 1896 he noticed on the dorsum of the penis and about its middle a small hard round nodule of about the size of a pea. Since his marriage this has increased in size, and during erection the organ is so much bent to the left that, as he says, had his wife not

made the acquaintance of several gynæcologists before she made his, he never would be able to fulfil that most important, though unwritten, condition of the marriage contract. He declares that gynæcologists are Heaven-sent.

*Examination.*—About the middle of dorsum of the penis is found a broad plate of bony hardness which extends forwards and becomes narrow, reaching almost to the glans. The narrowed part feels like a pipe-stem, and is grooved on its upper surface, which is flat. It occupies the septum. When young, patient had the habit of bending penis during erection, and since then that organ has always had a tendency to double up when distended.

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### A CASE OF BICORNATE UTERUS MISTAKEN FOR ECTOPIC GESTATION.\*

BY W. J. GIBSON, M.D., BELLEVILLE.

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As the condition known as bicornate uterus is of rare occurrence, and when present renders diagnosis extremely difficult in diseases of the uterine appendages, I desire to place on record a case that came under my observation a few years ago and led to an error in diagnosis.

I was consulted in October, 1895, by a young unmarried woman who complained of a profuse leucorrhœal discharge which for some months previous had been a source of very considerable discomfort. Her general health was good, menstruation regular, and except for the irritation caused by the discharge she was apparently in good physical condition. There was no suspicion of specific cause. No examination was made at the time. Complete rest and astringent douches were ordered, and in a few weeks the discharge ceased.

I did not see the patient again until March of the following year, when I was called to attend her for a severe attack of bronchitis. At this time she complained of pelvic pain of a bearing down character, and stated that she had not been regular. Further questioning elicited the fact that there was a suspicion of pregnancy, and that menstruation, hitherto regular, had failed to appear in January. Of her own accord she had tried a number of domestic remedies, and in February, about the usual time, menstruation returned, lasting three or four days, of normal amount, and accompanied by a great deal of pain. The character of the flow was, as she described it, shreddy.

I did not make any examination, but advised her to keep quiet until her cold was better and then to let me know how she was. A month elapsed before she again consulted me. She looked very much run down; said that the period had failed to return, and that

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\*Read at the Canadian Medical Association, Quebec, August, 1898.

she was constantly sick at the stomach, could not retain anything. I sent her to the hospital, and on making an examination found the cervix softened, an ovoid tumor lying to the left of the uterus, apparently continuous with it, and in size about two inches wide and three inches long. It was extremely tender to the touch; slightly movable. Further examination disclosed to the right what I believed to be the body of the uterus. I was puzzled as to the condition; I thought there was a congenital lateral displacement of the uterus to the left, and to the right a fibroid growth. It seemed to me that if my conclusion was correct, the severe and almost constant pain could be accounted for by the firm attachment of the organ in an unnatural position, preventing its gradual ascent from the pelvis. Again it struck me that it might be a case of ectopic gestation. The great amount of pain, threatening rupture, together with the history of flow in February, of a shreddy character, gave strong probability of ectopic gestation.

Still another solution presented itself. There was a possibility that it might prove to be a bicornate uterus. I determined to give the patient chloroform to facilitate examination. I accordingly asked Drs. Clinton and Yeomans in consultation and explained the nature of the case. Chloroform was administered, and we proceeded to make a careful examination. I stated I was in doubt as to tubal pregnancy or bicornate uterus.

Both Dr. Clinton and Dr. Yeomans made an examination and found the condition as stated. I determined, therefore, to find out if possible whether the body to the right was the uterine body; and with this object in view, cautiously introduced the sound, directing it to the right, and it passed in without resistance to a distance of three and one-half inches. By external pressure from above, and gentle movement of the sound, it was clear, from the very perceptible movement, that the sound was in the uterine cavity; that much at least was clear. There appeared to be no means of determining between tubal pregnancy and bicornate uterus, except by exploratory incision. The patient's condition was fast becoming desperate from the constant pain, incessant vomiting, and loss of sleep. She was terribly emaciated, and was evidently fast going down. It was decided to make an exploratory incision, our conclusions leaning towards tubal pregnancy. Preparations were accordingly made, and on the following day, assisted by Drs. Clinton and Yeomans, I opened the abdomen and the condition was at once disclosed. The tumor proved to be the impregnated left horn of the uterus; the tube and ovary were normal. On the right side was the other horn with tube and ovary. Ovary on the right was smaller and tube shorter than that on the left. I at once closed the abdomen with three tiers of catgut sutures. The skin was approximated with fine silk sutures, and the usual dressing applied. Patient returned to bed very weak, but soon rallied. Vomiting and nausea increased; pain also continued more severe than before. Hypodermic of morphia and

atropine was given which produced some relief. The history of the following eight days was indescribable. What with thirst, nausea, vomiting and pain, it was almost impossible to keep her in bed. She could not be kept quiet in any position, but tossed restlessly to and fro, apparently in agony. I was in constant fear that the wound would open from the severe strain put upon it. I felt the patient would surely die unless abortion was induced, and this I was afraid to attempt lest the accompanying labor pains should force open the wound. So restless had she become that she would sit up in bed in spite of the nurse's efforts at restraint.

On the eighth day after the operation I was hurriedly summoned, and found her flowing, the os dilated, foetus presenting, and labor pains severe. In less than twenty minutes after my arrival the foetus came away, quickly followed by the placental structures. The foetus was quite macerated, and had evidently been dead for two or three weeks. I at once gave her an inter-uterine douche of one to five thousand sol. bichloride. I do not know which was the more relieved at the result, the patient or myself. Her recovery, though slow, was uneventful. The abdominal wound stood the strain and the union was perfect. She remained in the hospital for six weeks following, and before dismissing her I passed a sound without difficulty into each horn of the uterus, and the horns could be easily made out by bimanual examination. Only one cervical canal could be discovered.

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### PULMONARY TUBERCULOSIS—SYMPTOMS AND DIAGNOSIS.

BY JOHN HUNTER, M.D., TORONTO.

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PROBABLY no other disease, unless it be syphilis, presents such a diversity of symptoms, in number, kind and degree. A person may have lived many years after the primary infection without sign or symptom of the disease, and yet after death from some other cause, tubercular foci may have been found in the lungs. At the Congress of Tuberculosis recently held in Paris, Beclère read a communication in which it was stated that out of 124 cases admitted into the hospital for medical or surgical treatment, and who had been carefully examined by the usual methods for evidence of tuberculosis, and pronounced free from it, yet, on being submitted to the X-ray test, fifty-one presented abnormalities of various kinds—lessened transparencies of the apices, enlarged bronchial glands, opacity of the pleura, diminished movement of the diaphragm, etc., appearances quite characteristic of tuberculosis. His conclusions are that latent tuberculosis exists in two or three out of every five young people, and that the tubercular lesions are dis-



guised under the mask of anæmia, chlorosis, dyspepsia and neurasthenia.

On the other hand, so pronounced are the evidences of the disease that people, standing on the platform of railway stations at any of the Southern health resorts, keep facetiously remarking, "Hello! more lungers," as patients step off the cars.

There is a great contrast between the condition of those with latent lesions and those in which the lung tissue is extensively involved. The following description will include the symptoms most frequently found between the initial invasion of the bacilli and the fatal termination. The patient's attention is often first drawn to his condition by remarks made by his friends. They notice that he has changed somewhat. His features are more pinched; skin dry, sallow or pale; lips parched; one or both cheeks flushed; eyes bright; emaciated; short, dry, hacking cough. He admits that he is not quite himself, and attributes his condition to a "cold." He says he cannot get altogether rid of his cough.

*Cough.*—This is one of the earliest and most persistent symptoms. It is influenced in frequency and character by impure air, anything that causes irritation anywhere in the respiratory tract, and by the conditions and contents of the tubes and air cells. It may be attended with expectoration of a small quantity of frothy serum or mucus, or by a very large amount of muco-purulent matter. Change of position is very apt to excite an attack of coughing.

*Sputum.*—This is modified in quantity, consistency and character by the amount of secretion and exudation, dilatation of bronchi, and presence of cavities with patulous openings. The quantity may be very limited or so excessive that pints may be expectorated during the twenty-four hours. The consistency varies from a watery serum to thick agglutinated masses, and in character it may be simply serum or mucus, blood, pus, or any admixture of these.

*Temperature.*—Unless in hospital cases it is very difficult to get a reliable temperature record during the early stage of the disease. However, if the temperature be taken—especially in the rectum—say, every fourth hour throughout a period of two or three weeks, a series of pretty uniform elevations and remissions will be recorded—the former beginning about 1 or 2 p.m., reaching a maximum between 4 and 7, and subsiding to normal by 10 p.m. Between midnight and noon the temperature may remain about normal, but often in the early morning hours it may be subnormal from  $\frac{1}{2}$  to  $1\frac{1}{2}$  degrees. As the disease advances, septic conditions arise with characteristic temperature fluctuations. The range may extend from 95 to 108°. In some cases there is a reversion of the usual type—the elevation occurring in the morning and the remission in the afternoon

*Pain.*—This is pre-eminently cosmopolitan. Any organ in the body may be the initial "storm centre." Slight or intense pain,

cranial, aural, ocular, facial, laryngeal, cardiac, gastric, hepatic, splenic, intestinal, renal, ovarian or cystic may antedate the pulmonary symptoms. In a recent case intense pain over the gastro-hepatic region preceded for fully a month the appearance of any sign of lung trouble. The pain may be located over any part of the pleura and be due to a localized pleurisy.

*Emaciation.*—The fatty tissues usually waste away early. The tissues above and below clavicles and between ribs atrophy, giving the chest quite a characteristic shape—supra and infra clavicular and intercostal depressions, antero-posterior diameter diminished, transverse and longitudinal apparently increased. The atrophy of muscles about scapulæ allows these bones to project, forming the so-called “winged scapulæ.” The emaciation varies very much in degree and may be general, or certain parts of the body may be much more affected than others.

A change of climate often enables a patient to regain his weight, even to the extent of 20, 50 or 100 lbs., although the physical signs still show extensive lung trouble. Patients admitted into hospitals or sent to a sanatorium frequently gain in weight during the first few weeks, or even when the disease becomes quiescent several pounds may be regained.

*Digestive System.*—Closely associated with, and often a potent factor in producing emaciation, is disturbance of the digestive functions. The appetite may be impaired early and even vomiting may occur, although much more frequent at later stages. It is often a very troublesome factor at or soon after meal-time, or during paroxysms of coughing. The tongue may be pale, flaccid, indented with the teeth, pretty uniformly covered with a thin white, or thicker yellowish fur, or some areas of it may be clean, with papillæ, large, red and irritable. The amount of fever influences the condition of the lips, tongue, fauces and pharynx. The mucous membrane becomes parched, raw and fissured. The tonicity of the stomach is very apt to be impaired, permitting a large amount of distention, so that food or medicine is very imperfectly prepared for assimilation or absorption. The secretions and digestive functions of the intestines may be disturbed, producing constipation or diarrhœa. Ulceration may occur anywhere along the tract, giving rise to pain, tenderness or hæmorrhage. Anal fistula, especially in male patients, is quite common.

*Nervous System.*—All, or any of the “side shows” accompanying the aggregation styled neurasthenia, may be in evidence under the canvas of tuberculosis—innumerable pains and aches, persistent or recurring at intervals; insomnia or drowsiness, buoyancy or depression. However, one mental characteristic is especially well marked, and that is “irrepressible hope.” He feels sure of being better by and by.

*Cutaneous System.*—In the earlier stages and often throughout the whole course of the disease, and especially with those who are somewhat vaguely classified as of nervous or sanguine tempera-

ment, the skin becomes quite transparent and mobile, giving the patient a delicate, hyper-sensitive expression. In other cases more or less pigmentation occurs, giving rise to freckles or yellowish brown patches. The presence of more or less profuse perspiration, especially at night, is an early symptom, and may become very troublesome and persistent.

#### DIAGNOSIS.

Frankly assuming that pulmonary tuberculosis is one of the most curable of chronic diseases, and considering the relationship existing between patient, relatives and public, as to infection, the importance of the earliest possible recognition of the disease cannot be overestimated.

Ever since the discovery of a specific bacillus its presence in the sputum outweighs all the other evidences of the disease. It follows then, that the most scientific microscopic tests be persistently made, if necessary, for several months. The bacilli may not be found until the contents of a cavity appear in the sputum, or they may be absent during some stages in all cases, especially when there is no active softening going on. Their continued presence in the sputa may also be accepted as positive proof of the character of the disease. In the absence of the bacilli the symptoms already enumerated and the following physical signs have to be relied upon for making a diagnosis:

*Initial stage.*—When the apex becomes infiltrated with tubercular deposit, respiratory movement is diminished. This is more distinctly observed by standing behind the patient and looking over the shoulder, or by fixing attention to the movements of the second rib. Palpation reveals increased vocal fremitus. However, great care must be exercised in comparing the two sides, remembering that it is normally more pronounced over right apex; hence, when it is equal on both sides, the left apex is probably involved. Percussion may elicit a duller note, above, over, or below the clavicle. Slight differences in the amount of resonance may be made more appreciable by having the patient retain his breath for some time after a deep inspiration.

*Auscultation.*—In the healthy chest the inspiratory murmur is somewhat higher pitched, and the expiratory more prolonged on the right side than on the left. Overlooking this condition may lead to serious error. Making due allowance then for the difference, in the two sides, the harshness or feebleness of the sounds are to be estimated. Usually the harsh sound with prolonged expiration is heard first. As the disease advances the breath sounds become feebler and interrupted, and after coughing râles may be heard. The harsher and the feebler sounds indicate stages in the progress of the disease, the latter the more advanced, the former the initial process. Neurotic subjects, with healthy lungs, may present bilaterally interrupted wavy sounds. Where considerable infiltration has taken place, the voice and heart sounds are con-

veyed more distinctly. The patient should be asked to fold the arms, and bow the head forward in order that the upper parts of interspace between the scapulæ can be thoroughly examined for involvement of the apex of the lower lobe. Special attention should be given to the fact, that when only one lung is impaired, the functional activity of the healthy one is increased. There will be puerile breathing and increased expansion. Overlooking this fact has led to many ridiculous blunders, one physician locating the trouble in the healthy lung, another in the diseased one, the patient being much embarrassed to know how both lungs can be sound and diseased at the same time.

*Râles.*—These sounds vary in character with the progress of the disease. At first a few fine crackling sounds are heard on deep inspiration, but later as liquids accumulated in cells and tubes, they become numerous, and of a louder, moister tone. Careful search should be made in supra-spinous region, as the disease is usually more advanced over posterior portion of the apex. The change in the number, size and quality of the râles indicates the progress of caseation or softening going on in the tubercular lesions.

*Cavities.*—When these become numerous or extensive about apex, the shoulder is depressed, clavicle and scapulæ elevated, supra-spinous and clavicular fossæ sunken, intercostal spaces widened and chest flattened. Percussion note may be high pitched, tubular or tympanitic. Vocal fremitus increased. On auscultation the breath sound varies with the extent of the openings, condition of cavity walls and contents of cavity. The following are some of the terms used to describe the sounds associated with cavities: hollow, cavernous, metallic or amphoric, gurgling, echoing, etc. "Post-tussic suction is another highly significant sign; it consists of a high-pitched, sucking, inspiratory sound immediately following the forced expiration of cough, and is due to the elastic recoil of the cavity walls."

*Sequelæ.*—The ordinary course of this disease may be very much modified. The presence of pneumonia, pleurisy, emphysema, bronchitis or laryngitis adds its own specific features.

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DR. CHAS. ROBINSON, of Brampton, was seized with heart failure on October 17th just at the completion of a surgical operation that he had performed, assisted by Dr. Bowles, of Woodhill, near Bolton, and expired almost instantly. Dr. Robinson was born at Claude sixty-three years ago, and lived there for thirteen years, when he bought Dr. Pattullo's practice and property in Brampton. He contested the riding of Cardwell twice in the Liberal interests, and was returned once, but defeated subsequently. He leaves a widow and three daughters. The funeral took place on Wednesday the 19th.

Selected Articles.

**THE ELIMINATIVE TREATMENT OF TYPHOID FEVER—A  
REPLY TO A RECENT CRITICISM OF THIS METHOD.**

BY W. B. THISTLE, M.D., L.R.C.P. (LOND.), TORONTO,

Lecturer in Clinical Medicine and Diseases of Children in the University of Toronto; Physician to the  
Victoria Hospital for Sick Children and to the Out-Patient Department, Toronto Hospital.

IN a recent paper on "Some of the Intestinal Features of Typhoid Fever,"<sup>1</sup> Dr. Osler refers to the eliminative plan of treatment as follows: "We have possibly been too fearful of the dangers of the use of purgatives in typhoid fever. The experience of a great many men who have adopted the eliminative method of Thistle, or who have given salines or calomel freely, shows that the mortality is not materially increased over that from the ordinary symptomatic plan. My contention, however, is that they are not indicated, as it is not likely that the typhoid bacilli multiply and develop their poison to any extent in the intestinal contents themselves."

The first sentence in the above quotation would seem to indicate a remarkable change in the mind of the distinguished author regarding the use of purgatives in typhoid fever. Hitherto their use has been denounced by him as "wrong in theory and dangerous in practice." Now, accepting the experience of a large number that the practice of giving purgatives in this disease is not dangerous, and thus having got rid of "the lion in the way," he still maintains that their use is wrong in theory. The eliminative and antiseptic method of treatment has on other occasions received some attention at the hands of Dr. Osler, but always in the way of denunciation and adverse criticism.

To this course one could not possibly have the slightest objection but for the fact that the criticism has been directed, not against the theory advanced, but against what the objector supposed to be the theory. From the consistent way in which the theory of eliminative treatment has been misstated and misunderstood by him,<sup>2</sup> the only inference open is that my papers on the subject in which the theory involved in this plan of treatment was set forth had unfortunately escaped his notice.

The quotation from his recent paper, given above, illustrates admirably what I have just stated. His contention that purgatives are not needed, because he considers it unlikely that the typhoid bacilli multiply and develop their poison to any extent in

the intestinal contents themselves, would imply that in carrying out this plan of treatment purgatives are given with the sole purpose of clearing typhoid bacilli and the poison generated by them from the intestine.

Such is not the case, and it is manifestly a misrepresentation of the theory of eliminative treatment to convey any such idea to the mind of the reader. In all my published papers<sup>3</sup> I have taken the utmost pains to combat this error and to point out that the idea of elimination by means of purgatives must not be limited or confined to the simple clearing of bacilli and toxins from the intestine, but must also embrace withdrawal of toxins from the body by way of the intestine. In short, elimination in typhoid fever must be understood in the same sense as elimination in, for example, lead poisoning.

The idea in the use of purgatives in the treatment of typhoid fever, if I may be permitted again to outline the theory, is:

1. To facilitate throughout the entire duration of the disease elimination of toxins from the body.

2. To clear out the intestines at the earliest moment, carrying away bacilli and toxins which would otherwise in all probability go to increase the existing infection and intoxication of the body.

3. To keep the intestines as free as possible from bacilli and toxic substances, thus preventing in a great measure reinforcement to the bacilli and toxins already located in Peyer's patches, the solitary glands, mesenteric glands, spleen, and other parts of the body.

4. To maintain the bowels free from bacilli, of all kinds, and from accumulations of decomposing and toxic substances, and thus to enable the liver to exercise its poison-destroying and depurative functions to greater advantage against the poisons produced by the colonies of bacilli situated in the lymphatic structures, spleen, or elsewhere in the tissues and fluids of the body.

Modern physiology has made it clear that one of the greatest functions of the liver is to intercept and destroy or cast out of the body toxic substances found in the circulation.

The toxic substances must of course be carried to the liver either by the blood stream in the hepatic artery or by the veins of the portal system.

As a result of this poison-abstracting function of the liver, the pint or more of bile daily poured into the intestine is under ordinary circumstances in the healthy body highly toxic. Semmola and Gioffredi in their recent work on "The Physiology of the Liver and the Function of Bile," in the "Twentieth Century Practice,"<sup>4</sup> accept the estimate made by Bouchard, that the bile is under ordinary circumstances nine times as toxic as the urine.<sup>5</sup> They also draw attention to the fact that in case of bacterial invasion, such as typhoid fever, the toxicity of bile becomes immensely increased.<sup>6</sup>

It is therefore most reasonable to assume that by frequently

and repeatedly clearing from the intestine this highly toxic bile the sum of poison in the body is lessened, for be it remembered, if the bile poured into the intestine be not carried on out of the intestine, it to a great degree becomes reabsorbed, and thus the effort of the liver to free the body of the toxic substances is in a measure rendered nugatory.

In the case of the typhoid toxin Semmola and Gioffredi quote Roger as having demonstrated that it actually is intercepted by the liver.<sup>7</sup>

Clearing out the intestine and maintaining it as free as possible from all forms of bacilli and toxins indirectly assists the depurative function of the liver, for the less the amount of poison carried by the portal system from the intestinal tract, the more effectually will the liver deal with the toxins in the general circulation. This scavenger function of the liver is, however, exercised within certain limits, and if excessive quantities of poison should be carried from the intestine the function may be taxed to the full; and so the liver will be unable to deal with the toxins in the systemic circulation. Or, again, the portal blood may carry so much toxin from the intestine as completely to overwhelm the liver, so that it is able neither to guard the portal entrance nor to intercept toxins coming through the general circulation. The irritation of hepatic tissue in this way would seem to furnish an explanation of the tenderness and enlargement of the liver sometimes noticed during the course of typhoid fever.

Consideration of these facts in hepatic physiology cannot but impress one with the desirability of constantly clearing away the toxic bile and of keeping the intestine as free as possible from bacilli and toxic substances throughout the entire duration of the disease. It also shows the wisdom of employing intestinal antiseptics and of exercising care in the arrangement of the patient's food, so that the least possible residue may escape assimilation and remain in the intestine to undergo decomposition.

The antiseptic substances chosen should, however, be the least harmful, for, if poisonous substances are selected to purify the intestine, they themselves become a tax upon the liver. I have before pointed out that toxic antiseptics—*e.g.*, salol—can be used much more freely if at the same time purgatives are employed frequently.<sup>8</sup>

Elimination of toxins by way of the intestinal canal, although mainly through the medium of bile, occurs to a very considerable extent through the serous exudate from the intestinal wall.

None, I imagine, will question the correctness of this view. In a condition such as typhoid, where the fluids of the body hold in solution excessive quantities of toxic substances, the serous exudate into the intestine in response to purgatives must of necessity bring with it some of the toxins. Purgatives, then, facilitate elimination of poison from the body through the toxic bile, and to a lesser degree perhaps through the toxic serum.

One cannot leave the consideration of this subject without noticing the indispensable relation which the giving of large quantities of water bears to the use of purgatives in this scheme of elimination. Unless care be exercised in this matter the fluids of the body would be drained off, to the serious disadvantage of the tissues. Moreover, the toxins in the body would become more concentrated and therefore more harmful.

A moment's reflection will show the wisdom of this course during the employment of purgatives, in this way replacing the toxin-laden fluid which has been carried away.

Although the purpose of this paper is to indicate the use of purgatives in the treatment of typhoid fever, yet in the eliminative plan of treatment which I have advocated the excretory function of the kidneys was not lost sight of, and it was shown that elimination of toxins by the kidneys is facilitated by the giving of large quantities of water.

I have before also advocated the use of calomel, in connection, of course, with salines, because of its excellent diuretic action.<sup>9</sup> It consequently promotes elimination through both the intestines and the kidneys.

To summarize, the use of purgatives in typhoid fever and the purpose of the eliminative plan is:

1. To limit the original infection and intoxication of the system generally.

2. To carry away the toxic bile as it is poured into the intestine.

3. To promote elimination through the medium of the serous exudate into the intestine.

4. To promote excretion of toxins by the kidneys.

5. By lessening the toxæmia, to increase the resistance and aggressive action of the tissues. (I have before drawn attention to the fact that the aggressive and defensive action of the cells must be in inverse ratio to the degree of toxæmia.<sup>10</sup>)

6. To prevent excessive accumulation of bacilli (typhoid bacilli, colon bacilli, etc.) and toxins in the intestinal glands, thus lessening the likelihood of extensive necrosis and ulceration, and the dangers incidental to that condition.

7. By maintaining the intestine as free as possible from bacilli and toxins, and frequently clearing it out to lessen the work thrown on the liver from the portal side, and thus to enable it to exercise its depurative function more fully in the interception of poisons in the general circulation.

8. To lessen the chance of death from exhaustion due to the long-continued action of large quantities of poison on the tissues.

9. To lessen the amount of poison in the body and avert the danger of death from excessive accumulation of toxin, *i.e.*, acute toxæmia.

10. To prevent the discomfort and danger arising from accumulation of gases in the intestine.



11. To prevent or control diarrhoea. Whether the diarrhoeal flux be due to bacilli or irritant matter in the intestine or is the physiological result of toxic substances in the system, in either case the action of purgatives would be beneficial. In the one case the irritants, whatever their nature, are removed; in the other the systemic toxæmia is lessened.

12. By keeping toxæmia at the lowest possible point, the functions of digestion and assimilation are less interfered with and nutrition is better maintained.

Dr. Osler will have it that the advocates of the use of purgatives and antiseptics look upon typhoid fever as a disease of the intestines, while he himself would be with those who have learned within the last few years that it is an infection of the system generally. Such an assumption is entirely unwarranted. My own position has always been that typhoid fever is a disease primarily of the intestines, the bacilli first invading the tissue in the intestinal wall and afterward reaching all parts of the body. Although primarily a disease of the intestine, it quickly becomes a general infection. So great an authority as Prof. Sydney Martin adheres to that view of the question, and considers that "the arguments advanced in support of the belief that typhoid fever is a general infection with a secondary intestinal lesion, are not very satisfactory."<sup>11</sup>

He considers that, "from our knowledge of other intestinal infections, the view that the infection in enteric fever is primarily intestinal is the more logical."

That intestinal ulceration is not an essential or necessary feature in typhoid fever I fully believe. I advanced that view in my paper published in the *Medical Record* of March 1, 1894, and pointed out that if the intestine be thoroughly cleared the process of infection is interrupted, the local infection of the gland to some degree limited, and as a result the glandular tissues are more likely successfully to resist the bacilli already located in them and to escape necrosis and ulceration.

Coming now to the contention that it is not likely that the bacilli in the intestinal contents multiply and produce their poison there to any extent, at the outset I desire to point out that the presence of specific bacilli in the intestinal contents is not essential to the theory of eliminative treatment. In their entire absence the effect of purgatives would still be to carry out of the body the poison-laden bile and the serous exudate containing its quota of toxin. However, the objection does not appear to be well taken. There are many reasons that make it extremely likely that the specific bacilli do multiply and produce their poison in the intestinal contents themselves.

Presumptive evidence of their multiplication in the intestines is furnished by the fact that the infection is carried by the intestinal contents. The simultaneous infection of several feet of the intestinal mucosa I have before advanced as a reason for believing in a previous multiplication in the intestinal contents.<sup>12</sup>

There is much difference of opinion among bacteriologists concerning the identification of typhoid bacilli in the intestinal contents. The very close resemblance to the colon bacillus is the great difficulty. As bearing directly on this question, I quote the following from the recent Croonian lectures by Prof. Sidney Martin.<sup>13</sup> "It has been said that inasmuch as the bacillus is not constantly found in the motions and is found in the urine, that there are not many bacilli in the intestine. There is nothing whatever in this argument. We can readily see that the bacillus might not be discharged in the fæces in sufficient numbers to be easily found. Moreover, if there is a great increase in the number of bacillus coli in the intestinal tract, not only is there great difficulty in finding the typhoid bacillus in the presence of large numbers of this micro-organism, but the more vigorous bacillus coli might actually beat out of the field the less vigorous typhoid bacillus."

One must also not lose sight of the fact that much of the toxæmia is, as I have before argued,<sup>14</sup> in all probability due to the products of associated bacilli and to decomposition in the intestine.

In the case of the bacillus coli the probability is exceedingly strong that it plays a very considerable part in the production of the symptoms seen in typhoid. In a former paper I drew attention to the fact that the damaged intestinal wall opened the way for the migration of the colon bacillus from the intestine.<sup>15</sup>

The recent experiment of Sydney Martin<sup>16</sup> would seem to have definitely settled the point. He extracted colon bacilli from the spleen of a patient with typhoid fever, and found that their virulence was much increased over that of colon bacilli from the normal intestine. He assumes, also, that the colon bacillus had been carried from the intestinal canal.

We have in this experiment an actual demonstration of the correctness of the view held by many that the bacillus coli becomes increased in virulence when associated with the typhoid bacillus. It is also confirmatory of the belief that the injury done to the intestinal wall by the specific bacillus opens the way for the colon bacilli. These facts being borne in mind, it is surely not difficult to appreciate the advantage of keeping the intestine as free as possible from bacilli of all kinds, even if one were to grant, in spite of evidence to the contrary, that the typhoid bacilli do not multiply and produce their poison to any extent in the intestinal contents themselves.

I believe, too, that in preventing decomposition and bacterial accumulation in the intestines, the liability to those bacterial invasions of the weakened body in the late stage of the disease, commonly spoken of as "terminal infections," is greatly lessened. Undoubtedly the invading bacilli in the vast majority of these cases come from the intestine.

The constant effort to facilitate elimination and keep the toxæmia at the lowest point throughout the disease of course con-

tributes in lessening this liability, owing to the fact that nutrition is less interfered with, and consequently the tissues maintain a higher quality of resistance.

In advancing the theory of eliminative treatment in typhoid, I have always adhered to the view that much of the toxæmia and many of the symptoms were due to the associated bacteria;<sup>17</sup> that there was, in other words, a mixed infection, if not primarily, at all events as a later development.

Regarding the experience of those who have adopted the eliminative plan of treatment, I am not disposed to accept what Dr. Osler asserts is their verdict, namely, that the mortality is not materially increased over that of the symptomatic plan. Their experience, I believe, and I have had many communications and many opportunities for discussion, goes to show that the adoption of the eliminative plan lowers the mortality in a remarkable degree. More than that, it lessens the severity of the symptoms and the duration of the fever. Indeed, many of the symptoms wholly disappear under this form of treatment.

I might instance the record of the Toronto General Hospital, although not all the cases were treated on this plan. However, the vast majority were treated either on the eliminative plan or by means of calomel and salines or other purgatives freely and frequently given. No selection of any kind was made and there was no attempt to make a record. One of the deaths occurred on the day the patient was admitted. No cases are excluded from the list. In the four years from 1893 to 1897 there were 563 cases, with 37 deaths, 6.57 per cent. mortality.

In the paper above referred to and on a former occasion, Osler, in referring to this plan of treatment, directs attention to the fact that La Roque, of Paris, advocated the use of purgatives in the treatment of typhoid cases in 1849, and is inclined to make it appear that the plan of treatment advanced by me is simply a revival of an old treatment. While I would not for a moment detract from whatever credit is due M. La Roque, yet I altogether fail to see how the empirical giving of purgatives in utter ignorance of the nature of the disease, at a time when no distinction was made between typhus and typhoid, and when the existence of bacteria was not even guessed at, can be made to appear identical with the eliminative plan advanced by me and based on the relatively clear light which the most recent facts of physiology and bacteriology have thrown upon the pathology of typhoid fever and upon the nature of bacterial processes in the body generally.

Reference is also made to what Professor Osler somewhat contemptuously calls the "gunshot" Woodbridge tablet. Examination into this method of treatment shows it to be simply an adaptation of the eliminative and antiseptic plan. At first the use of the calomel and antiseptic tablets was unaccompanied by any theory as to their action, but gradually the theory advanced by me,

setting forth the eliminative and antiseptic plan of treatment, has been utilized, until recently the title chosen by me for my first communication on the subject has been appropriated, and one reads of "the eliminative and antiseptic treatment of Woodbridge."

Why simply combining a purgative with antiseptics in the form of a tablet, after the theory and principles involved have been fully set forth, should be considered a special form of treatment, passes comprehension. One cannot easily see, either, the advantage of a scheme which make the attending physician simply an automaton.

Surely the choice of purgatives and antiseptics and the apportioning of them may with much greater advantage be left in the hands of the physician at the patient's bedside. Having a clear conception first of what he hopes to accomplish by them, he may then make his selection and arrange dosage from day to day, according to the requirements of the case, in a rational manner.

In conclusion I may be permitted to point out that my contention in the article in which the theory of the eliminative and antiseptic plan of treatment was first set forth, in the *Canadian Practitioner* of April, 1893, was that the profession had, to use Osler's words, been too fearful of the danger of purgatives in typhoid fever, that the danger had practically no real existence, and that the imaginary danger most effectually barred the way to treatment which appeared to be the logical outcome of the clearer ideas concerning the nature of typhoid fever, and in a general way, of bacterial processes.

So unorthodox a contention met with widespread opposition, as might have been expected, because it was diametrically opposed to the teaching found in every text-book on medicine. However, since that time opposition in this country has gradually disappeared, until now we have this virtual acknowledgment of the correctness of the position I then took, coming from one of its most pronounced and most powerful opponents.—*British Medical Journal*.

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## URIC-ACID DIATHESIS.

[DIGEST.]

At the recent meeting of the Association of American Physicians, held at Washington, D.C., in a discussion which took place on "Uric-Acid Diathesis," Dr. James Tyson, of Philadelphia, said that the uric-acid diathesis was hard to define. It was generally a weakened condition showing scant, highly-colored urine, which deposited a copious sediment of uric acid mixed with urates of oxalates. Later on there were some albumen and casts. This did not tell what the uric-acid diathesis was, but it gave certain points from which we might infer its presence. The tendency of the uric-acid diathesis might lead further on to uric-acid gravel and calculus, with consequent irritation of the urinary tract, perhaps with cystitis and nephritis. It might mean even more than this. It might cause depression of spirits. The pulse was low and there was marked lithæmia. Measures should be used to eliminate and get rid of this latter. Migraine might be another symptom of the uric-acid diathesis. The speaker related a case of migraine which was cured by large quantities of Célestine Vichy. Eye-strain and other reflex causes might be active factors. Again, the uric-acid diathesis might be the cause of endometritis, degeneration of the blood cells, and hypertrophy of the left ventricle; it might cause vertigo of the most distressing forms. Uric acid and its congeners played an important role. It was not known whether it produced glycosuria, asthma, bronchitis, and other such conditions, or whether it caused rheumatism and gout. The speaker did not think that uric acid had anything to do with rheumatism. Gout usually attacked well-to-do persons past forty who had lived high. Muscular rheumatism usually attacked younger persons. Haig thought that rheumatism could be cured by making the blood alkaline. The term rheumatic gout was not a happy one, and rheumatic arthritis also was an expression that should not be kept up. Another form of gout was found among the poor; it was not hereditary and it was not like the other form of gout. Mixed diet was necessary. Persons so affected should be well fed and they usually got well; food was better than medicine. Rheumatoid arthritis or deforming arthritis was a very distressing form of the disease. It occurred between the ages of twenty and thirty, and might be caused by grief or anxiety. It was doubtful whether epilepsy could come from uric acid. Uric-acid sediments had been found in diabetes, but with this the resemblance of the latter to the uric-acid diathesis ceased. The specific gravity was high, but this was usually from the sugar. Excess of uric acid could be caused by overstudy. It was not so common in this country as abroad. In a certain number of cases of supposed diabetes tests had shown uric acid to be the trouble.—*New York Med. Record.*

## Orthopedic Surgery.



... IN CHARGE OF ...

B. E. MCKENZIE, B.A., M.B., AND H. P. H. GALLOWAY, M.D.

### ARTHROTOMY OF KNEE.

O'CONNOR (*Amer. Jour. of Surgery and Gynecology*, May, 1898) reports twenty-two consecutive arthrotomies of the knee for various conditions. The operation was done six times for traumatic hæmarthrosis, three times for traumatic serous effusion, once for chronic synovitis (six months' duration) following injury, twice for chronic rheumatic arthritis with effusion, four times for acute rheumatic arthritis, and six times for gonorrhœal arthritis. Details of each case are given, and the results appear to have been remarkable, a practically complete cure having resulted in every case. In some of the cases, notably those of rheumatic origin, other plans of treatment had been ineffectual.

All the joints were irrigated during operation with mercuric lotion, and in five cases it was daily repeated. Drainage was continued in each instance until the serous discharge had ceased and nothing but normal synovial fluid trickled from the wound. This period appears to have been usually from two to eight days, but in several instances the author has omitted to state the exact time in giving the history. Splints were used in six cases, but were early discarded, active motion being enforced as soon as the gauze drain was dispensed with. In no case was there any cause for post-operative anxiety.

H. P. H. G.

### ACHILLODYNIA.

GOLDTHWAIT (*Boston Med. and Surg. Journal*, May 27th, 1897) reports a case of this affection, of which too little has been written. The exostosis near the tendo-achillis was diagnosed by means of palpation, but diagnosis was confirmed by a skiagraph. The tendo-Achillis was drawn aside, and under an anæsthetic a large bursa was opened, the lining membrane of which was found to be hypertrophied. Synovial fringes of the bursa were found which, being caught between the bone and the tendo-achillis, caused pain. Exostoses, as described by Albert, Brackett and others, were present. The symptoms disappeared for a while by rest, but an operation, removing the enlargement of the bone, was done with satisfactory results.—*Boston Medical and Surgical Journal*.

H. P. H. G.

### ARTHRODESIS IN TIBIO-ASTRAGALOID JOINT IN PARALYTIC JOINTS.

HENNERBERG (Inaugural Dissertation, Berlin, 1896) describes four cases. In one, of a child eight and a half years of age, a firm ankylosis followed in nine weeks. In one, a child fifteen and a half years of age, a firm ankylosis was found at the end of three months. In a third, seventeen and a half years of age, after four months firm ankylosis was observed. In a fourth, success was obtained in a patient twenty years of age, but in this latter case ankylosis was observed five months after operation.

Kirmisson (*Revue Orthopédic*, 1896, No. 2) recommends careful laying bare of cartilaginous surface of bone with an ivory wedge placed between astragalus and calcaneum. He bases his conclusions recommending this method on fifteen operations.—*Boston Medical and Surgical Journal*.

H. P. H. G.

### TRIGGER-FINGER.

JEANNIN (Inaugural Dissertation, Paris, 1895) describes as a cause of this deformity a narrowing of the tendon sheath of the flexors at some point. The treatment should usually be expectant, as the affection is not infrequently self-limited. When operative treatment is necessary, it should consist of a widening of the sheath and the complete removal of the obstacle.

Heiltorn (*Loc. cit. Erlangen*, 1895) had an opportunity of observing this affection upon himself. It was developed during his military service, and began with slight pain and a sense of fatigue following a drill at the manual of arms. On the metacarpo-phalangeal joint of the middle finger enlargement was to be felt. A smaller but similar one was felt on the little finger. Straightening of the finger was accompanied by a sharp, cracking noise, and bending with a duller crepitus. Recovery followed an operation, which remained permanent two years after the operation.—*Boston Medical and Surgical Journal*.

H. P. H. G.

DR. MONTIZAMBERT, of Toronto, has been retired from his position as chief quarantine officer at Grosse Isle, and succeeded by Dr. Guay.

At the nominations of Medical Council Division No. 6, held at Owen Sound on November 8th, Dr. James Henry, of Orangeville, was re-elected by acclamation.

Dr. W. W. DICKSON, Pembroke, has been elected representative of District No. 15, on the Medical Council of the College of Physicians and Surgeons of Ontario.

# The Canadian Journal of Medicine and Surgery

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## Editorials.

### MEDICINE AND SUPERSTITION.

As will be readily acknowledged by readers of history, the practice of the healing art is as old as history itself among cultivated races. Even among races without a literature, such as the Zulus and Duallas of Africa, the medicine-man and the witch-doctor exercise their skill with more or less success; and, although their medicines are as primitive as their costumes, yet their ideas of professional decorum illustrate some of the natural foibles of more cultured physicians. For instance, they strongly resent the invasion of their preserves by outsiders. Recently, in Mashanoland, two



medical missionaries nearly lost their lives at the hands of native doctors, who found their incomes reduced by the cheap and efficacious treatment of the foreigners. After all, this is very human. A medical missionary and his wife, who, though educated and refined people, cannot earn a living at home, go to reside among savages and induce them to listen to religious teaching by curing their diseases. Their own salaries being guaranteed by a Board in Europe, they are not obliged to collect fees from their patients, who had previously been in the habit of paying for medical attendance, and so the missionary doctors get the credit of doing a great benefit for no apparent reward. Here legitimate medicine breaks a lance with barbaric superstition, but not exclusively for her own cause. This harnessing of medicine to the chariot of missionary enterprise may be a successful method of catching souls; but it is a bribe and an artifice, as far as religion is concerned, and unfair to medical science. Since the days of St. Luke, physicians have helped to advance the banner of the Cross, and some of them have been men of note, but not in the domain of pills and powders has their renown been won. The founder of Christianity did not utilize the medical skill of His day when He healed the afflicted. And it would seem more in keeping with His practice if the Christian churches of the present age would confine their efforts in healing disease to faith in His name and invocation of His power. When looked at from this standpoint the practice of the Christian Science cult has a certain appearance of consistency, and, whether the result in any given instance is good or bad, the practitioner and patient may at least claim to have the courage of their convictions.

While this may be conceded, it seems strange to a physician, that disbelief in the power of medicine should manifest itself among people of a considerable degree of cultivation, just at a time when medicine is being studied in a true scientific spirit. Had the Christian Science cult developed and reached its present magnitude in the days of the Puritan ascendancy in England, it would be more intelligible to us. Then, however, popular medical science was linked with the grossest superstitions. In the last century, says Darnell, "The European leech held in high esteem the ashes of a burnt witch for gout or fever. Ague, in Ireland, was to be cured by the sufferer swallowing a living spider. In Somerset, England, a large black spider was shut in a box and left to perish; and in Flanders, a spider is imprisoned in a walnut shell and worn

around the neck. In Lincolnshire a girl suffering from ague cuts a lock of her hair and binds it around an aspen tree, praying it to shake in her stead. The first violets of the season may be chewed or a three-colored cat kept in the house. Sir James Simpson knew of a case in Ross-shire, of a lad affected with fits. Mole's blood was given but failed, and a messenger was sent nearly a hundred miles for a bit of the skull of a suicide, which was scraped to dust, mixed with water and administered to the boy." Apart from popular superstition in treating disease, "The London Pharmacopœia, published in 1724, refers to unicorn's horn, human fat, human skulls, dog's dung, toads, vipers and worms as possessing real value in disease." Truly, a list to make a modern physician feel profoundly humble. Yet the very fact that these and other strange, unnatural remedies were employed by the people, is itself a proof of profound, unquestioning faith. Is faith in medicine less strong to-day, when the pharmacopœia has become less fantastical? The crowded hospitals and dispensaries, the numerous pharmacies, some of them even in departmental stores, the employment of physicians by numerous benefit societies, the increased number of registered physicians in Ontario, the operation of Provincial and Local Boards of Health, give a negative reply to this question.

It would take us too far afield to account fully in this article for the origin of the tenets believed in by the "Peculiar People." A wish to save doctors' bills and a too literal interpretation of St. James, chap. v., verse 14, "Is any sick among you? let him call for the elders of the church," etc., may, however, suffice. Parsimony will not explain the origin of the Christian Science cult, for according to the London *Outlook*, "Their consulting charges are heavy and the literature they foist upon their converts is highly priced." A reasonable explanation of their existence might be that as medicine more precisely limits the exercise of her powers and proclaims her weakness as well as her strength, so much the more will imposture raise its head to make the mystic and the unfathomable fill the gaps. To-day, as of old, men hate to die, and if medicine can offer no balm to heal their diseases, they cling in their despair to the veriest driftwood, that is tossed within their reach.

As practised to-day, Christian Science is a system of suggestive therapeutics, in the exercise of which the hierophant, generally a woman, claims solemnly to have a message from God to cure disease, and having thus prepared the mind of the recipient, suggests certain ideas, which may prove curative, if the disease is of such a nature that it can be benefited by suggestion.

While we denounce the blasphemy of the operator and pity the superstition of her dupe, it is permissible to think that in a disease, which may be influenced by hypnotism, viz., insomnia in a hypochondriacal invalid, no harm is done and some good may result. When medicine has said its last word, as in inoperable cancer or advanced tuberculosis, should the Christian Scientist be permitted to earn fees by humoring the whims of the wretched sufferer and filling his mind with vain hopes? By no means. Moreover, if a man suffering from pneumonia, a child with diphtheria, a woman with puerperal fever, should be treated by a Christian Scientist, medical and surgical treatment being stopped or never used, the hierophant is certainly guilty of a crime, should a fatal result occur, and it is the duty of the State to punish such a person for causing loss of life through superstitious practices and in defiance of scientific medicine.

J. J. C.

#### PARISIAN METHOD OF DISINFECTING THE DOMICILES OF THE TUBERCULAR POOR.

At the Congress of Tuberculosis held at Paris last July, Mons. M. A. J. Martin, Inspector-General of the Health Department of that city, read a paper descriptive of the effort made to restrict human tuberculosis by procuring the disinfection of the lodgings occupied by tubercular patients. He endorsed the recommendations of the French Academy of Medicine, which favored: (1) The use of spittoons for the pocket or the apartment. (2) The disuse of sweeping and the use of a damp mop for cleansing floors. (3) Disinfection of the domicile after a patient's death or even after a short occupation of the premises by a tubercular patient, and also disinfection of body linen, bed linen, etc. After describing the present status of gaseous disinfection by sulphur or formaldehyde, he gave the preference to the washing or spraying of surfaces with antiseptic liquids. Washing or spraying, the latter, especially, if done in a careful manner by practised hands, possess the double advantage of securing the cleanliness of the place to be disinfected and of rendering it habitable in a relatively short period. The necessary displacement of the furniture also brings into notice portions of the room which too frequently remain in a flagrant condition of filth. Floors are scrubbed or mopped. Whitewashed walls and ceilings are retouched. Where the walls are papered antiseptic sprays of mercuric chloride and chloride of sodium are used, and a sterilizing of tubercular dust has been thus obtained,

equal to what has resulted from a lengthy contact of the surfaces, of a room with an antiseptic gas. The principal antiseptics used are: Fresh milk of lime, solution of chloride of lime, 100 grains of commercial chloride of lime to 1,200 grains of water, then, after filtration, diluted to a strength of 1 in 10; solution of commercial formol, 5 grains to the litre of water, solution of carbolic acid, 5 per cent., solution of cresyl, 5 per cent., wood vinegar, solutions of soap, and especially the solution of mercuric chloride mixed with chloride of sodium, which, as Miquel has recently shown, procures the definite and immediate sterilizing of tubercular sputa, owing to the property possessed by the chloride of sodium of dissolving the insoluble albuminate of mercury.

The disinfection of domiciles for tuberculosis has now been in operation in Paris for six years. The number of disinfections asked for or accepted was 4,541 in 1892; 8,128 in 1893; 7,514 in 1894; 9,225 in 1895; 9,330 in 1896; 10,194 in 1897, and 6,970 in the first half of 1898. These figures will be increased during the second half of the present year, because the sanitary authorities of Paris intend to extend, experimentally, to an entire *arrondissement* of the city the preventive measures which have been applied systematically to the tubercular poor who have been cared for in their own homes. Over two years ago the French Commission on tuberculosis had recommended a certain number of preventive measures to be put in force in the case of poor people treated in their own homes. Closely adhering to the instructions of the Commission, the following plan of action was adopted: (1) Two spittoons were placed in the domicile of each patient. After different trials the department decided in favor of a colored glass article, flat-bottomed and formed of two opposite cones; it is made so that the fingers are protected against soiling by the expectoration, which drops easily into the contained liquid, and it is steady enough to be placed near the patient who, in many cases, is often left alone in his room. It seems to answer better than the heavier articles formerly in use, for which the patients substituted a wash-basin or enamelled spittoons. (2) A certain amount of liquid should be left in the spittoon. This regulation has been generally observed, but in a great many cases the patients have objected to carbolic acid on account of its disagreeable odor increasing their cough. Plain water is therefore used instead. (3) The spittoon should be cleaned every day by putting it into cold water, which is subsequently raised to the boiling point. The physicians, however, unanimously recommend that the spittoons should be emptied into the water

closets and then rinsed out. The department agreed to this innovation, being convinced that, in the homes of the poor, it is often impossible to obtain the cleansing of a spittoon with boiling water, as frequently the necessary kitchen utensils are lacking and for the greater part of the year a fire is not available. (4) Soiled linen ought to be steeped in boiling water for five minutes. For reasons similar to those last given, in nine-tenths of the cases this precaution could not be observed. Where conveniences were wanting the department recommended that the soiled articles be put aside, so that they could be disinfected by the municipal sanitary service. This was done and without much trouble, save in one of the quarters of Paris, where the tubercular poor had no linen to wash. The Public Assistance will assuredly interfere to provide for such a lack of clothing. (5) After death, cure or departure, the disinfecting service performed the usual offices without much difficulty. The disinfectors go at least once a week to the domicile of each patient. They exchange disinfected linen for soiled linen, which they carry off to the disinfecting machine; the water closets and utensils used by the patients are cleansed with antiseptic fluids.

The greatest obstacle to practical disinfection has been the notification of the patient's disease to the authorities. Soon after notification the patient was considered as if he were a leper and, in some instances, was expelled from his lodgings. Thus the disinfecting operations were not regularly and completely carried out except in a little over 50 per cent. of the cases. It was the same after a death. These difficulties, however, were noticed only in some places. The spittoons and disinfection were accepted and even asked for in three *arrondissements*; in two other *arrondissements*, however, some ignorant or evil-minded neighbors caused the failure of the municipal preventive measures. "The spittoon is a great success," says one of the physicians who have taken most interest in introducing it, "because it collects all the contagious droppings which, formerly, were discharged at the caprice of the patient, and most frequently on the floor of his room. Our tubercular cases accept freely the spittoons and the weekly cleansing of the water closets. The sanitary service does the work with great regularity."

The regular disinfection of consulting rooms, houses of refuge, civic offices, or places frequented by the tubercular poor, is done without difficulty. Whenever a tubercular patient is admitted into a hospital, notification by telephone is sent to the civic health authorities, who immediately dispatch the disinfectors to do the

necessary work at his vacated domicile. These officials are not, in all cases, permitted to do this office, for the simple reason that the transmission of tuberculosis from one person to another is still very far from being believed in by the Parisian people.

Such are the measures, which will be applied systematically and as fully as possible, in one of the *arrondissements* of Paris and, doubtless, later on, in others. Joined to disinfection, directly asked for, accepted after a death has occurred or during the course of a patient's illness, as well as disinfection of lodgings, after location and before inhabitation, which is asked for more and more every day, the sanitary resources of the French capital against tuberculosis will be very much strengthened and improved. J. J. C.

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### CORONERS' INQUESTS.

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"LEGISLATION has from time to time been enacted with a view to regulating coroners' inquests, but the complaint is still heard that some of the coroners are too free with their warrants and that there are far too many post-mortem examinations. The intention of the law is that a coroner's inquest shall be held wherever, as the statute expresses it, 'there is reason for believing that the deceased did not come to his death from mere accident or mischance, but came to his death from violence or unfair means, or culpable or negligent conduct of others, under circumstances requiring investigation by a coroner's jury.' An inquest thus becomes proper in every case of homicide, and in every case of death under circumstances of suspicion which are not made plain on investigation, such as the law contemplates shall be made by a coroner before summoning a jury. No exact line can be drawn with regard to deaths by accident or suicide, but generally it may be said that, where it is already plain that no legal responsibility attaches to anyone but the deceased, no inquest ought to be held. This test, unfortunately, is not uniformly applied.

"With reference to post-mortem examinations, the law provides that the coroner may at any time before the termination of the inquest direct such an examination by a medical practitioner, and to cover cases of more than ordinary obscurity it is provided that on request of a majority of the jury the coroner may direct a post-mortem by two medical practitioners. The intention, of course, is that post-mortem examinations shall only be held in cases where the cause of death is not plain. If a man falls down an elevator shaft, or is run down by a trolley car in the presence of witnesses, it is not necessary to cut up his body to ascertain the cause of death. Nevertheless, it is the practice of some coroners to order post-mortem examinations in every case where they hold an inquest, and a few go so far as to get the jury to consent to a second medical man being called in to assist, even in cases where

the cause of death was perfectly plain before the coroner appeared upon the scene.

"These things give color to the suggestion that inquests are sometimes held and post-mortems ordered rather for the fees they carry for the coroners and the medical men who may be called in than for any public purpose they serve; and it is just a question whether, in the case of Toronto at all events, the time has not arrived for putting an end to the present chaotic and sometimes scandalous state of things by appointing a coroner for the city at a fixed salary. Many of the present coroners are able and worthy men in their profession, but the duties of a coroner are essentially those of a judge, and the coroner should preferably, therefore, be a man with a legal training. Such an officer would save the city every year the amount of his salary several times over, and we would cease to hear of races between coroners to get their warrants filed, or of this or that coroner's 'pull' with the police."

The above editorial we quote verbatim from the *Globe* (Toronto). As most playwrights are satisfied with one murder to appease the gods, so the majority of editorial writers are satisfied with one grievance, making it the pivot on which they turn their pen-and-ink remarks. But this is a progressive age; old methods are now voted flat, stale, and unprofitable; the up-to-date play, to appeal to the gods, must electrocute the villain, and "most foully murder" an innocent man, to bring plaudits, and wring tears from pit and gallery. And so the editorial writer of to-day, even upon the morbid subject of "Coroners' Inquests," must unfold a triple grievance to make his article thoroughly enjoyable reading for the curious public. We hereby tabulate the complaints asserted therein against the Toronto coroner:

1. The coroner orders too many post-mortems, and holds too many inquests.
2. His relations with the police are too friendly, and he thereby has a "pull" with them.
3. There are too many coroners.

In passing let us look at the coroner himself, the august personage who is so unceremoniously dealt with. "In days of old when knights were bold," the coroner was "ordered" by the Statute of Westminster the First to be none other than "a lawful and discreet knight," and was forbidden to take reward under pain of great forfeiture to the king. One instance is recorded where a coroner was removed from office for "insufficiency of estate." However, a few years later, lands to the value of £20 per annum were considered "foot of land enough to possess" to satisfy the requirements as to estate in the case of a coroner. Under the old law the

appointment was held for life, but vacated by the coroner being made a sheriff, or the Lord High Chancellor had power to remove any coroner for inability or misbehavior in his office.

To return to the charges made, we do not think this once grand but now common-place person, the coroner (who, like other public officers, now receives filthy lucre for his services), orders too many post-mortems nor holds too many inquests. In the first instance, as a respected and respecting medical man he knows his business, the requirements of the case, his own status, and that of his fellow practitioners too well to fill their hands with bribes, such as unnecessary post-mortem fees.

In the second instance it is required that the coroner, ere holding the inquest, take the statutory oath, in which he swears that the person died of other than accident or mischance; consequently he cannot, in all honesty, hold uncalled-for inquests. We feel this charge to be untrue. The second charge, that the coroner has a "pull" with the police, is unfounded as far as the majority of Toronto's coroners are concerned. If it is known to be true of any one of them, the charge should have been laid at his door, and not sweepingly asserted.

The third grievance, that there are too many Toronto coroners, is a matter of opinion. Some are busy most of the time; others are busy some of the time, none are otherwise unoccupied, nor starving, nor asking alms because they are coroners. This city is growing rapidly, and cases requiring this officer's attention are multiplying. When a man is proficient in, and has kept up his study of medical jurisprudence, would it not be a pity if he never had the chance to get writer's cramp, and speaker's sore throat, fulfilling his destiny as a presiding coroner?

True, the city might save money by having one lonely coroner without any one to put him in a vulgar hurry by "racing" him (as averred) to headquarters to file his lonesome warrant. True, the city may need to save money to recoup itself for its lavish expenditure in this connection in the past, for then—it must have been in the glacial period—the city built the morgue, you know.

W. A. Y.

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### THE DECLINE AND FALL OF OLD TRADITIONS.

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THERE was a time when the proceedings of academic bodies were fraught with a certain austere dignity which held in awe the cruder laity. Though less opulent perhaps than some other classes,



there were certain devices to which men of learning would not stoop, certain things at which they would stop; which in some vague way gave them an ascendancy over the more sordid classes referred to, who stoop to anything and stop at nothing. But the old niceness seems to be on the wane of late, and finding itself in a more spacious field, a cheerful approachment has been observed in the election methods of the academic class to the election methods of a municipal campaign. The recent university elections, as a case in point, were strikingly aldermanic, and yet upon closer scrutiny the parallel hardly seems quite just—to the alderman. For while the alacrity with which the university candidates canvassed for themselves had about the same dignity as an aldermanic contest, it was hardly as fair an election. The municipal electors at least know who is in the field, and on a given day cast their votes decently and in order; while in university politics (for it seems to have come to that) the candidates themselves go about, weeks before the time, importuning each voter with blank ballot forms which they carefully gather up in person when signed. The more self-respecting are forced by the tactics of the unscrupulous to resort to similar measures, though sorely against their better understanding. In the meantime the easy-going and unwary, cajoled with this or that gew-gaw, or menaced with the dire vengeance of this or that secret society, are thus sometimes induced to commit themselves before they even know all who are in the field, and often before they have received any official notification of the impending election from the University itself.

When things have come to such a ludicrous and mischievous pass it would certainly seem that it was time for the universities themselves to actively interfere, and correct, as the academic authorities alone can, a system of abuse which outrages the gracious traditions of learning and courtesy.

E. H. S.

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### CHRISTMAS GREETINGS.

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WE have endeavored to fulfil our promise by inserting in this issue a few glimpses of Toronto. Our efforts may not have been as successfully carried out as we would wish, but to many readers, especially those living at a distance, we hope, enhanced by the glow of the Christmas-tide fire, and under the soothing influences of a friendly hookah, a view of what was home in student days, the days of Old Grimes and Auld Lang Syne, may recall a happy memory. To all we wish a jolly Christmas and a happy New Year. W. A. Y.

## A Christmas Canticle.

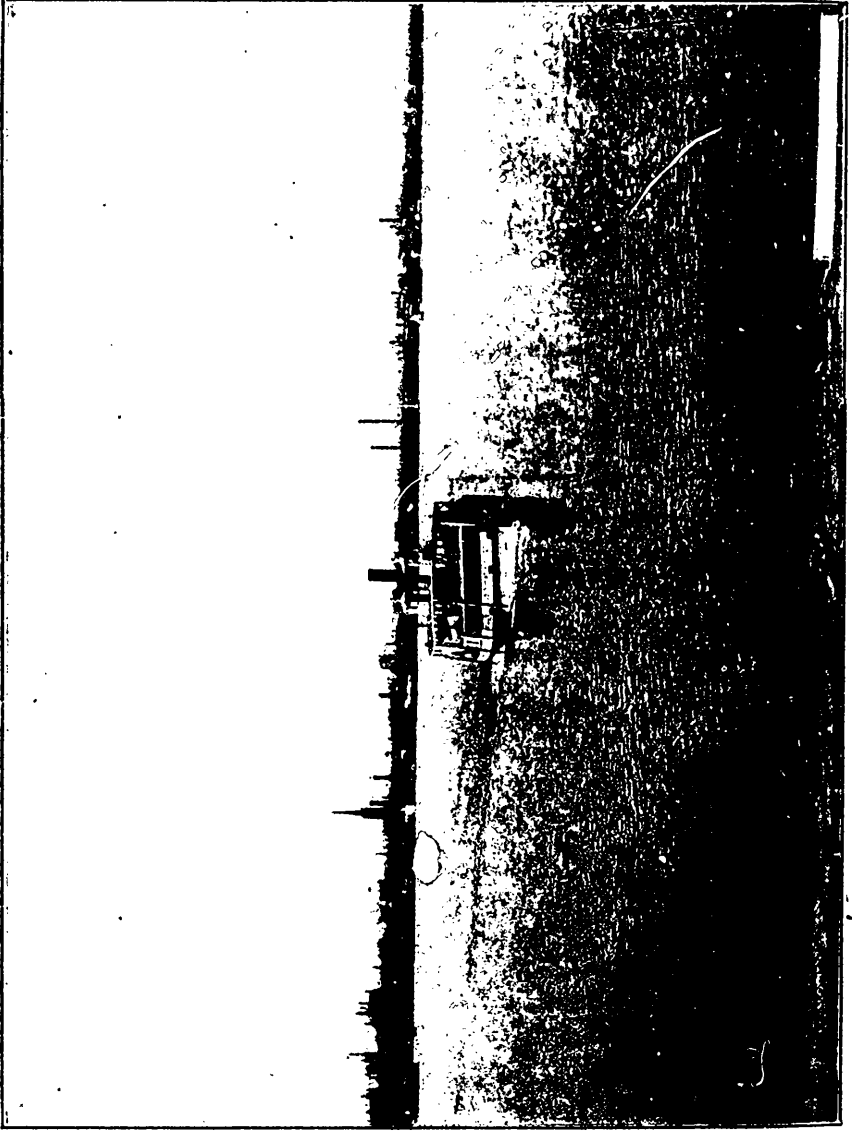
**D**ARKLY through the awful gloom  
Thunders now a nameless doom ;  
On the hills the camp fires glare  
Wildly in the blackened air,  
And the Old Fear all have known  
Hisses in our ears alone.

From the temple's dark alcove  
Men of Athens cry to Jove,  
By the Nile's most sacred wall  
Frantic priests to Isis call ;  
Only back through countless years  
Mocks the music of the spheres.

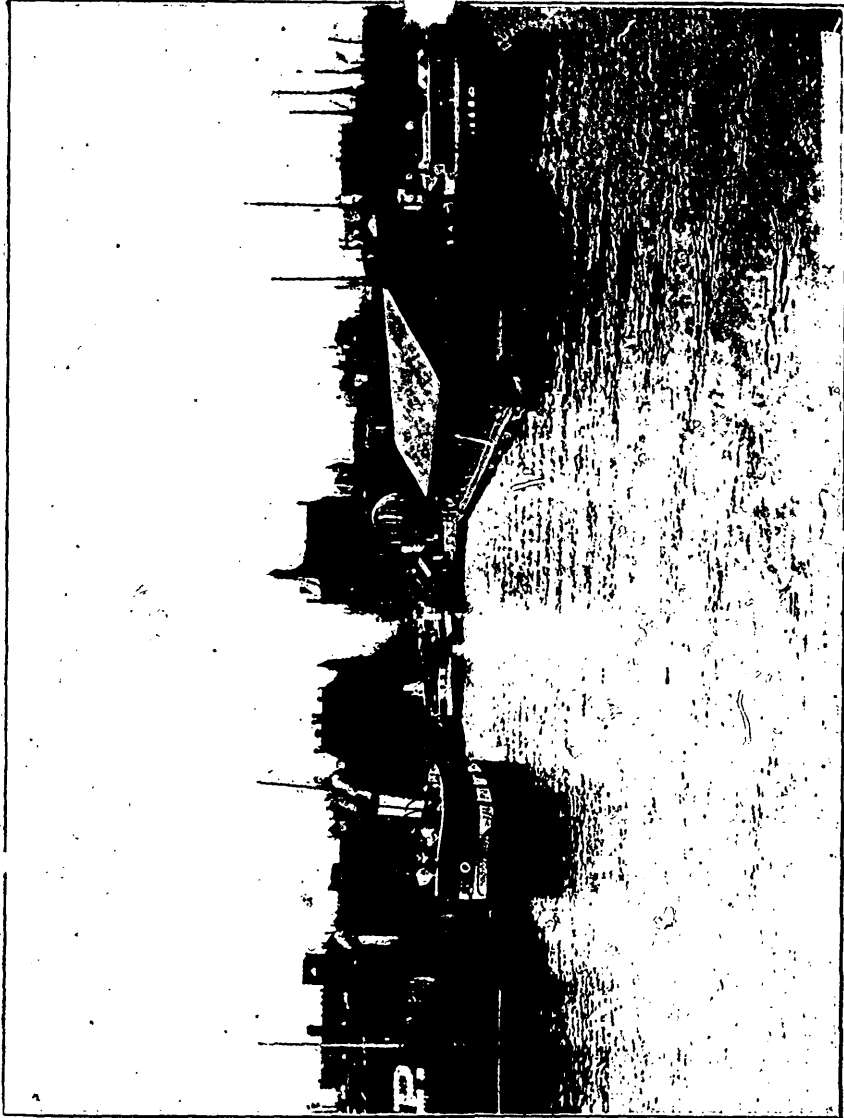
Out on pastures far away,  
Kneeling shepherds sadly pray,  
When, behold ! a golden star  
Rolls in molten light afar,  
And along the sylvan hills  
Night undimmed with glory fills.

Gathering white on Heaven's rampires,  
Sweetly sing celestial choirs,  
For to-day, sublimely born,  
Christ has sanctified the morn :  
From their thrones our tyrants hurled,  
Soothed our woe, and saved the world.

—E. H. STAFFORD.



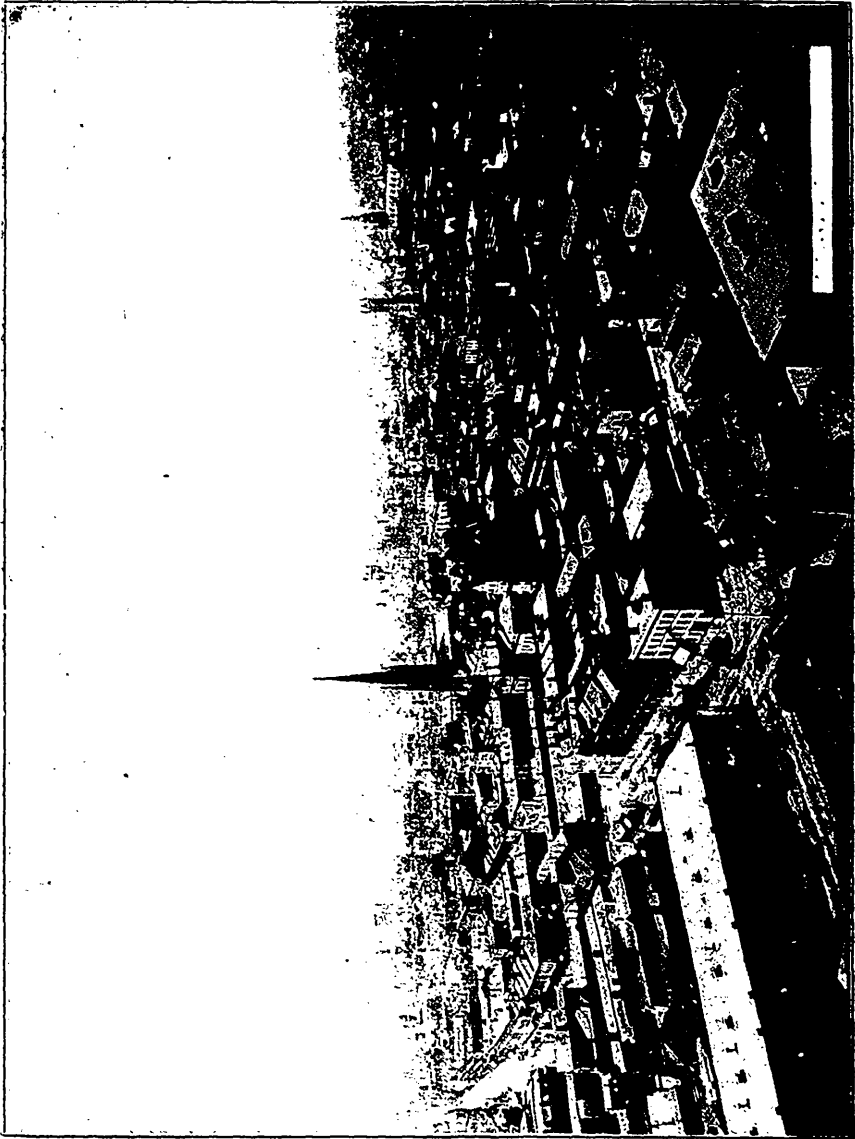
TORONTO, FROM THE BAY.



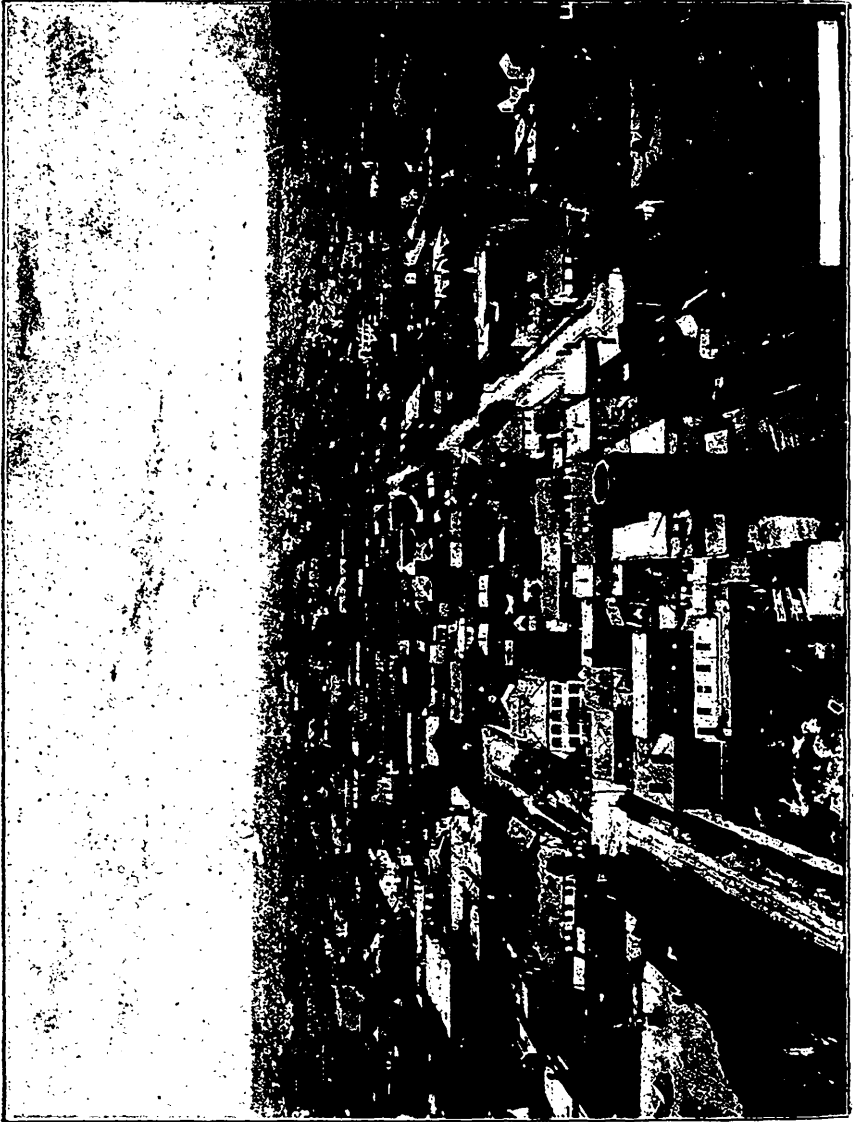
YONGE STREET DOCK.



1. BIRD'S-EYE VIEW OF TORONTO (South-West)



BIRD'S-EYE VIEW OF TORONTO (North-West).

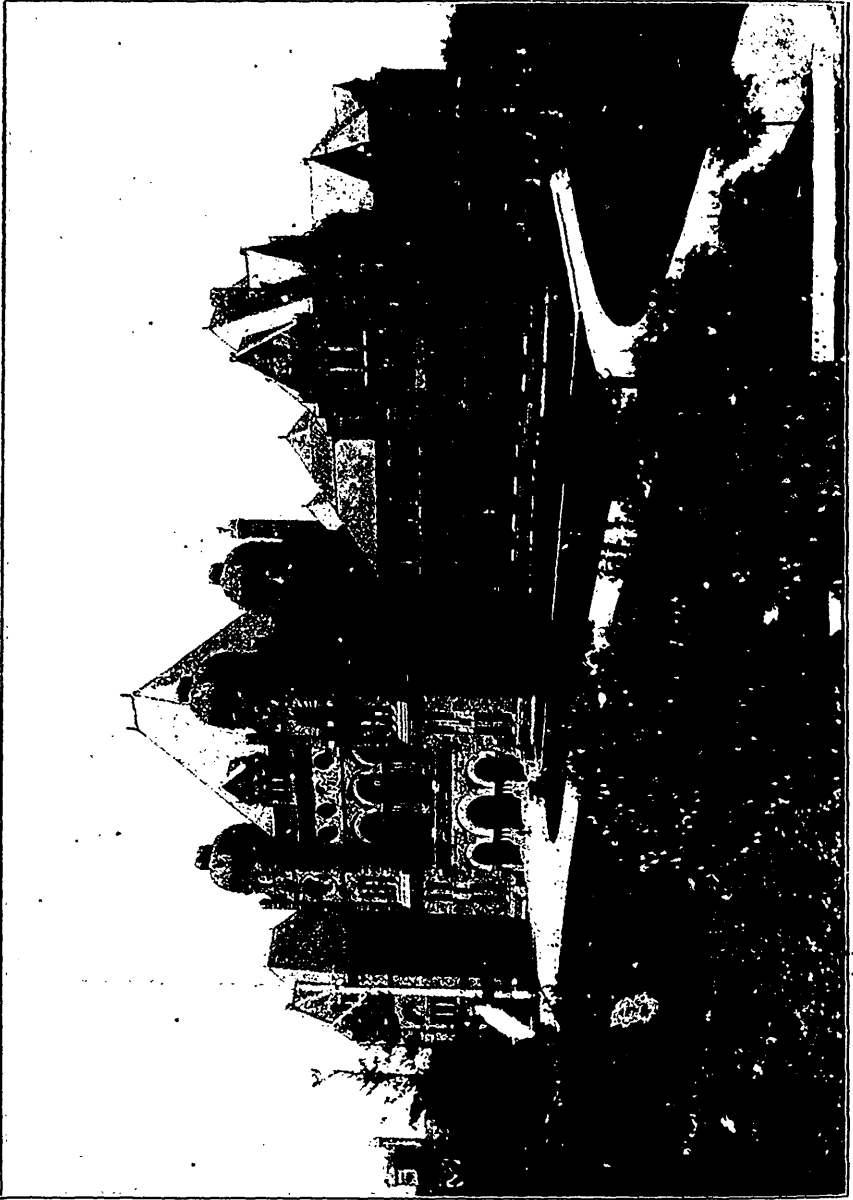


BIRD'S-EYE VIEW OF TORONTO (North).



BIRD'S-EYE VIEW OF TORONTO (East).

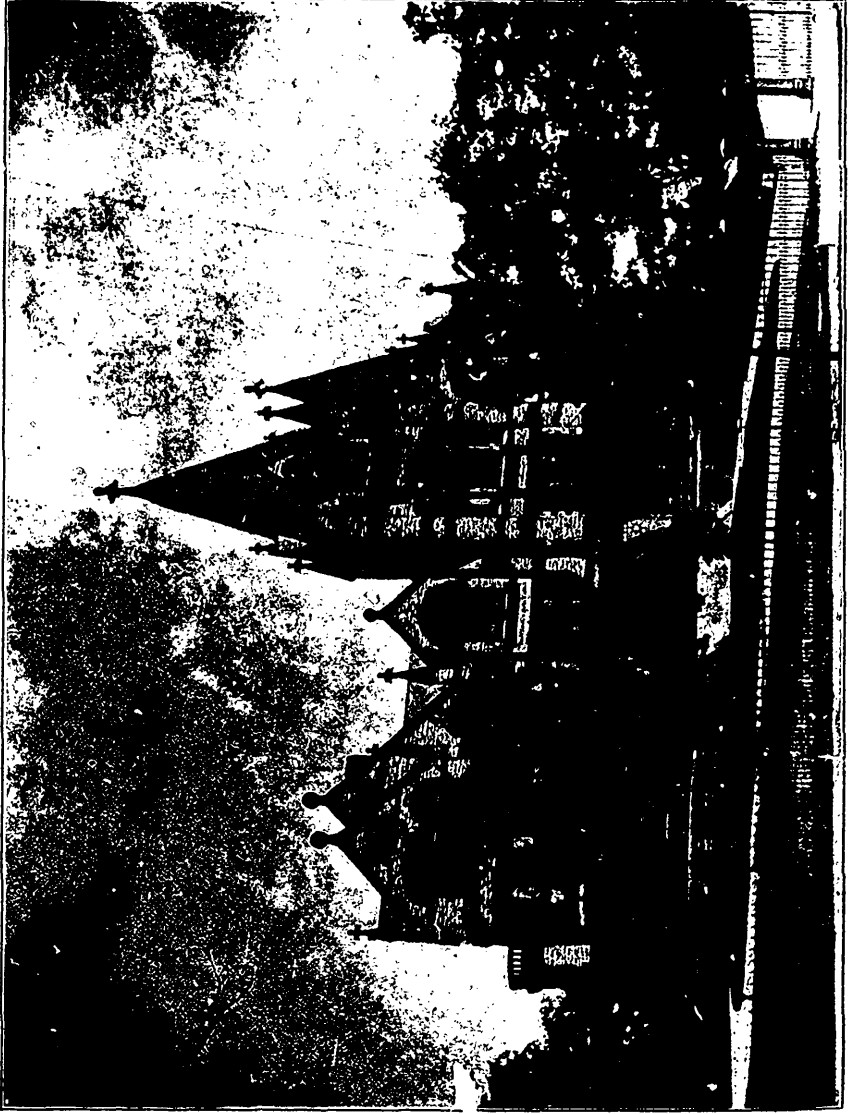




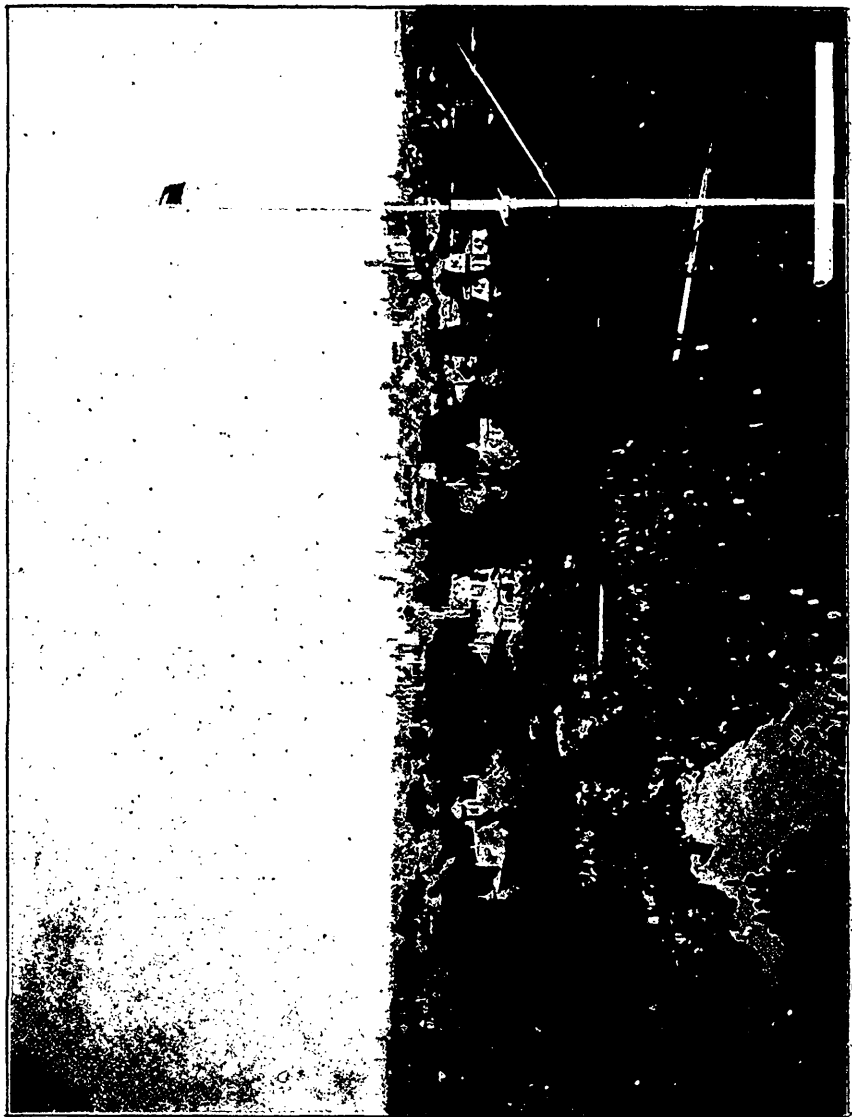
PROVINCIAL PARLIAMENT BUILDING.



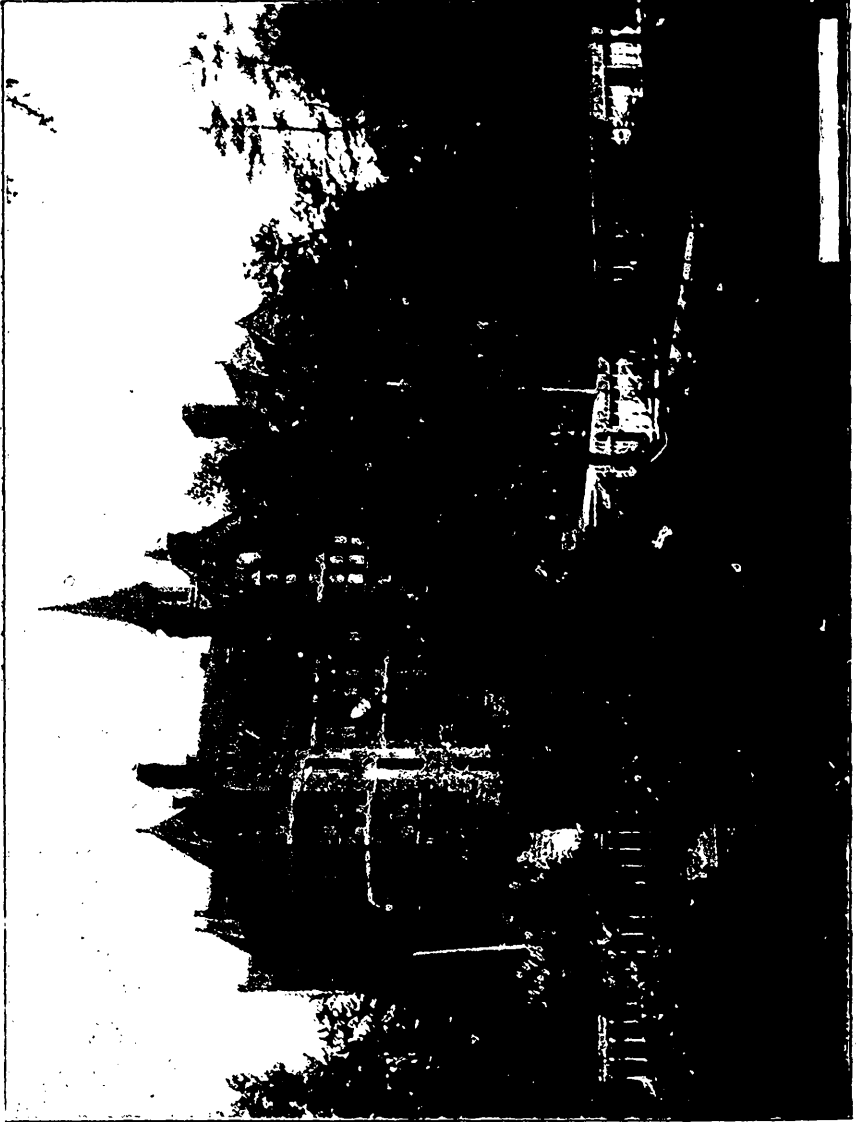
TORONTO UNIVERSITY.



VICTORIA UNIVERSITY.



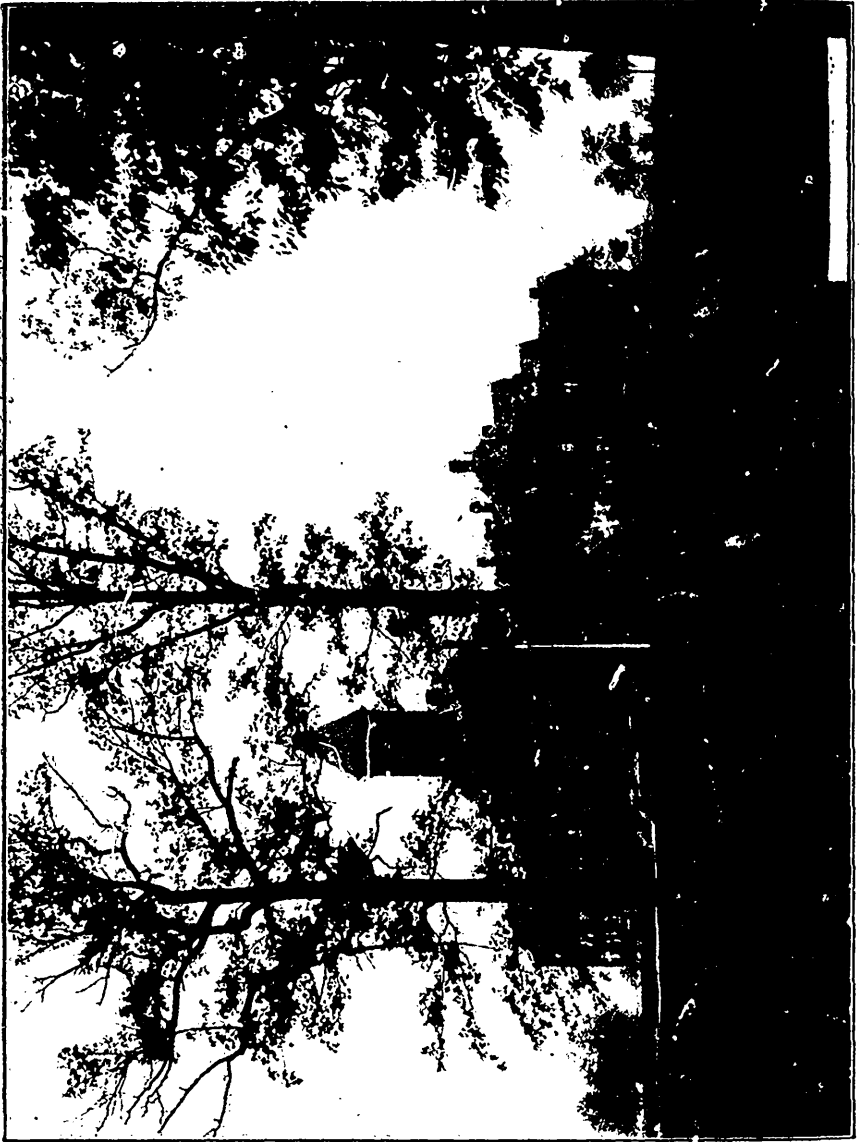
QUEEN'S PARK.



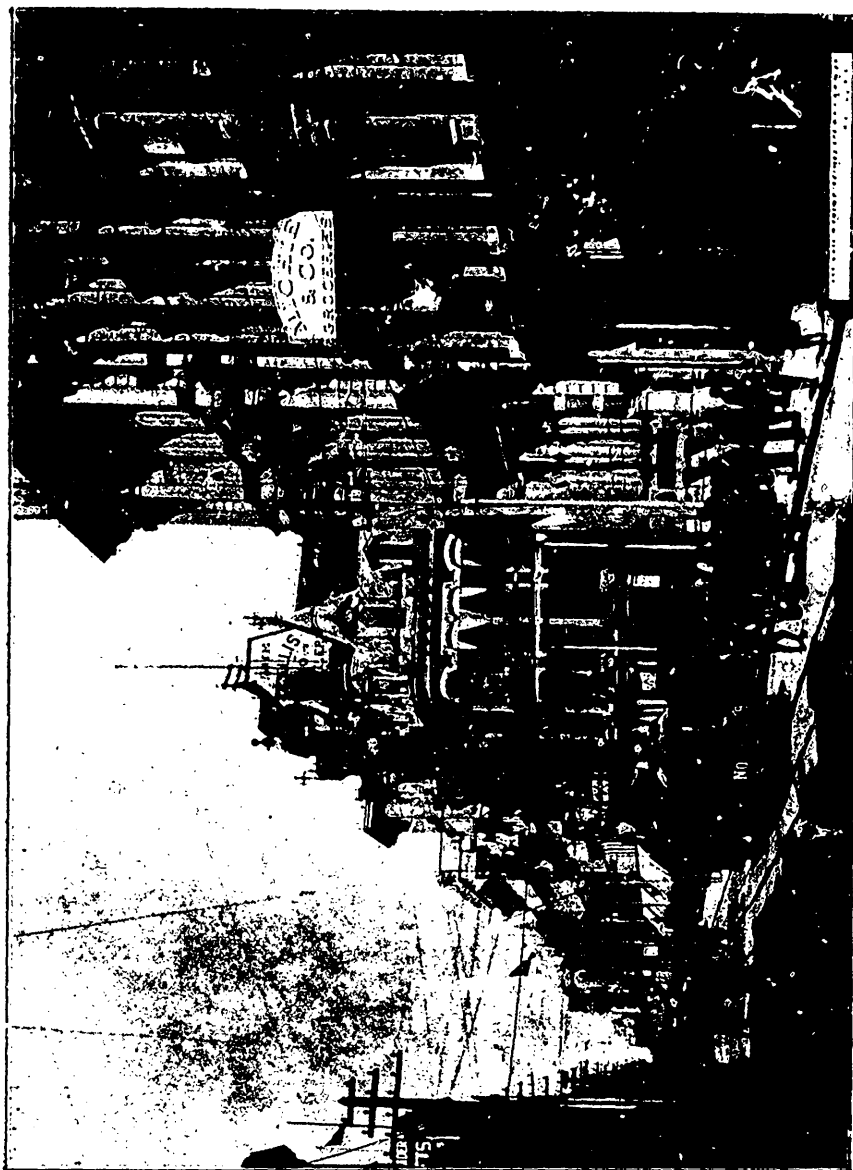
MCMMASTER UNIVERSITY.



OSGOODE HALL, THE LAW COURTS.



UPPER CANADA COLLEGE.



KING AND YONGE STREETS.

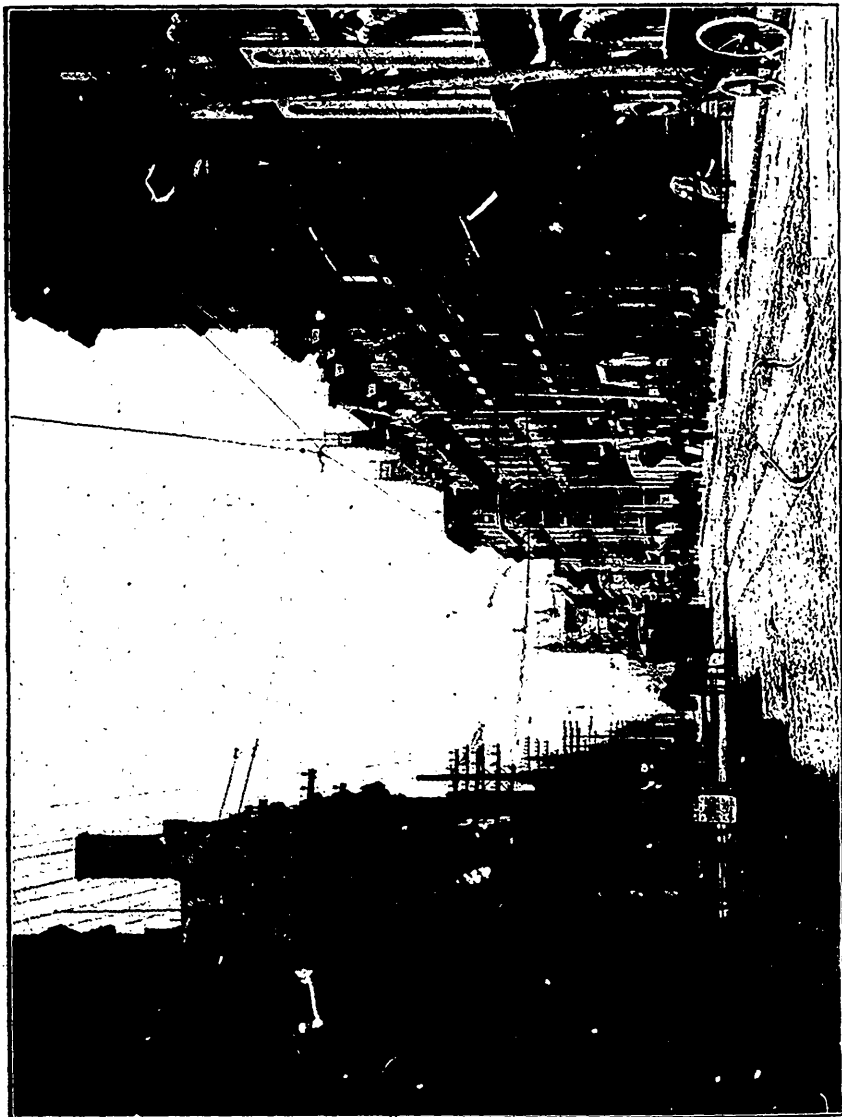




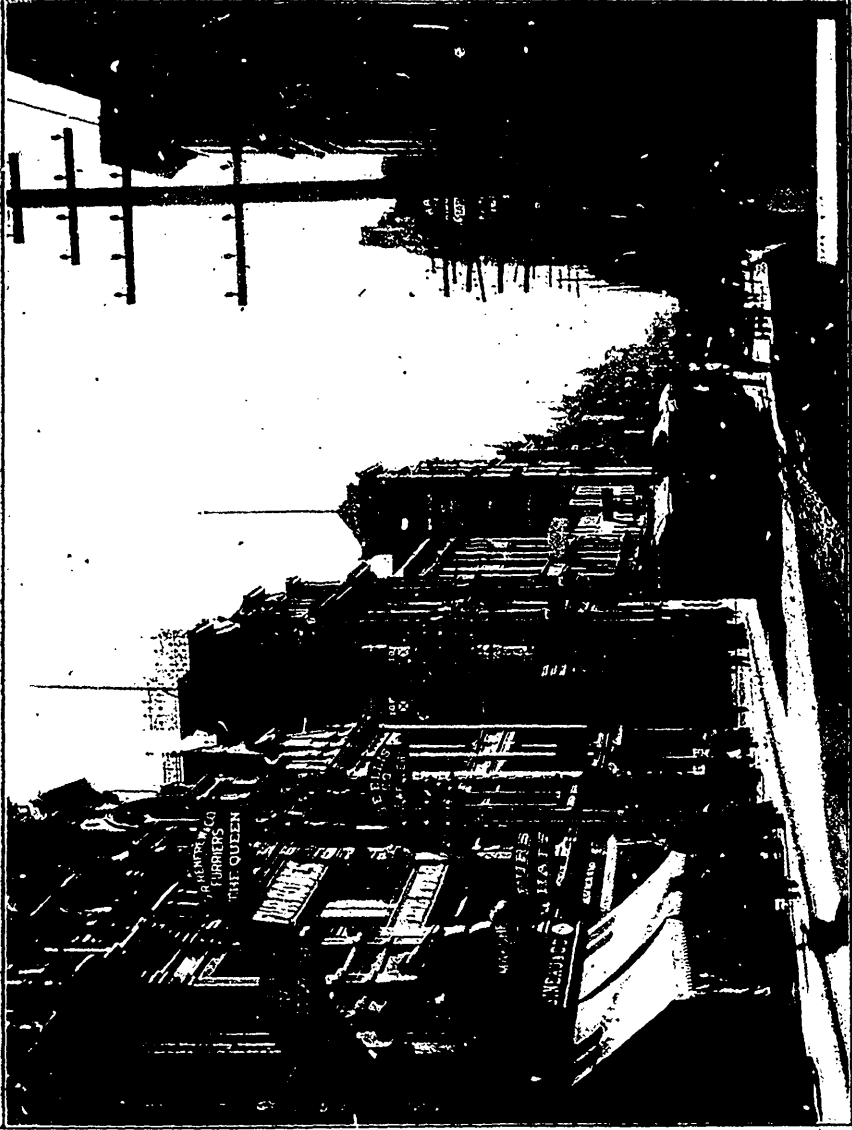
KING AND CHURCH STREETS.



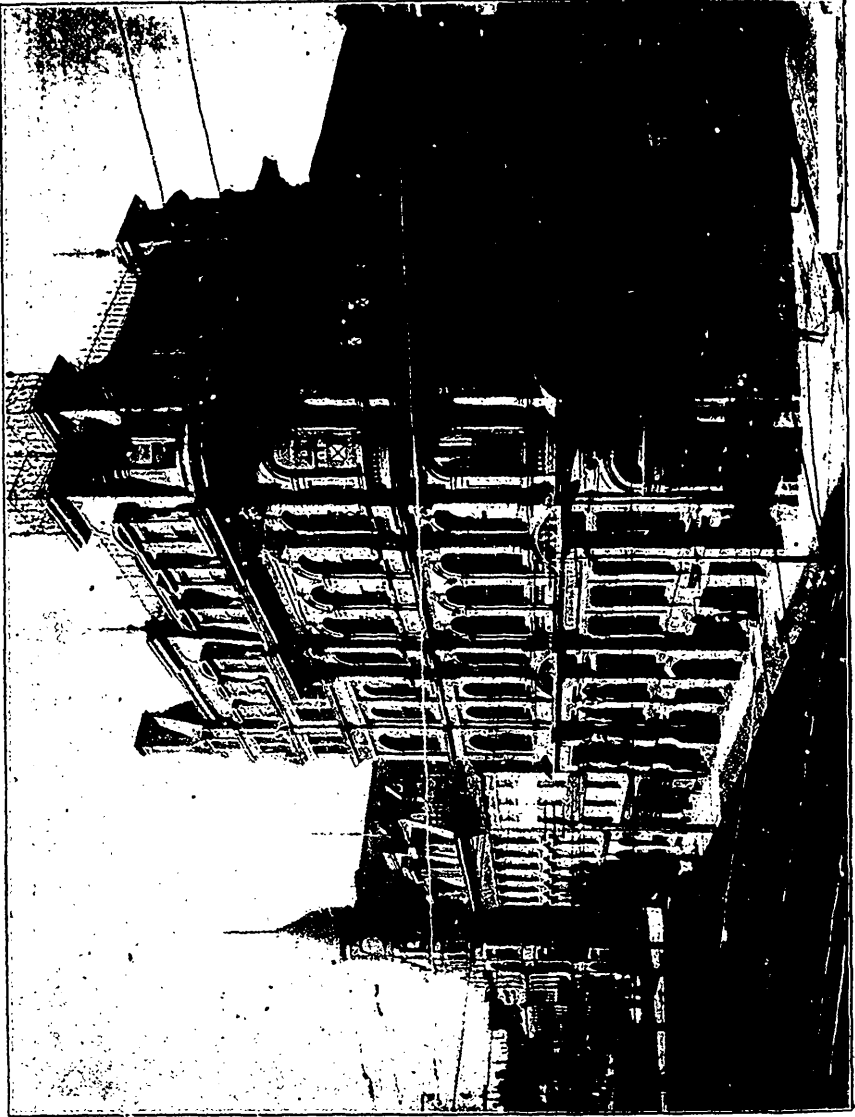
TORONTO STREET.



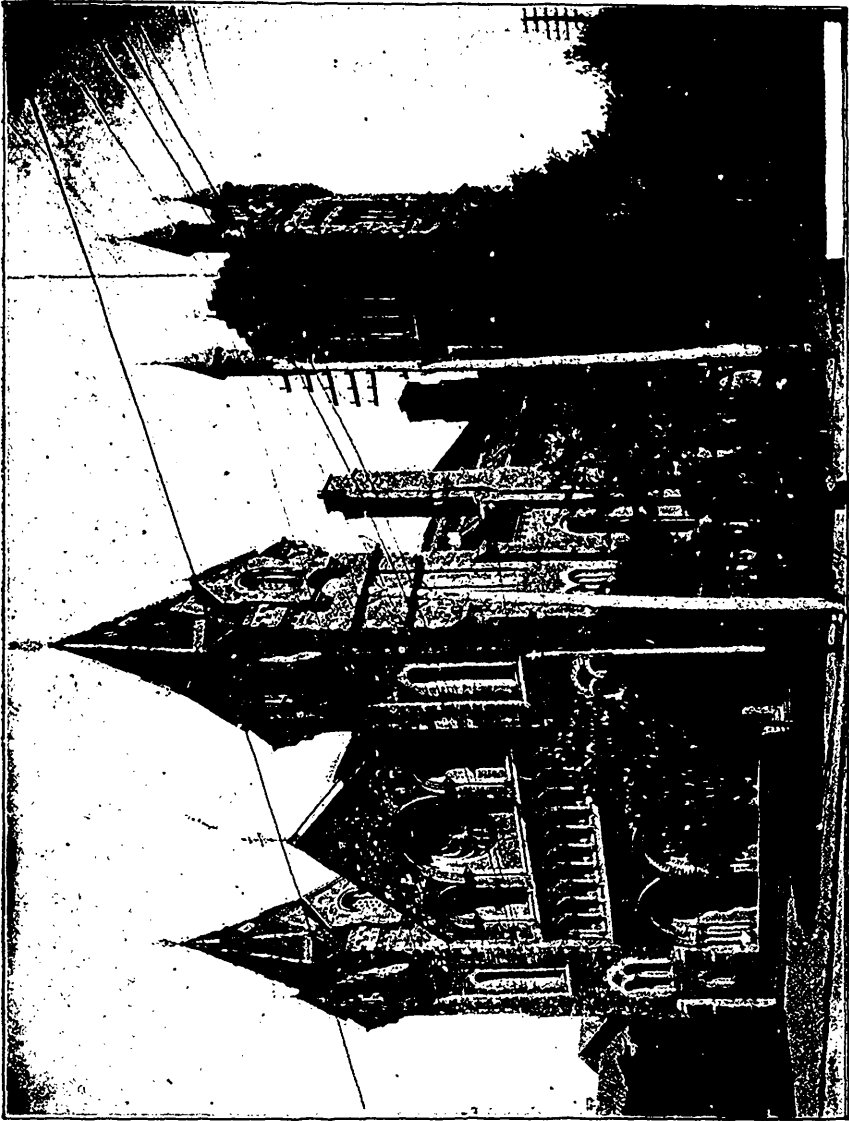
YONGE STREET, NORTH FROM TRADERS' BANK.



KING STREET (West from Yonge Street).



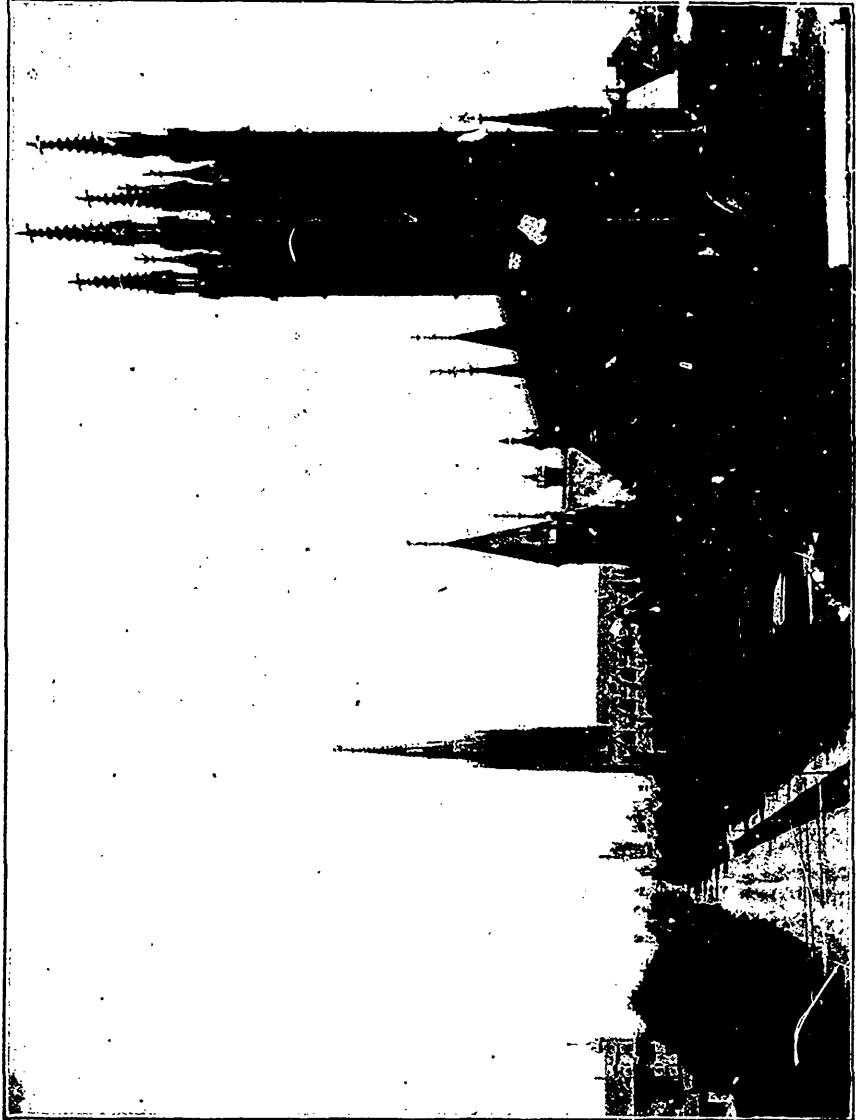
DOMINION BANK.



ST. ANDREW'S.



METROPOLITAN METHODIST CHURCH.



BOND STREET.





ST. GEORGE STREET.



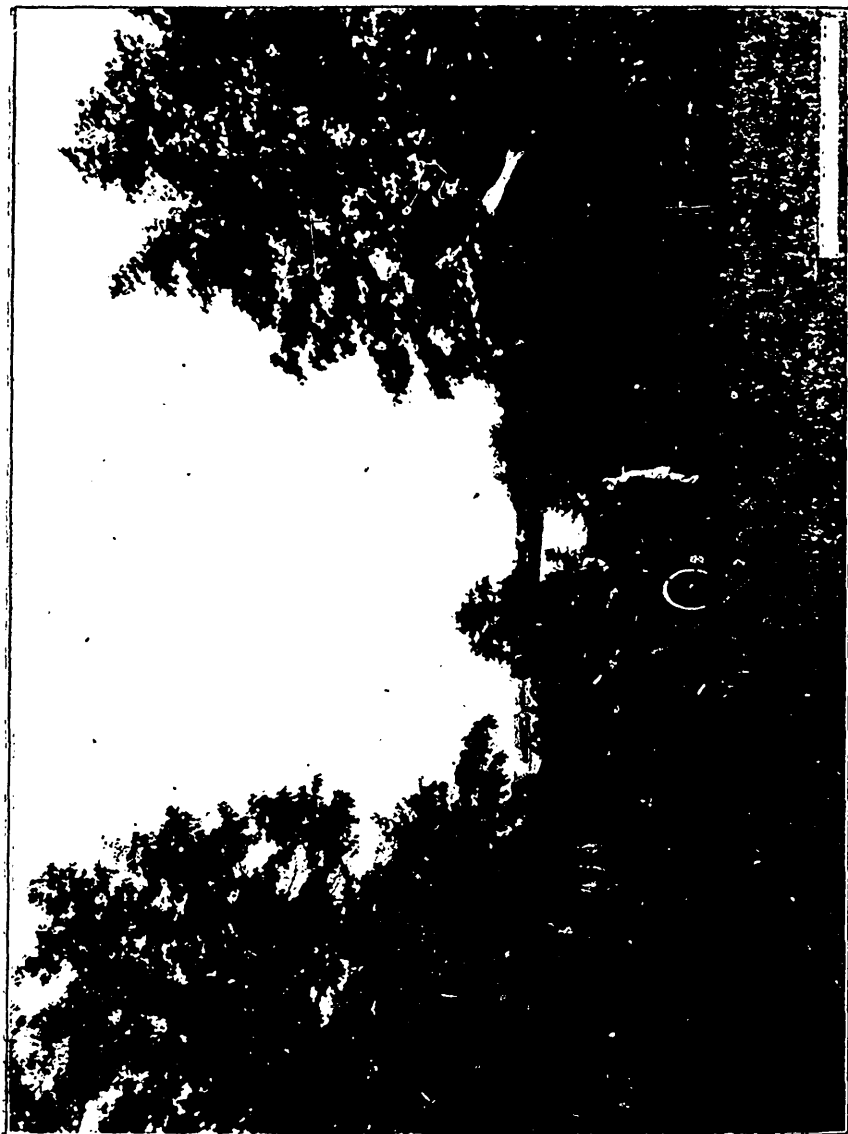
SHERBOURNE STREET.



JARVIS STREET.



DRIVEWAYS IN HIGH PARK.



PICNIC GROUNDS, HIGH PARK.



ROSEDALE DRIVE,



ROSEDALE RAVINE.



HORTICULTURAL GARDENS.





ISLAND PARK.

## Correspondence.

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

### THE "IRRIGATION TREATMENT."

To the Editor of THE CANADIAN JOURNAL OF MEDICINE AND SURGERY :

MY DEAR DOCTOR,—In view of the well-established fact that you always strive to present your readers with the newest in everything, it is surprising to find pages 295 to 309 of your November, 1898 issue, occupied by what purports to be a copy of my article originally published in the *New York Medical Record*, for June 5th, 1897.

The article you reproduce has been entirely superseded by another published in the *International Journal of Surgery* for September, 1898, which contains the result of sixteen months' more experience.

Two pages of rambling, incoherent and misrepresenting addition to my article, of whose authorship I know nothing, convince me that you have been imposed upon in the whole matter. And, when an article of mine is unscrupulously used for the purpose of deliberate misrepresentation, I deem it my duty to call your attention to it.

To show that neither you nor I have been guilty of endeavoring to deceive your many readers, I shall be glad to send them, at my expense, a copy of my recent article on the "Irrigation Treatment."

Yours very truly,

New York, Nov. 7th, 1898.

FERD. C. VALENTINE

[It is quite unnecessary for us to say that we greatly regret the above, as had we known that the entire article which we published did not proceed from Dr. Valentine's pen (of whose ability almost everyone is aware), or at least that the 2-page addition was not written by him or under his guidance, we would never have allowed its publication.—EDS.]

### POSTPONEMENT OF PAN-AMERICAN MEDICAL CONGRESS.

CINCINNATI, Nov. 5th, 1898.

MY DEAR SIR,—I have the honor to announce that in April, 1898, I received from Dr. José Manuel de los Rios, Chairman of the

Committee on Organization of the third Pan-American Medical Congress, a request that, in consequence of the then existing rebellion in Venezuela, no definite arrangements be made at that time relative to the meeting of the Congress previously appointed to be held in Caracas in December, 1899.

The following communication relative to the same subject is just at hand:

CARACAS, Sept. 24th, 1898.

DR. CHARLES A. L. REED,

*Secretary of the International Executive Commission, Cincinnati, Ohio.*

DEAR SIR,—After having sent my communication dated April last, I find it to be my duty to notify you that, although the considerations pointed out in it have already ended, our country has been scourged by small-pox which has taken up all our physicians' activities and time, depriving them of going into scientific works. And, as that state of mind of our people and government after such calamities as war and epidemic, would greatly interfere with the good success of our next meeting, I beg leave to tell you, in order you will convey it to the International Executive Committee, that our Government and this Commission would be grateful to have the meeting which was to take place in Caracas in December, 1899, adjourned for one year later. I am, Dear Doctor, yours respectfully,

THE PRESIDENT.

(Signed) DR. JOSE MANUEL DE LOS RIOS.

In accordance with the request of the Government of Venezuela and of the Committee on Organization, the third Pan-American Medical Congress is hereby postponed, to meet in Caracas in December, 1900.

For the International Executive Commission.

CHAS. A. L. REED, *Secretary.*

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#### A DISCLAIMER.

DR. W. H. B. AIKINS wishes it stated that, though he has retained his grip on the medical electorate of Toronto University, the operation did not involve the use of massage or digital pressure of any description, Masonic or otherwise.

Dr. Aikins also desires to say that the *Canadian Medical Review* has not been sold to Drs. Wright and King, but that he and the members of his staff have united with the staff of the *Canadian Practitioner*, and that in future the new journal will be known as the *Canadian Practitioner and Medical Review*. We extend congratulations and wish our confreres success.

W. A. Y.

## The Physician's Library.

*Therapeutic Suggestion in Psychopathia Sexualis.* By DR. A. VON SCHRENCK-NOTZING. The F. A. Davis Co.

The present work should be read in conjunction with the earlier treatise of a somewhat similar title, by Dr. R. Von Kraft-Ebing. The two certainly form a scathing comment (though unintentionally perhaps) upon the pernicious practices of *fin-de-siècle* civilization: a comment as useful to the physician and criminologist of to-day as to the historian and sociologist of to-morrow.

A simple physiological function (procreation)—thanks to the prejudices of the early Fathers who made a virtue of celibacy, has been gradually separated from its correct place in the life of the human race and invested with a strained and fatuous religious significance. Veiled, far-fetched and askew in the stilted fabric of modern society, the ancient relationship of the sexes has lost all its naturalness, and instead of being regarded now as simply one of the primitive instincts of the race, it has been branded by the theologians as in itself a form of crime against decency—a foul defect to hold in secret shame. By the pronouncement, however, of a certain sacerdotal *Abracadabra* on the part of the ecclesiast the instinct may afterwards be safely indulged; but without such a mystic ceremonial of purification the expression of this instinct is superstitiously claimed by them to be indecorous and even criminal. The ecclesiastic having thus in an age of credulity taken possession of one of the fundamental functions of the species, increased his power enormously by restricting and regulating its practice to suit his own ends. The species suffered.

The early association of the sexes originated in this function of procreation, but the partnership under the benign influences mentioned has developed for the most part into a form of corporeal barter, degrading and monstrous, in which procreation is the last thing thought of and the least thing wished. However, this is one of the keys of ecclesiastical power, and it simplifies political calculations. Should the human race (the hewers of wood and drawers of water) throw down their axes and buckets to-morrow and decide to live naturally, the chaos so often prophesied would certainly take place. But in Nature a condition of similar chaos occurs annually at the approach of the vernal season, and at much longer intervals the same alternation of order and confusion may be noticed in history. The phenomenon is manifestly a necessary factor in any condition of progress. It certainly is in the realm of nature and the race is only a humble part of nature and amenable to her laws.

Furthermore, every departure from nature breeds disease, and the wider the departure the more deadly the disease. In the contemptuous abuse of this simple procreative function the departure from nature has been very wide, and the disease of the race, heralded as it is by many sinister harbingers, bids fair to be a very grave one.

It is with these first degenerative symptoms that the present writer dwells. Dr. Schrenck-Notzing assumes a conservative attitude, and while the work under consideration might be very acceptable to the salacious, it was certainly not written especially for them—an unblushing practice with certain pornographic writers who enjoy considerable repute. The methods of therapeutics described will prove in some cases efficacious, but cannot be relied upon to always succeed in the more persistent forms of perversion, which occur among the technically insane. He refrains from suggesting marriage (a vile and thoughtless crime often committed by practitioners) as a panacea for all disorders of this class. Nothing could be more cruel or reprehensible: nothing more unjust to the normal contracting party. The tainted half-insane degenerates of society are the irreclaimable refuse of the species, and the pure and unpolluted should not be immolated in this brutal and most flagitious manner, in the chance hope that some such charnel-house marriage might possibly prove of some slight benefit to the degenerate. Fanatics ever resort to the cheerful task of cleansing the filthy instead of keeping the pure uncorrupt.

E. H. S.

*A Pocket Medical Dictionary*, giving the Pronunciation and Definition of the Principal Words in Medicine and the Collateral Sciences. By GEORGE M. GOULD, A.M., M.D., author of "The Illustrated Medical Dictionary," "The Student's Medical Dictionary," Editor *Philadelphia Medical Journal*, etc. A new edition, entirely re-written and enlarged, including over 21,000 words. Philadelphia: P. Blakiston's Son & Co. 1898.

With the experience of Dr. G. M. Gould in dictionary work, it is hardly necessary that we do more than announce that he not only invented this stylo of book himself, but was the one who introduced all the new features contained in it. Every word is pronounced clearly and simply, a large number specially so. The definitions are most concise and easily understood, all rare and obsolete words are left out as being unnecessary, many valuable tables are introduced, which alone are worth the price asked for the book, and the book, being made of a specially thin, yet a good quality of paper, is most acceptable in every way.

*American Pocket Medical Dictionary*. Edited by W. A. NEWMAN DORLAND, A.M., M.D., Assistant Obstetrician to the Hospital of the University of Pennsylvania; Fellow of the American Academy of Medicine, etc., etc. Containing the pronunciation and definition of over 26,000 of the terms used in medicine and the kindred sciences, along with over sixty extensive tables. Philadelphia: W. B. Saunders. Toronto: J. A. Carveth & Co.

It is necessary for a medical dictionary nowadays, which has come to be almost a *rade-mecum* to the busy practitioner, to be of such a size as to be easily carried around. In Dr. Dorland's pocket dictionary, we have one which includes between 25,000 and 30,000 medical terms and names, pronounced and defined in a clear distinct manner. It is most complete and should meet with a large sale.

*The Physician's Visiting List* (Lindsay & Blakiston's) for 1899. Forty-eighth year of its publication. Philadelphia: P. Blakiston's Son & Co.

This list is now too well known to make it necessary to state any more than that it is once again on sale for the coming year. The regular edition can be procured for from twenty-five to one hundred patients per day or week, and also has a special memoranda page. A perpetual edition can also be purchased, if so desired, without any dates and with special memoranda pages. This edition can be started at any time and used until full. A monthly edition, where the name of the patient need be written but once a month, is also to be had.

W. A. Y.

In Saunders' Series of Question Compendis is a compact little work, on "Essentials of Materia Medica and Therapeutics," by HENRY MORRIS, M.D. This little book is admirably adapted for the use of students, being arranged according to the physiological action of the several drugs in such a way that there is no difficulty in finding the drug one requires or its therapeutical action. This is the fifth edition, and has been revised and enlarged. It is published by W. B. Saunders, of Philadelphia. J. A. Carveth & Co. are the Canadian agents.

A. J. H.

In the review of Vol. II. of "Sajous' Annual and Analytical Cyclopedic of Practical Medicine," appearing on pages 341 and 342, November issue, by a typographical error, we are made to say "Bromide of Ethyl of Diphtheria" in place of "Bromide of Ethyl to Diphtheria," meaning that Vol. II. commences with articles coming under the letter B, giving in each instance the very latest facts and information on each subject, and ends with those coming under D. Sajous' Cyclopedic of Practical Medicine has, we understand, even thus early met with a larger sale in Toronto than any other similar book ever has. This must be a source of great pleasure to the author, as well as the publishers. And why is this the case, we ask? That is easily answered—Because it deserves it. Never before, we venture to say, has a book been attempted on such a system where every chapter, yes, every page, is not only up-to-date, but contains the latest facts on each subject *right up till the day that particular chapter went to press.*

W. A. Y.