

The Late Dr. James H. Richardson.



The Late Dr. Uzziel Ogden.

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## EDITORIAL.

### THE ONTARIO MEDICAL COUNCIL.

This body has most important matters consigned to its management. It is very necessary, therefore, that its actions should be of a most regular character. At the present moment there is grave reason to fear that this is not the case. The council should not take any action on any important measure without first obtaining legal advice of such a character as to leave as little uncertainty as possible.

There is every appearance of a legal fight over the standing of several members of the council. Should it be shown that some of those who took part in the deliberations of the council had no legal right to be regarded as members, the entire actions of the council may be attacked, and may be set aside by a court of competent jurisdiction.

Section 6 of the Ontario Medical Act sets forth the composition of the medical council. There should be five representatives of the Homœopathic physicians of the Province. This has been duly complied with. There should also be seventeen members elected to represent the regular practitioners of the province. This has also been complied with. There are neither too many nor too few of these classes.

When we turn to the class of representatives for the colleges and universities the ground is not so clear. It would appear, however, to our way of looking at the wording of the act that the letter and the spirit have been broken by the council. Here is the portion of the act dealing with this class:—

“One member to be chosen from each of the universities, colleges and other bodies hereinafter designated to wit: The University of Toronto, the Queen’s University and College of Kingston, the University of Victoria College, the University of Trinity College, the Royal College of Physicians and Surgeons of Kingston, the Toronto School of Medicine, Trinity Medical School, the Ottawa University, Regiopolis College, the Western University, and of every other university, college or body in the province now by law authorized, or which may be hereafter authorized to grant degrees in medicine and surgery, and which establishes and maintains to the satisfaction of the College of

Physicians and Surgeons of Ontario, a medical faculty in connection therewith."

Toronto School of Medicine and Trinity Medical College have passed out of existence. The former has no representative on the council. This is perfectly right and proper, notwithstanding that its name still remains in the Act. Regiopolis College still appears in the Act, but has no representative on the council. This is also right; for the college never had a medical faculty nor did it ever grant degrees in medicine or teach medical subjects. Trinity Medical College should not be represented any more than the Toronto School of Medicine; for it has ceased to exist.

But the University of Ottawa has a representative on the council. This university has no medical faculty, does not teach medicine, and does not grant degrees in medicine or surgery. It is no more entitled to a representative than Regiopolis College.

The case of the Royal College of Physicians and Surgeons of Kingston deserves special mention. It had the right to representation and at one time taught medical subjects. It has given up teaching and granting degrees or diplomas. It has cast in its lot entirely with Queen's University. When the Toronto School of Medicine gave up teaching and cast its lot in with the University of Toronto, it ceased to have a representative on the council. There is no argument that can be advanced to show why the Royal College of Physicians and Surgeons of Kingston should have a seat on the council now that it has passed out of existence like the Toronto School of Medicine.

The Universities of Victoria and Trinity College no longer maintain medical faculties. They do not give examinations in medicine nor do they grant degrees. They are no longer entitled to seats on the medical council. In the case of Victoria University it is many years since it federated with the University of Toronto. We understand that an effort will be made to prevent a teacher in one college representing another college. This would have the effect of preventing Dr. F. N. G. Starr sitting on the council for Victoria College, and Dr. J. A. Temple for Trinity Medical School. It would not, however, disqualify these bodies, as they would choose others.

We have thus shown that there are five bodies with representatives on the council which do not maintain a medical faculty. The council is made the judge of this fact by the Act; for it states "to the satisfaction of the College of Physicians and Surgeons of Ontario." We do not think that the council is doing its duty to the profession to allow this state of affairs to continue. The direct representatives of the medical profession number 22, made up of 17 from the regular practitioners and 5 from the Homœopathic practitioners.

Here, then, we have five members of the council who attend its meetings and receive their per diem allowance and their travelling expenses, who, in our judgment, have no right to seats in the council. The bodies thus represented are the University of Victoria College which has ceased teaching and granting degrees, and has no medical faculty; the University of Trinity College, which has ceased teaching medicine, has no medical faculty, and does not grant medical degrees; the Royal College of Physicians and Surgeons of Kingston, which has merged itself into Queen's University and has no medical faculty and does no teaching; Trinity Medical College, which suspended teaching some years ago, and is now absolutely out of existence and has no medical faculty, nor does it grant degrees or diplomas; and the University of Ottawa, which never did have a medical faculty and has never given medical degrees nor held medical examinations. Here we have five dead bodies represented by five very active members of the medical council.

From the treasurer's report we find that the meetings of the council cost \$6,950.45. This gives an average of \$225 to each of the 31 members. For the dead bodies this would represent an outlay of about \$1,100 or \$1,200. This is quite serious when we consider that the finances of the medical council are going behind. Dr. J. A. Temple, in addressing the council, stated: "When we sold our late building we had \$55,000 in cash after paying the expenses, mortgages and so on. To-day you will notice, notwithstanding the large receipts of the council, we have only \$44,745. We have, therefore, spent \$10,255 of our capital. If we go on at this rate, in two or three years we will have no capital left."

We know of six members of the council representing the profession at large, and not colleges, who received last year in per diem and expenses, nearly \$3,000. Shall this continue?

This state of affairs cannot be permitted to continue. If the direct representatives of the medical profession will only do their duty this would soon be put right. Medical men are long suffering, patient and slow to anger, but they will not bear with this condition of things much longer. The council must find ways and means to reduce its numbers to those who can claim a clear legal right to seats; and also to curtail its expenditures within its income. The financing of Wilkins Micawber still holds good. We ask the medical profession throughout the province to look into this matter carefully, and to take a serious interest in the legislation that will be sought for this session by the council.

The points we make are as follows:—

1. Five universities or colleges are represented on the medical council which either never had a medical faculty, or which have gone

out of existence as teaching bodies, or as retaining power to give degrees.

2. These five representatives cost the council last year in their attendance on meetings about \$1,100 to \$1,200, while the finances are going behind.

3. Two of these representatives are teachers in one college, while they represent other colleges. This is clearly illegal as the Act distinctly forbids such in these words: "No teacher, professor or lecturer of any of the bodies in this section mentioned shall hold a seat in the council except as a representative of the body to which he belongs."

4. The presence of these representatives on the council may render all its acts illegal.

5. This abuse of representation must be remedied and this is clearly the duty of those who are elected by the various territorial ridings and therefore represent directly the medical profession. Dead constituencies must be cut off.

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#### THE GENERAL LAURIE MEDICAL ACT.

In 1886 an Act was passed in Great Britain which enabled any self-governing colony to enter into medical reciprocity with Great Britain. In the case of Canada matters of an educational character are under the control of the provincial governments. For this reason there could be no reciprocity with Great Britain as in Canada there was no medical council under federal control or with jurisdiction for the whole Dominion.

To meet this difficulty, General Laurie introduced into the Parliament of Britain a bill to make each province of Canada a colony in the meaning of the Act. This became law. Under the provisions of this Act of General Laurie any one of the provinces of the Dominion may enter into medical reciprocity with Great Britain, and thereby have those entitled to practise in said province recognized in Great Britain and vice versa.

An important condition of this Act is that those provinces which enter into reciprocity with Great Britain must recognize each other. So far Nova Scotia is the only province that has secured reciprocity with Britain. Should Ontario secure reciprocity it would follow as a consequence that Ontario and Nova Scotia would then recognize each other as equals in matters medical. By this arrangement a registered practitioner from Nova Scotia could practise in Ontario, and so could one from Ontario practise in Nova Scotia. Through the gateway of reciprocity with Britain, they would have reciprocity with each other.

In the Province of Quebec some advance has been made. The medical council of Quebec will recognize registered practitioners from Britain if educated there; but not those who may be registered there but educated in a British colony. This has rendered the reciprocity between Britain and the Province of Quebec only partially effective. If the Quebec council would recognize registered practitioners from Nova Scotia the reciprocity between Britain and Quebec would be complete, as it is between Britain and Nova Scotia.

It is almost impossible to understand the reasons for the medical councils of the various provinces taking these narrow views of medical registration and practice. There is no reason why Quebec should not recognize Nova Scotia, and in turn be recognized by Nova Scotia. This doctrine of "I am holier than thou" has lived too long now.

If Ontario secured reciprocity with Britain any registered British practitioner could settle in Ontario, and likewise any Ontario licentiate could locate any where in Britain. Further, a qualified practitioner of Nova Scotia could come to Ontario, or one from Ontario could go to Nova Scotia. Great Britain has adopted a five years' course of study and this may be said now of most of the Canadian provinces. There need be no fear of "an easy route into the medical profession" by reciprocity. Go where he would the medical student would be confronted with a five years' course of study.

We trust the medical council of Quebec will take the broad view and make the requisite changes called for under the General Laurie Act so that there may be complete reciprocity between it and Great Britain and Nova Scotia. This would be a splendid example for other provinces.

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### THE CONQUESTS OF MEDICINE.

Those who heard Professor L. F. Barker, of Johns Hopkins Hospital, when he paid a visit recently to Toronto, must have been convinced that the medical profession has accomplished wonders for mankind. Diseases that a few years ago were entirely beyond our ken are now understood and can be easily prevented.

As the result of experiments in the hands of Von Behring and others a serum had been discovered which had robbed diphtheria of its terrors. When this serum is properly used and in the early stage of the disease the death rate is almost nil. Compare this with the old death rate of 40 to 50 per cent.

Could there be anything more gratifying than the recent triumph of Professor Flexner, of the Rockefeller Institute, of New York, over

that dread disease, cerebro-spinal meningitis? The germ in this disease was isolated by Weichselbaum; but this knowledge was put to the practical test by Prof. Flexner. An agent has been now obtained that has reversed the sad figures. The death rate of 70 to 80 per cent. has been converted with a recovery rate of these figures. This is not all. Those who now recover escape the fearful results too common before the Flexner treatment.

But the work of Reid, Carroll, Lazear, and Agramonte on yellow fever deserves a place in the roll of fame. Their work has reclaimed large areas from this terrible scourge. Yellow fever is now chained. It is truly a Prometheus vincetus. How it is spread by the stegomyia mosquito is a well-known story.

Whole regions have been made habitable and a vast amount of sickness and many thousands of deaths are prevented through the work of Leveran, Donald Ross, Manson and others on the cause of ague. It is now known that the cycle is a person with ague, the anopheles mosquito, and a well person to be infected by the mosquito. The evidence is now conclusive, and the means of prevention a simple question of care and money.

Though the work of Pasteur on hydrophobia may not have saved so many lives as the discoveries in some other directions, that discovery was a most brilliant achievement and has wrought marvels for a certain class of sufferers. The horrors of death from the bite of a rabid dog has practically disappeared.

Malta fever which was such a scourge along the Mediterranean has been also run down and captured. It is known that the disease is due to a certain organism that is spread by means of infected goats' milk. To avoid this is to avoid the disease.

The death rate from tuberculosis is being greatly reduced. In Britain it is safe to say that it has been cut down by 50,000 a year as compared with 30 years ago. This reduction is only the commencement of what is yet to be. In this country this disease in lives lost and in loss of time and the necessary expenses involved is costing the people not less than \$50,000,000 annually. Nearly all of this could be prevented.

Smallpox is another disease that has caused terrible havoc in times past. There is now known a very simple and safe way of curtailing, indeed, stamping it out, but through the ignorance of many of our public boards of education a sure foundation is being laid for a wide spread epidemic some day in the not far off future. A few years ago Montreal had her scourging, when over 3,000 persons died in a few months. In face of the evidence we possess is there any madness equal to the madness of not insisting upon vaccination.

Professor Barker stated that typhoid fever was responsible for 100,000 deaths yearly in the United States. This is a fearful bill and to this must be added the sickness of those who recover. All this is due to dirt—practically to human excrement getting into water. Some care and some money will put an end to most of this time and life loss.

The ravages of sleeping sickness are now coming under control. It is now known that monkeys, dogs, horses, cattle and man may be among its victims, and that *glossina palpalis*, or tsetse fly is the carrier. Rooting out the breeding grounds of these flies, and at once destroying infected animals in time will convert the stricken regions into healthy ones. It is thought that about 40,000 persons annually die of this disease.

But this by no means tells the whole story. The plague and cholera will never again stalk across the earth's surface as in days gone by. The wings of these disease have been clipped and their feet have been bound.

The good work has not been ended. There is much yet to be done. Attention must be directed to the venereal diseases. Widespread instruction must be given on these diseases. It is estimated that in Germany there are 40,000, in Britain 10,000, and in the United States 15,000 persons blind owing to attacks of gonorrhœal ophthalmia. This is only a tithe of the damage. Think of the vast amount of disease special to women from this disease! In the case of syphilis the evils are quite beyond calculation.

In the face of what the medical profession has done unaided, it is high time the people opened the public purse to aid in this work. It is true some rich persons have done well, but countries as such have not. Can they give a reason? Poor Morton was refused a grant by the United States Government, yet, during the great civil war what would that country have done without anæsthesia?

When Carroll lost his life in his work on yellow fever it was not his country, but his professional brethren that stayed the hand of the holder of the mortgage on his home, and prevented his widow and children being turned on the street.

Two things are needed for the people and by the people—education and money.

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#### THE ONTARIO UNIVERSITIES AND THE MEDICAL COUNCIL.

The time was when no very clear conception existed as to what was best in medical education that it was thought the proper course for all to be examined by the medical council. In those days the universities did not teach medicine and gave degrees in medicine as the result of writ-

ten examinations solely. But we are a long way in advance of that state of affairs.

The council has power to refuse the degrees of any university that would not live up to a proper standard or adopt the five years' course of study. The council might ask to have some sort of censorship or inspectorship in the examinations to satisfy itself that a proper standard was being lived up to.

But we contend that with these precautions the medical council should accept the medical degrees of the universities of the Province of Ontario. In Manitoba the medical council some years ago handed over the task of examining students to the University of Manitoba. In Quebec the medical council accepts the degrees from McGill and Laval universities. But here in Ontario the holder of a degree from the University of Toronto, the Western University, or Queen's University must pass the council tests before he is permitted to practise. In Great Britain the general medical council is only a fixer of standards and a registering body. It does not hold examinations.

In the year 1908 the council expended \$7,548.92 on examiners' fees. If the council had charged a moderate sum for registration and accepted the degrees of the universities it would have been money in pocket, and the public would have been just as well served and the standard of the profession maintained at just as high a level as it has been. The council could see to it that the examinations of the universities were adequate. This duplicate system of examination is not required for any purpose that is worthy of serious consideration.

In Quebec and Manitoba and Britain the people can have their broken bones set, their dislocations reduced, their appendices removed, and the pneumonia treated, and quite successfully too, by those who have secured a university degree or a college diploma and then registered themselves. But here in Ontario the student has to pass his university examinations and the council examinations before he can register. This is in our judgment quite unnecessary.

The assessments collected from doctors for the year 1908 amounted to \$6,027.00. This is \$1,521.92 less than was expended on the spring and fall examinations. All this examination testing of candidates for registration is accomplishing nothing for the profession. Sooner or later they all pass and register. It is not protecting the public by securing more efficient and skilled attendance. If the council properly looked after the examinations set by the universities, and charged a proper fee for registration, there would be no need whatever to charge the annual assessment of \$2.00 from every practitioner, which is more than expended on the conduction of examinations that we have shown could be easily dispensed with without in the least lowering the stan-

dard of medical education. What we here urge works well in Manitoba, Quebec and Britain. It would work equally well in Ontario, would save money to the council, would relieve the doctors of the province of the annual assessment, and would lighten the burdens of the student without impairing in any way his fitness to enter upon the practice of his profession.

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#### TYPHOID FEVER IN MONTREAL.

For those sick with typhoid fever in Montreal we have all possible sympathy, but not for the city. For long that city has had ample warning that the water system was bad, but unless some stern warning came nothing would be done.

From evil sometimes good comes. Let us hope that it may be so in this case. If Montreal will only arouse itself from its fatal slumber and put the water system in order, the present outbreak of typhoid fever may not have come in vain. We hope it may be the suffering of some for the good of many.

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#### THE JUVENILE DELINQUENT.

This is a very important subject, and touches very closely upon preventive medicine. *Mens sana in corpore sano* is still true, and, therefore, the study of eugenics should receive an ever increasing attention.

It is a very difficult task, indeed, to so direct the education of a child that it will prove a useful member of society when it has a bad heredity behind it, and faulty environments during its formative period. It has been observed that the children of drunken parents yield a very high percentage of dullards at school and delinquents in conduct.

Stringent laws should be placed upon the statute books of all civilized countries which would go as far as possible to prevent the constant crop of degenerate children that are coming into the world each year. Criminals, drunkards, epileptics, etc., should not be permitted to marry. From such parents nothing can be expected but degenerate children; and degenerate children too frequently becomes our future criminals.

But for the delinquents we have much that may be done. They must be placed under proper tuition. They must be taught such trades or callings as they may be best adapted for. An effort must be made to secure positions for them. In some instances they may have to be housed and clothed at public expense. In the unfortunate instances

where they become juvenile criminals they must not be housed up with the "old sinner" and recidivist.

Britain and some other countries are becoming awakened up on this question. Night schools are being opened. Children are admitted as young as three years of age when the mothers have to go out to work. Committees look after these children and where necessary supply them with food and clothing. All this is preventive medicine of a most valuable kind. Let us have much of it; but above all, curtail to the lowest limit the bringing into the world of degenerate children.

Wherever there is degeneracy there is sure to be pauperism. Dr. Barker, of Johns Hopkins University, said recently in Toronto, that if we could only do away with drink and prevent syphilis the jails, asylums and poor houses would soon go out of business. We may never take the spartan position of destroying all deformed and imbecile children, but surely we should take the position that they should not propagate their kind. We talk a great deal and we spend a vast amount of money on the eugenics of live stock. The most important of all forms of animal life—man—is allowed to select to suit each individual. There ought to be limitations.

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#### THE VITAL STATISTICS OF ONTARIO.

We have before us the report of the births, deaths and marriages of Ontario for the year 1907. The report is only recently issued, and it would seem that some steps should be taken to have the material contained in the report given to the public at an earlier date.

There were 53,584 births, 21,915 marriages, and 33,502 deaths. This gives a total of 109,001 registrations as against 104,340 for the year previously. The population of the province is estimated at 2,220,430. This gives a birth-rate of about 25, and a death-rate of 15 per 1,000. There were 105.4 males born to each 100 females.

It is interesting to note that tuberculosis in all forms caused the death of 2,530 persons, and pneumonia 2,564. Typhoid fever caused 520 deaths. The infant mortality is very interesting. Under 5 years of age there were 9,930 deaths. Under 1 year there were 8,041, 1 year 986, 2 years 396, 3 years 299 and 4 years 208. This would give for the whole Dominion about 33,000 deaths under five and fully 25,000 under 1 year. This gives to the birth-rate a death-rate under 1 year of 150.

There is certainly something wrong when 2,564 die of pneumonia, 2,530 of tuberculosis, and 8,041 under 1 year. Much of the pneumonia is preventable by suitable clothing, regular hours, temperate habits, and properly ventilated houses. With regard to tuberculosis we have often

said that most of this loss of life is preventable. There is also something seriously wrong when 150 children to every 1,000 born die under 1 year mainly from diseases of the digestive organs.

Another disease that figures large when all the circumstances are considered is typhoid fever. There were 520 deaths from this disease, and as the death rate is not high to the total number ill, the time loss must have been very great. Here there is work for the sanitarian.

The report furnishes abundant proof of a very great waste of human life, and an enormous loss of time through sickness that might be greatly reduced with education on these matters.

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#### THE CANADIAN HOSPITAL ASSOCIATION.

The report of this association has come to hand. It is got up in a neat form and contains a considerable amount of useful information on the management of hospitals and the training school for nurses. One gathers from the reading of these papers that the Hospital Association of Canada is destined to do much good. We think that hospital trustees would do well to secure a copy of the report and carefully peruse its contents. They would be well repaid for their trouble.

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#### MEDICAL REPORT OF THE HOSPITAL FOR SICK CHILDREN.

If this report is intended only for the medical profession, then we have no fault to find with its contents. If it is given out to the general public we would have to take exception to its contents. It contains a great many articles and papers, several being illustrated, of the treatment of disease, with the names and medical standing of the writers. This might easily become a very objectionable method of advertising. We hope the staff of the Hospital for Sick Children will not break the ethical rule.

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#### THE MEDICAL FACULTY, UNIVERSITY OF TORONTO.

The report of the governors of the University of Toronto, for the year ending 30th June, 1909, is just to hand. We wish to offer a few remarks on the medical department.

From the report on page 59 we learn that the total income of the medical faculty from all sources was \$82,121.50. On page 115 the total disbursements are set down as \$69,235.44. This would leave an apparent balance of \$12,886.06.

On page 10 we are informed that the total number of students in the University was 3,901. The medical students numbered 681.

On page 63 the cost of administration is given as \$153,050.46. If the medical department paid its share, in proportion to its students, of this general expense, the sum would be \$26,718.

Turnning to page 86, we find that the department of physics costs \$15,143. The medical students attended these classes, but no charge is entered against the medical department for this tuition. We have been informed that the medical students take up about one-fifth of the time in the physics department. This would represent about \$3,000.

On the same page the cost of chemistry is given as \$16,968.50. Here again we are informed that the medical students monopolize about one-fifth of the teachers' time. This would call for \$3,656.

On page 87 biology is stated to cost \$15,535. Of this department we are informed that the medical students take up one-third of the time. This would mean in money about \$5,145.

Botany is put down as costing the University \$4,700. Some of this, say \$1,000, should be charged to the medical faculty.

Physiology comes to \$10,525. We gather that about two-thirds of the time in this subject is given to the medical students. This would mean \$7,000.

If these various sums be added they amount to \$46,519. This should be added to the cost of the medical department as given to arrive at the true cost.

Cost as given .....	\$69,235.44
Cost not given .....	46,519.00
	<hr/>
Total cost .....	\$115,754.44

From this the income should be deducted. This would leave a loss on this department of \$33,632.94 if the accounts were correctly adjusted. In other words, the medical department is subsidized out of general revenue to the extent of about \$33,000.

We have always felt that such professions as law and medicine should not be paid out of State funds. The students should be called upon to contribute in fees the cost of their medical education. If this be not possible, then the expenditures should be curtailed. If we have in any way misstated the case we would be glad to be put right by the University officials.

## ORIGINAL CONTRIBUTIONS.

## COLONECTOMY.

By ERNEST A. HALL, M.D., Victoria, B.C.

**F.** aged 24, health excellent until about two years ago when he began to suffer from constipation. Becoming dissatisfied with aperients he was induced to take sterilized sand. He received a 2-lb. packet from a quack with instructions to take one tablespoonful after meals. Receiving no benefit from this amount, and with the assurance that it was perfectly harmless he increased the dose to three tablespoonsful with similar negative effect; the dose was increased until half a pound was taken in

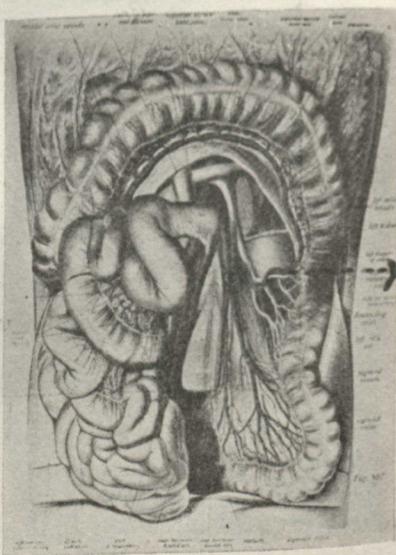
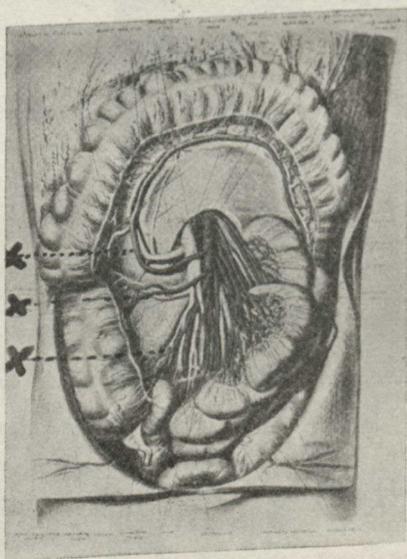


twelve hours. No result was attained, and to quote the patient's own words "then my troubles began," and he commenced "the round of the doctors." The bowels at this time could be relieved only by enemata, pills having no effect. From the said quack, via the regular profession of an osteopath, through delays and washouts the patient was assured that all his troubles resulted from a lateral curvature. Two "treatments" assured him that he had met a genuine fakir, and in disgust he tried hydropathic methods, failure also greeted him there. Again, into the hands of the regular profession he had his abdomen opened in hopes of

finding an obstruction, but none was found. The constipation becoming more obstinate the patient consulted me, and was placed under the most modern treatment at the hands of my brother, Dr. T. P. Hall, of Vancouver. Dieting, massage, electricity, lavage, etc., were given a thorough



trial for four months, without any beneficial result. Melancholia began to develop with suicidal tendencies, so I considered something radical should be done, but until having seen the results of Mr. Lane's work at



Guy's Hospital, I refused to operate. Upon my return from Europe the patient was placed in the Jubilee Hospital and the colon removed.

The after history presented little of interest except the apparent ease with which the intestines adapt themselves to the new conditions.

On the second day a small dose of oil resulted in two motions. The third day there were none; on the fourth day five. For eight days the average motions were from seven to nine. The next six days the average was four. On the nineteenth day two, on the twentieth day two, and on the twenty-first day only one.

On the fifteenth day the patient was walking around his room, and in the afternoon of the nineteenth day he spent a social two hours in my home.

The highest temperature was 102:6 on the sixth day as was also the highest pulse rate 91.

The subsequent recovery was hindered some by a stitch abscess which gave more systematic disturbance and a higher temperature than the operation.

Dr. Sharples, of Seattle, reported a case of resection of the colon at the last meeting of the Washington, Idaho and British Columbia Medical Association. A lady of sixty-six years, who, for the past five years, suffered severely from constipation, also suffered severe abdominal pains and became so feeble and nervous that she could not do her work, at the time of the operation weighed but eighty pounds. The colon was removed and the ilium anastomosed with the sigmoid. Convalescence was excellent and six months after she weighed one hundred and eight pounds. She has had once to take an enema of soap and water, two or three times she has taken half an ounce of castor oil, which is always effective in half an hour or less. Dr. Sharples goes on to state, "I believe that the chief reason for the general changes in the patient has been the improvement in the general condition from cessation of the absorption of the toxic element and the relief of the pain."

To one accustomed to abdominal surgery the removal of the colon presents no difficulties. The operation, though formidable, can easily be completed within one hour and a half. The bleeding can be reduced to a minimum by the ligature of the colic arteries before section of the meso-colon. The anastomosis between the proximal ilium and distal pelvic colon should first be made, so that the intra-circulation of the bowel be interfered with as little as possible, and especially in extreme cases where there has been considerable toxæmia, and as the condition of the patient might be such as to make this measure all that could be done at the time, necessitating the postponement of the removal of the colon until the patient has regained strength. In the case here reported, forty inches of the bowel were removed, including three inches of the ilium and to the junction of the middle and lower third of the pelvic colon pos-

sibly the whole of the sigmoid could have been left without prejudicing the result, but we have much to learn yet. In a case so obstinate with suicidal symptoms I determined to do the ultra-radical operation.

As Mr. Lane has pointed out the operation is greatly simplified by the preliminary ligature of the colic arteries. Their relations are excellently shown in the accompanying plates from Sabotta. In the ligature of the ilio-colic care should be taken not to include any branches supplying the ilium. These should be separately ligatured in order to secure ample circulation to the ilium to ensure adequate nutrition for the anastomosed portion.

A new surgical procedure has come to demand our attention. Shall it meet the fate of decapsulation of the kidney, or shall it pass through various stages of development as has gastro-enterostomy, until it shall be accepted as a procedure of recognized merit? The critic who cries "unsurgical" without a knowledge of the embryology, development and function of the colon, and with no practical experience of a procedure that has no greater mortality in its inception than gastro-enterostomy had when first introduced, is not to be considered in the discussion of this matter. As the physiology of the stomach and duodenum had largely to be relearned from the Mayo operating table, so must the physiology of the large bowel be relearned. Who thought but a few years ago when we talked glibly about the drainage operation of the stomach, that we were frequently dealing in fairy tales. We still operate for ulcer of the stomach but for other purposes than drainage. The fact remains that nature's cures are in spite of our half-digested theories and comparative ignorance of her methods. Then let us approach the question of resection of the colon calmly and dispassionately, with an earnest endeavor to determine if herein lies a procedure of merit.

The presence of any organ in the body in the light of evolutionary development is not a proof that it is of value to the organism at the present state of its existence. With regard to an organ that is becoming atonic either from alteration of environment or from irregular habits, an organ that at least is becoming racially unfitted to cope with modern life—since constipation is practically a racial condition—it remains for us to show whether or not it has, like other organs we could mention, outlived its usefulness, and is becoming a menace to the comfort and welfare of the race. No word has become more frequent in modern medical literature than that of auto-intoxication, and no part of the body more frequently named as the seat of the chronic trouble than the colon. Again, how rapidly is the class of disease due to auto-intoxication increasing, and if the colon can be shown to be the chief seat of auto-intoxication, is it not reasonable to suppose that we are remarkably

near to the centre of an amount of causation of chronic disease too large for present discussion, opening up a field limitless in its probable application? The relief from gastric disturbances, the mild course of infective diseases, and the easy convalescence after surgical operations when the colon is kept comparatively empty are factors in everyday experience, and conversely. We all agree that an atonic and distended colon, with its attendant load of faeces, is a systematic menace, rather than its inability to discharge its function is the cause of retention of material, the absorption of which acts prejudicially.

Now, if we can show that this part of the elementary canal is not necessary for the nutrition of the system, that digestion is completed in the small intestine, and that the system suffers no lack in nutrition when this part is removed, or that the loss suffered is so small that it is more than outweighed by the benefit obtained by the removal of this magazine of decaying organic matter, and that this organ can be removed with a mortality rate acceptable to ordinary major operations, then the way becomes clear.

As substitutes for the removal of the colon, removal of the mucous membrane might be suggested, or perhaps better still, the severance of the ascending colon above the ilio-cæcal valve, occlusion of both ends, and the severance of the pelvic colon at the junction of its first and second thirds, the anastomosis of the distal end of the pelvic colon to the cæcum, and the attachment of the proximal end of the pelvic colon into the distal segment at the junction of the middle and lower thirds; this forming a colonic Y, similar to the Roux method of gastro-enterostomy. This method should effectually prevent the faeces filling up the unused colon by antiperistalsis and would preserve three inches more of the ilium with the valve. This method is easily performed and will be given an early trial.

Mr. Groves, M.S., before the Royal Society of Medicine, London, reported a case of constipation in which he attached the ilium to the pelvic colon, with temporary benefit but afterwards found it necessary to remove the colon, twenty-nine inches in length. She made an uneventful recovery, gained in weight and resumed her former occupation as dressmaker. The second operation was made necessary by pain and swelling in the flanks and epigastrium, and most conspicuous on the right side, the temperature ran irregularly, rising at times to 104, no doubt owing to fermentative changes in the contents of the occluded bowel. Mr. Groves stated that in cases in which the colon was left in after the anastomosis was made, the patients did all right so far as the constipation went, but after a few months they began to lose flesh and became anemic and suffer pain, not on account of the metabolic changes from short circuiting, but to the fact that they had a great cesspool in

which there was no stream and in which the contents decomposed and toxic substances are generated.

Lowenstein (quoted by Groves), collected facts regarding the treatment of constipation dependent upon atonic dilatation of the colon and concludes that these cases require surgical treatment and recommends the removal of the large bowel down to the pelvic colon. His table is:—

	Medical.	Surgical.
Number of cases .....	59	44
Died .....	39, 66%	21, 48%
Unaltered .....	4	2
Improved .....	9	7
Cured .....	7, 12%	15, 34%

Ito and Soyesuece, quoted by the same author, relate 21 cases of resection, of which fourteen gave good results, five dying during the operation, one dying of diarrhoea, and one remaining unchanged. He also stated that Mr. Arbuthnot Lane had described thirty-nine cases in which the colon was either excised or short circuited. Lane's mortality as given by Groves is 23%. In contradistinction to this latter statement I quote from an article by Lane in the *Annals of Surgery* for July: "Of the many cases of chronic intestinal stasis in private practice which called for operative interference, in nine only have I removed the large bowel, of these one died and that accidentally from the bursting of a small deep seated abscess into the abdominal cavity."

Hospital patients in London belonging to the poorer class, many of whom were neglected, and advanced cases would naturally give a greater mortality than private patients. Mr. Lane goes on to say with reference to the risk of operation, "I do not pretend that removal of the large bowel is not a very serious operation in certain circumstances, indeed, in many of these patients any serious operation must be regarded as being dangerous to life, the danger varying with the degree of the toxicity. The risk can be very greatly diminished by the subcutaneous injection of a large quantity of normal saline solution immediately before the operation."

As to digestion of food after anastomosis, and after excision of the colon,—

(1) Time required for the passage of food. In my own case the passage of food required on the average nineteen hours, the normal period being from twenty-four to thirty hours. In the case related by Groves, sixteen hours elapsed between the taking of food and the appearance of the debris in the motions. About four hours is required to pass through the small intestine.

(2) Relative amount of fluids in motions after iliosigmoid anastomosis, and removal of the colon—Mr. Groves' observations after anastomosis gave water 80.21%, solids 19.79%, after removal of colon 87.16%, solids 12.84%, but 6.85% more water in amputation than in anastomosis.

(3) As to the amount of nitrogen and fat in the faeces—Groves' experiments lead him to the conclusion that after anastomosis "the amount of nitrogen and fat in the faeces, although high in proportion to the intake, represents only the almost irreducible minimum that is always present in the faeces," and following excision of the colon, "that the absorption of nitrogen, fat and carbohydrate is practically normal."

In a case of faecal fistula of the caecum Mr. Groves had an opportunity of comparing the canal faeces with those passed *per rectum*. The canal faeces contained but 2.82% more water than those discharged *per rectum*. Mr. Groves, in summing up this part of the enquiry, says, "The most striking thing about these results is the comparatively slight alteration that occurs in the faeces in the passage along the large bowel. There is, of course, an absorption of water, but this only amounts to about 5%, and the absorption of fat and nitrogen is so small as to be negligible." He further states that after anastomosis or the removal of the colon water absorption is amply carried on by the rectum and pelvic colon, in sufficient amount for the nutritive economy.

(4) As to antiperistalsis,

That antiperistalsis exists the normal colon is no longer questioned, but it appears to be confined to the transverse ascending colon and caecum. Now numerous experimental work upon cats has shown this to be a fact. The opinion held by Mr. Eccles is that antiperistalsis seemed always to be due to some irritation in the lower part of the large intestine, and that the anastomosis becomes a point of irritation causing reverse peristalsis of the colon from that point upwards. Mr. Groves gives the history of a case that appeared to emphasise that point. "Lady, aged 41, obstinate constipation for years, a right inguinal colotomy was performed, the colon was emptied by irrigation from both ends. Some months later the transverse colon became inflamed so that the irrigation was impossible, an iliosigmoidostomy with complete division of the ilium, twelve months after the colotomy; and this acted very well at first, but two months later faeces began to discharge from the colotomy wound, and during a further period of four months more and more escaped from the colotomy wound and less from the anus, until at last nothing came from the anus. The colon was then excised, the patient dying within twenty-four hours with symptoms of cerebral embolism. Mr. Grove says, "In this case there is an absolute demonstration that in the partially excluded colon there exists so marked a reverse peristalsis that all the faeces were returned from the sigmoid

to the ascending colon. If this is the explanation of the pain and general ill nutrition after partial exclusion of the colon, it is evident that it must be met by removal of the colon, or else by providing for the drainage of its proximal portion. This latter alternative may be done temporarily by bringing the distal stump of the ilium through the parietes and tying in a Paul's tube, or permanently, by implanting both ends of the divided ilium to the pelvic colon some inches apart."

Mr. Grove's conclusions are in part, the following:—

"(1) That the colon absorbs from 10 to 20 per cent. of the water from the faeces.

"(2) That the absorption takes place rapidly and is quite efficiently performed by the rectum and pelvic colon alone.

"(3) That the absorption of food stuffs in the colon is so slight as to be negligible.

"(4) That therefore the greater part of the large intestine is functionally unnecessary.

"(5) That as the contents of the colon consist of nearly one-third part by weight of bacteria, the absorption of coluble bacterial products probably occurs in all cases of colic stagnation."

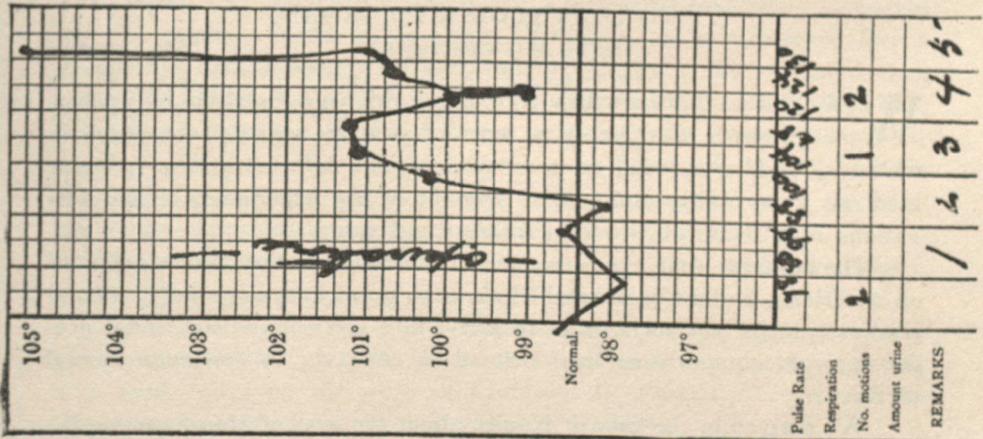
We are yet far from the possession of sufficient data to enable us to speak with any desirable degree of definiteness regarding colectomy, but the forecast is that in this procedure we have a method worthy of trial in those diseases in which auto-intoxication, and abdominal congestion are prominent factors of causation, inasmuch as it assures a more rapid exit for the faeces, thus avoiding much absorption of matter that must severely tax the over-burdened excretory organs, especially the kidneys. Have we not herein a method of relief for over-burdened kidneys? If so, how wide is the application of this operation? What of the rheumatism, anaemias, the arterial degenerations, the asthma, the neuralgias and anginas, As a drainage operation in ascites from organic liver disease it should be the operation *par excellence*, first, by lessening the volume of blood passing through the liver, and secondly, by the increased drainage facilities.

And again, what of epilepsy, other than Jacksonian? Is not this disease due to some autogenetic poison irritating the nerve centres? "It is hardly probable that the toxic materials elaborated in epilepsy are any different from these forming on occasion in other subjects. The difference in results is due to trophoneurotic instability and inherited irritability of the brain in the epileptic." Is there not, in colon resection at least, a theoretical therapeutic measure worth a trial in this distressing disease? One step further—what of the application of this procedure in profound neurasthenia, nerve degeneracy, and so on until the insanities are touched, and where shall the end be? All of these

suggestions are as reasonable as that of Mr. Lane when he states that black haired children with a predisposition to tuberculosis would be assisted in the battle of life by excision of the colon, as the poison absorbed from the colon lowers the resisting power to the tubercular germ. Does not this stimulate an attack upon the "germ" of old age?

Since writing the above a case of epilepsy presented, although there was a vague history of injury to the head in early childhood with convulsions following, no depression, cicatrix, nor tenderness could be elicited. He had lost so many positions on account of his illness that he became discouraged and expressed himself willing to accept any risk that might hold out the least benefit.

After fully explaining to him the gravity of the operation he



decided to accept it. He gave an early history of chronic indigestion with continual constipation requiring repeated aperients. I could trace no increase of constipation directly previous to the attacks. The operation was more difficult than the previous one as the bowel was not dilated and more firmly attached, especially along the splenic flexure.

This patient vomited considerably for two days. On the third day the bowels acted. This patient passed a comfortable day after the operation. The following day he suffered severe intermittent pain, vomited some food, and exhibited epigastric tympanities. Calomel not relieving the condition, I decided to re-open the abdomen the next morning and search for obstruction, but the condition appeared so much better, the bowels acting and the patient feeling and looking well. In fact he wanted to get out of bed and write a letter. The pulse fell to 99 and the temperature to 99 also, but during the day the pulse ran to 124 and the vomiting became fecal. I did not see him in the afternoon. The

following night he had an epileptic fit and did not regain consciousness. The post-mortem showed a kink in the ilium sixteen inches from the anastomosis which had caused complete obstruction. This evidently dated from the day following the operation as some liquid faeces had passed. The anastomosis was intact and the general condition within the abdomen satisfactory.

Although this case ended fatally, death was not due to the colotomy *per se* but to a condition which is liable to follow any abdominal operation. Yet one must admit that the prolonged anaesthesia, the exposure and handling of the bowels are most important factors contributing to intestinal paresis.

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### OTO-LARYNGOLOGY ABROAD.

By Dr. D. J. GIBB WISHART.

**W**HILE the Clinics which it was my privilege to visit last spring, are known presumably to most of you, the constant evolution in methods, and men, renders a renewal of our information at frequent intervals a necessity, and a brief account of my experiences and observations may therefore prove of interest and value.

The contrast that exists between the administration and conduct of an American, and a Continental Clinic is so great that a species of mental readjustment is needed in order to arrive at a just comparison, but I prefer to avoid comparisons, and instead to endeavor to convey a mental picture.

We arrived in the City of Naples about the 21st of March, and spent a week there. This city, once the dread as well as the delight of all visitors is now wonderfully clean, healthy, and safe. It has a magnificent and abundant water supply, and claims now to possess the lowest death rate in Europe. The population numbers about 700,000, and they are an industrious and happy people, the streets are crowded with business, and the harbour filled with shipping. The most interesting spot for the visitor is the Museum, and it derives its interest from the material which has been reclaimed from the excavation of Pompeii. The most attractive corner to me, was that which contained the medical and surgical appliances discovered in that ancient city, which were wonderfully up to date, the fine eye forceps, the bivalve vaginal speculum, and the ear scoop and director, so well known to the veriest tyro in medicine, might have been taken from an adjacent instrument shop so identical were they with those in use to day.

A new University Hospital is in course of erection, built in wings of several stories, and like all the buildings in Italy and Germany, abso-

lutely fireproof, concrete floors, stone staircases, etc. The operating rooms interested me, they are so arranged that the students or observers are accommodated in a ledge which projects three feet from the four walls, about six feet above the floor, with a complete wall of glass so shaped that it enables them to look right down at very close range upon the operating table, which is placed in the centre of the room, and yet without obstructing the light, which comes through a glass roof. In this way the operating room is kept completely sterile, and is not entered by any except those assisting.

The medical services are three in number and co-equal.

Our department is under the control of Professor Massei, whose writings and investigations are so well known, but up to the present it has had to be contented with its old quarters which are somewhat out of date. There was abundant material, and I found the time spent in watching the conduct of the clinic most instructive. The Professor has a device for demonstrating to his students which I saw nowhere else, and which obviated a difficulty with which I have always contended, viz., to know that the picture of the larynx as seen by the student is the one which the demonstrator designs him to see. Professor Massei had his mirror placed upon a transverse rod, and upon withdrawing his head could show his picture to several observers at the one time.

Professor Massei is a most quiet and courteous gentleman, and I received the most unexpected kindness from his hand.

Rome was reached in a few hours' railway journey through a very picturesque district. I spent the forenoon of each day during our stay of a week following the work of Professor G. Ferreri, Director of the Oto-laryngological clinic at the Poliklinico, Umberto, I.

The Polyclinic is situated outside the city walls, to the right of Porto Pia, and close to the ancient *Castra Prætoria*, where it covers a large area of ground. It was designed by Podesti, and built in 1896, but not opened for some years later, and may be considered to represent the very latest in hospital accommodation, upon the pavilion plan. Each building is connected with its neighbors by means of broad galleries, with abundant spacings for light and air, and all these buildings are of a uniform height and design externally. The gardens which surround the pavilions are neat and cheerful, and contribute by their beauty to render the whole place most attractive.

An entire pavilion is devoted to the Oto-Rhino-Laryngological Clinic, and is placed in the front row, immediately to the left of the central or Administrative Pavilion, and next to one of those devoted to Surgery. The ground floor contains in front, the Extern consultation room, waiting, electrical and inhalation rooms, and at the back commodious laboratories. The second floor contains a male and female ward, each accom-

modating ten patients, an amphitheatre for operations where students are present, two smaller wards, each containing two beds for special cases, two small operating rooms, offices for the Director, instrument rooms, kitchen, and room for the attendants. The basement is utilized for storage, and for anatomical examinations.

The building is connected with the central furnace department, and is abundantly supplied with heating pipes, live steam for the autoclaves, sterilizers, etc., and for the kitchen. Ventilation is effected by electric turbines installed in underground wells, with intakes in the gardens.

The ceilings are high, and each chamber is spacious, with large windows, walls of plaster covered in some to the height of seven feet, and in others completely, with a washable varnish, the angles are rounded to prevent the collection of dust, and the floors throughout are composed of brilliant cement, and are washed daily or oftener.

The kitchen, pharmaceutical, and linen departments are centralized, but admirable arrangements exist whereby each pavilion is rapidly served.

The out-patient examination room, about 45 feet long by 35 feet broad, and walls 16 feet in height, is equipped for six workers, each supplied with a table of enamelled iron, having an electric laryngoscope attachment, two glass shelves, the upper carrying two enamelled pans for sterilized and unsterilized instruments, etc. All instruments are sterilized by the attendant as each patient departs, and also before the commencement of the clinic which is held on Tuesday, Thursday and Saturday of each week. A wall cabinet placed close to each examiner contains the more usual medicaments, etc., required. New patients are examined by one of two Chief Assistants, and afterwards placed in the charge of one of the other workers for examination, treatment, etc. The notes of each case are dictated to a stenographer who sits behind and between the tables and these chiefs.

The Inhalation Chamber is provided with a marble table divided into six compartments, each supplied with a Bulling's Inhaler.

The Electrical Room, which is also a dark room for transilluminations, is furnished with a Rossi apparatus for ear massage, an apparatus for Finsen Phototherapy and one for galvanic, faradic, and sinusoidal currents, but Radiography and Photography are provided for in a central laboratory, accessible to all the departments, and under the charge of a highly experienced and trained specialist.

The laboratories are supplied with all facilities for histological, bacteriological and chemical examinations, and are in charge of an assistant of the Oto-Rhino-Laryngological Clinic, who is specially trained for the work, and devotes his time thereto.

The operating amphitheatre is constructed entirely of brilliant cement, and is supplied with powerful streams (three) of water for com-

plete lavage before and after operations, which are conducted usually on the alternate days from those of the out-patient clinic. There is in connection with this room a complete outfit of electrical transformers, motors, etc., so that electricity can be and is used in all possible ways in conducting operations.

The wards are exceedingly well ventilated, each bed is supplied with an electric bell, and the patients appeared to realize that their lot was cast in a goodly land.

In addition to all the above facilities, there is a library, and a private laboratory for the Director, and a trained attendant, who obligingly supplied me with a complete set of the Professor's reprints.

The outfitting of the Clinic, which was done largely at the expense of the Government, is so complete that de Carli, in a pamphlet which I have before me, contributed to the Archives Internationales de Laryngologie of Paris, is able to assert that it is supplied "with everything which is useful in the diagnosis and treatment of diseases of the throat, nose and ear."

The staff consists of the Director, Professor Ferreri, his Chief Assistant, Dr. de Carli, and a number of assistants and deputy assistants, who were present daily except Sunday, for the whole of each forenoon at least, and as was to be expected in consonance with the provisions, the technique of diagnosis and treatment, operative and otherwise, was thorough, up-to-date, and conducted with an earnest resolve to advance the science of these specialties with which it was concerned.

The department is the creation of Professor Ferreri, who, in addition to his own experience, made himself acquainted at first hand with the Oto-Rhino-Laryngological Clinics in the leading centres, both Continental and American.

It is to be feared that we on this side of the ocean are not as well acquainted as we should be with the excellent and advanced work in our departments that is being done in Italy, for while I found in Rome, assistants who had come from Brazil, Russia, and other distant points, I found none from North America, and yet every member of the staff spared no time or trouble to explain the details of the cases and the why and wherefore of the line of treatment adopted.

To the student in these branches of the healing art, who will take the trouble to acquire Italian or French, the Italian Clinics offer great advantages and he will be certain of polite and courteous treatment everywhere.

The Clinic is attended daily by an average of 200 patients, about 4,000 new cases appear in each year, and there is no slurring of the work in connection with any one of them, a characteristic that is not so apparent in the clinics of either Vienna or London.

I had intended to visit another throat clinic in Italy, that of Gradenigo in Turin, but finding that he would be absent, I turned my steps by way of Florence, Milan and Como to Freiburg, the place which Professor Killian has made so famous.

Freiburg is a little, purely German city, of 80,000 inhabitants, situated in Baden, on either side of the Dreisam, upon the edge of the Black Forest, and is reached in less than two hours from Basel. The beauty of its surroundings and its quaint old buildings make Freiburg a beautiful place of residence, and have attracted to it a number of cultured Germans, retired military men, etc. Its University is attended by some 2,500 students, and possesses some very strong men in its Faculty, such as Ashof in Pathology, Bloch in Ophthalmology and Otology, etc.; but its fame in Laryngology is second to none in the Continent.

Professor Killian has been assisted by Dr. von Eicken for seven years, and by Dr. Brunnings for three,—the former is well known as a writer and investigator, while Brunnings is ceaselessly working upon new devices for the instrumentarium, and the present perfection of the Killian Bronchoscope model is largely the result of his clever brain. Neither of these assistants are permitted to do private practice, but must depend upon the kindness of the Professor.

The Clinic occupies two somewhat old and cramped buildings,—the one used as a hospital and the other for the clinics and operating rooms. Contrary to our methods, the clinic is attended by both public and private patients, for whom waiting rooms exist side by side upon the ground floor. A common stairway carries these upstairs to a landing from which access is gained to the private room of the Professor and to the clinic hall. This hall is about 25 x 30 feet, and is arranged with four examination tables lined along the opposite walls. The centre of the room contains a table, and writing case, where the stenographer prepares and keeps all the histories. The clinic opens daily at about 9.30 a.m., and is attended by the full staff. Out-patients are dealt with first, and later the internes who are able to leave their beds. Operations are as a rule held before the clinic from 8 a.m.

The patients are summoned from below in batches by a bell, and are taken charge of indifferently by one of the assistants, the Professor devoting himself to the private cases, but as his door is always open, he is frequently in and out, discussing the public cases which are of interest. This free discussion of cases was a most outstanding feature of the clinic, frequently all four members of the staff would be gathered about a patient, or a "Roentgen Ray Photograph," or a new instrument, or an article from a Journal, discussing in the freest way the points presented, eliciting histories, or suggesting methods of diagnosis, and the stranger within the gates could not but feel that this method of

work stimulated the workers, as iron sharpeneth iron, and also made for the distinct benefit of the patient.

It was the same in the conduct of operations, one or other administered the anesthetic, and the rest assisted. The Schwester in charge, who also was responsible apparently for the in-patients as well, took entire charge of the instruments, and handed these out as called upon, and by dint of experience was a most useful assistant.

I was fortunate in being present when a large number of old frontal sinus cases were reporting in order that Professor Killian might collate his statistics for his paper before the Congress. Some of these were cures of six years' standing, and I had the opportunity not only of convincing myself of the thoroughness of the cure, but also of the absence of deformity or of squint.

Fortunately, again, a patient appeared with a chicken bone in his right lung, and I witnessed the ease with which it was seen and extracted by Dr. Brunnings through the larynx. Among other operative cases were Empyemas of all the sinuses, Mastoids, Resections, etc. The usual method of operating upon antral cases, was under local anæsthesia, the patient seated in a chair, and apparently conscious of no suffering. The method varied with reference to the membrane of the sinus, the tendency being to leave it as intact as possible. The entire outer wall of the nose was removed up to the attachment of the inferior turbinal, and the operation was completed by removing the middle third of this turbinal, a device intended to prevent the drip which may follow when the anterior part is taken away.

In acute antral disease, a most ingenious device is being worked out by Brunnings, by which the head and face are super-heated by electric lamps for half-an-hour at a sitting. It is claimed for this method that the pain is at once and permanently relieved at the first seance.

The tonsil is not enucleated in Freiburg, they are content to remove what is deemed sufficient, and usually by the snare.

The ample supply of instruments of all models and of the most modern is another outstanding feature. The instrument maker is in almost daily attendance and he is freely used in the manufacture of varieties or models as occasion arises. As each case is dealt with the notes are dictated to the stenographer, and the histories are all typed and filed so as to be easily accessible. The clinic closed as a rule about 2 o'clock, there was no hurry, every case was thoroughly gone into, and every point elicited.

As I have said, the population is small, only 80,000, and about 2,000 cases are seen in the year, but the character of the work is the drawing card, and the advancement of the staff depends entirely upon the scien-

tific results, while the Professor, being free from competition, is able to pay his assistants a fair living salary.

It is fully expected that the Professor may be called to Berlin when Frankel retires, and thus he will reach the zenith of his sphere, a deserved reward of his masterly work in Frontal Sinus, Septum Resection, and Bronchoscopy.

Munich lay upon our road from Freiburg to Vienna, and we paid it a four days' visit, but the Easter celebrations, most attractive to the visitor, demoralized the clinics, and beyond attending the Ear Department for two Extern Clinics, at which the Chief was absent, I did not derive much information.

I have already published an account of the Rhino-Laryngological Congress, which took place in Vienna, from the 20th to the 26th of April, and need not dilate upon it here. I did not, however, in this article, touch upon the interesting clinical side shows which we were privileged to see, and which were as interesting to some of us as the Congress itself. Chiari, Hajek and Koschier threw their clinics open to the Congress on the afternoon of the first day, and had summoned a number of interesting cases for examination. The one which interested me most was an example of Rhino-Scleroma, of which only some half dozen cases have been reported in America. The similarity of the lesions to those of syphilis was most striking. In the radical mastoids exhibited, the extent of the enlarged external auditory canal obtained, affording an excellent view of the parts, was remarkable.

Each morning we spent in Alexander's Clinic and operating room. The facility with which he handles a radical operation on the mastoid, proceeding with the utmost rapidity, and yet without error, is interesting. He uses no protector, as he considers that dislocation of the stapes is caused by its pressure. The chisels exhibited are the ones he employs. After ligaturing the jugular he did not desect it up, or wash it out, or the sinus. The packing employed was of cotton wick. In making his flap he made two horizontal incisions transversely, and removed a section of the cartilage.

Professor Kummel, of Heidelberg, is a most kindly man, profoundly interested in his work, possessing a fair knowledge of English, and cordial in his reception of strangers. This made the few days of my visit extremely valuable, and the clinic affords abundant facilities, especially if the visitor has a working knowledge of German.

A description of the building may be interesting. Upon entering the building by the main door, a large hall stretches before one, with the Extern Clinic room at the far end, on the right are private clinics and laboratories, etc., and on the left the various rooms belonging to the clinic. Upstairs were the wards and operating rooms. The waiting

rooms were beyond the Extern Clinic again, and reached from another street.

Arriving in the morning, early, I met an assistant, who kindly took me to the wards, where he was dressing the indoor cases. A separate room was provided for this work upon the first floor. I then accompanied him to the main clinic room, which I found very capacious, about 40 x 25 ft., provided with four stalls, each 8 x 8 ft., with sheet metal partitions for the assistant. The remainder of the room was occupied by instrument cabinets, and the tables upon which the records were kept, and prescriptions written. Each stall was provided with a hanging electric light, adjusted by a weight and pulley. The furniture was iron and glass, and the accessory supplies abundant. Here there were some five assistants, one of them a lady, and several attendants, and all busy. Off this apartment was a small room in which small operations were done, and the first assistant examined special cases.

Communicating with this clinic on the opposite side by folding doors was a large room, where selected extern and intern cases were attended, and examined later by Professor Kummel. This again opened into a dark room about 16 x 18 ft., in which there was installed a most complete Roentgen Ray outfit. This enabled the Professor to pass a probe into the frontal sinus of a patient, and immediately to demonstrate its correct position in the dark room. Beyond this again was an L shaped room, the teaching clinic, supplied in the short leg with three tables, each accommodating four students when making examinations, while the long leg, about 25 x 30 ft., was seated, and provided with lantern and screen, models, charts, etc., for class purposes. I spent several forenoons in the clinic, studying the methods of examinations and details of treatment used. I was only fortunate enough to see one operation, a mastoid, which presented nothing unusual.

Here, as in Freiburg, the material was abundant, and the cases received that close attention which is the joy of these continental clinics. As you all know, the City of Heidelberg possesses great attraction, and with such a valuable clinic at his command, no time could be employed better by the specialist than in paying an extended visit, when the eye and the mind are at once delighted and informed.

In London, my time was chiefly occupied in private business, but I had the pleasure of witnessing mastoid operations by Dundas Grant, Ballance, and Yearsley, each of whom presented some variation in method of his own. In fact no two of the eight distinguished operators whom I saw operate upon the mastoid employed the same methods, and the contrasts afforded gave one much new light.

It was an unexpected pleasure to receive an invitation from Dr. Paterson, of Cardiff, to witness the inauguration of the Extern Depart-

ment of the Cardiff Infirmary and a series of operations and cases during the two succeeding days. Dr. Paterson, as the readers of the *British Medical Journal* and *Journal of Laryngology, Rhinology and Otolaryngology*, are aware, has done more than any other in England to establish the adoption of Bronchoscopy, but in addition to this, possessing as he does a magnificent centre of work, and a faculty for work itself, he has built up a sound reputation, and anything that he publishes will be well worth your perusal, and coming from the north of the Tweed, and of a quiet, retiring nature, he is not set on a pedestal, and one cannot help receiving pleasure and profit from his quiet, unostentatious methods of research. I saw a valuable series of interesting cases, and inspected the post-operative results in cases of Frontal Sinus, Laryngotomies, etc.

In Glasgow, I was piloted over the Western Infirmary and its palatial out-patient department by Dr. McIntosh, whose precise knowledge of hospital requirements will, I trust, be used in the preparation of the plans for our Toronto General. Through the courtesy of Dr. Brown-Kelly, whom you will remember as Secretary of our Section of the British Medical Association in 1906, I was privileged to assist in a Bronchoscopic examination, and to examine a number of interesting and rare cases, among others examples of multiple telangiectasis of the mucous membrane of the nose and mouth, and Sclerotic Hyperplasias of the Pharynx and Nasopharynx.

A short visit to Edinburgh to avail myself of the invitation of Dr. Logan Turner and examine into the teaching methods employed by him, and a few days in Liverpool at the clinics of Middlemas, Hunt, and Hugh Jones completed a most stimulating and instructive experience.

47 Grosvenor Street.

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### A CONTRIBUTION TO THE STUDY OF SYPHILITIC ARTHROPATHIES.\*

By NOAH E. ARONSTAM, M.D., Detroit, Mich.

**N**EARLY every one of the intoxication diseases or toxæmiæ manifest a tendency toward joint involvement. We see this tendency most markedly displayed in the different exanthemata. Extraneous septic invasion—as from wound infection for instance—is likewise apt to spend its process upon the large or small joints. Gonococcic infection is another weighty etiological factor that has a peculiar predilection for the synovial and other serous membranes of the body. The profession is well acquainted with the arthritic manifestations that are at any time liable to complicate tuberculosis, leprosy and pellagra. But it seems that very

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\* Read before the Wayne County Medical Society, Nov. 15th, 1909.

little attention has been paid hitherto to the joint affections appearing during the course of syphilis. It is the latter that has influenced the writer to devote himself to a discussion of the joint affections caused by the syphilitic process. He has based this rather limited exposé of the subject, partly upon data obtained from his private practice and partly from the literature dealing with such cases.

Syphilitic arthropathies are fortunately not very common. Clinicians who have had a varied and extensive experience with this protean disease, have computed that in only 6.5% of the cases, may joint disease be encountered during the course of syphilis in any of its forms. No exact division or classification has as yet been attempted in the matter of syphilitic arthropathies, and yet it readily lends itself toward—and one may distinctly see—two predominating types, viz :

(1) *Inflammatory Conditions of the Joints Proper*—both large and small (although the burden falls upon the larger joints), occurring during the secondary stage of syphilis.

(2) *Indolent or Stationary affections of the Joints*, to which the term *arthropathies* may adequately be applied, appearing in advanced or late cases.

As to the first of these types, it may be remarked that the development of the joints differs in no respect from that seen in ordinary acute articular attacks of rheumatic origin. It possesses the same migratory tendency that is observed in inflammatory rheumatism. The joints of either the upper or lower extremities are inflamed, œdematous, fixed, mostly in a state of flexion; active and passive motion is impossible and engenders intense pain; the fever is high and the constitutional disturbances marked. Many a case of this type is apt to receive the ordinary designation of articular rheumatism, and may even for a time be ineffectually treated under this guise, until the error is recognized and the proper treatment instituted. And yet such mistakes may be readily obviated by a careful examination of the skin and mucous membranes for signs of syphilis. The former will nearly always bear the ear marks of this affection, for a roseola or a small papular syphilide will be found well erupted, while the mucous membrane exhibit the usual phenomena of superficial erosions in the form of mucous plaques of the buccal cavity and pharynx. The history of the case may elicit the primary lesion. Greater difficulty, however, will be experienced, if the initial infection is of extragenital source. Yet, close observation and a thorough inspection will in 90% of cases reveal the true nature of the malady. The therapeutic diagnosis will eventually come to our aid, if any other means of diagnosing the disorder have been exhausted. Yet it must not be forgotten, that such compulsory procrastination may entail great des-

truction to the tissues, and particularly so to the joints affected. We should therefore endeavor our utmost to arrive at a correct diagnosis.

The real pathology of the arthritic process of the first and second type has never been conclusively established, for there were no autopsies to throw light on the subject. The prognosis as to life is favorable.

Recovery is the general rule, if the treatment be appropriate; on the other hand a stiff joint may be the ultimate result if the therapy be based upon a erroneous diagnosis. Our conception, however, of the morbid anatomy of the parts implicated is thus far still *subjudice*.

Of greater interest to us, however, is the second type in our classification, namely, the late *arthropathies*, as seen during the course of late or tertiary syphilis. We have but very few cutaneous symptoms to guide us; the mucous membranes bear few imprints of the luetic process, that may have been subjugated by a previous effectual or partial treatment. As it was remarked before, the joints have none of the inflammatory characteristics of the early arthritic forms; on the contrary, the process is non-inflammatory, indolent and stationary. But on inspection the gross pathological changes soon become apparent to the eye; the joints are œdematous and deformed, very much simulating those of arthritis deformans or rheumatoid arthritis and on moving them a crepitant sound may be readily elicited. Pain is of a negative character. The patients may complain of vague, dull or dragging pain, or as they so fittingly term it "squeezing pains," as if the joints were compressed by a vice or some outside object. The pain is spasmodic or periodical, setting in mostly towards evening and lasting but a short time. Passive motion is not accompanied by any subjective symptoms; *stiffness and partial mobility are two features that go hand in hand with the above described symptoms*. While mostly the larger joints are involved in the early arthritic type, the smaller joints seem equally to suffer in the late arthropathies, so that the clinical picture will resemble that of a case of rheumatoid arthritis. It may not be amiss to state at this juncture, that perhaps the unsuccessful cases of the latter affection that are so persistent and resist any and all forms of the classical treatment in vogue, may have been cases of late syphilitic arthropathies. The author has on his record cases of both types, but will refrain from citing them, as he has in substance given the most salient points of this particular phase of syphilitic intoxication.

Very little need to be said about the *treatment*. When the process is so pronounced that it concentrates its violence upon the various joints, such as we find it in the early forms, then one must have recourse to a rapid saturation of the system with mercury. The best method under those circumstances is the *hypodermic*, or what is still better, the *intra-muscular* method. It is so simple and efficacious, that the author can-

not comprehend the aversion of some physicians towards it and cannot understand the reason of this method not being employed more frequently. The *bicyanide* is a preparation to be recommended. Its use occasions little or no pain. The bichloride may be mentioned in this connection in order to condemn it. When the arthritic process is very pronounced, 0, 02 of mercuric bicyanide may be injected in the gluteal region daily. If there are objections, and unreasonably so, towards this form of administration, the inunction method or mercury per os may be exhibited.

In the *late or indolent arthropathies* the iodides given alternately with stoxyl (the latter subcutaneously or intramuscularly) may be tried. The iodides must be given to the point of physiological saturation, while atoxyl may be used in a 10% solution, 1, 0 or 2, 0 twice or three times a week. This treatment must be varied by a course of mercury in any of the forms best seen fit by the physician. Mercurial inunctions to the joints act beneficially. As an auxilliary or supplementary measure, Bier's induced hyperæmia may be tried. The salicylates act indifferently in these cases, and are therefore useless. Mechanical measures do not afford much satisfaction, and after a prolonged trial will be finally discarded.

In conclusion, the author wishes to suggest that all acute articular affections, where the usual therapeutic measures, with the various salicylic acid compounds prove futile, one is justified to consider syphilis as a causative factor, and a thorough search should be maintained, with a view to elicit other corroborating symptoms or the initial lesion, that might have evaded our scrutiny. Furthermore, *that in all chronic and protracted arthropathies of the arthritis deformans type, the possibility of syphilis as an etiological agent must be entertained.*

32 Adams Avenue West.

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The 43 annual meeting of the Canadian Medical Association will be held in Toronto, on 1st, 2nd, 3rd and 4th of June, 1910. Names of papers must be submitted by 1st February and a synopsis of each paper by 15th April. The meeting promises to be a very successful one.

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## CURRENT MEDICAL LITERATURE.

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MEDICINE.

Under the charge of A. J. MACKENZIE, B.A., M.B., Toronto.

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CUGUILLERE'S SERUM

In the *Therapeutic Gazette*, June 15th, Muschlitz records his experience with this agent which has received unequivocal endorsement from several sources. The originator believed that he had succeeded in elaborating a substance which would destroy the organisms of tuberculosis in the human container as they are killed in vitro; the mineral compounds found in the vegetable kingdom were the agents found suitable and the formula as given to the Tuberculosis Congress by Cugui-llere himself in 1905 is as follows:—

Allylum sulphide, 1 gramme;  
Tincture of myrrh, 1 gramme;  
Hayem's glycerinated serum, 100 grammes.

The physiological action as given by Cugui-llere in 1905 is as follows:

1. "It is not toxic; the maximum useful dose for an adult is 15 Cc., and tuberculous guinea-pigs withstand a dose of 5 to 6 Cc. without the least inconvenience.
2. "It disseminates throughout the organism with remarkable rapidity. In thirty seconds at least the patient exhales from the lungs the characteristic odor of the essence of myrrh and the sulphuret of garlic.
3. "There is a remarkable action on the fever, and it is upon the temperature curve more than upon the stethoscopic signs that I rely as a basis for the direction of the treatment of pulmonary tuberculosis.

There is really no serum, Hayem's fluid being an artificial composition, the formula of which is usually given as mercuric chloride 0.5, sodium sulphate 5, distilled water 200, with the addition of glycerine. The oil of garlic, allylum sulphide, has always been esteemed of value in tuberculosis; indeed, Koch states that the disease is rare in those countries or parts where such of the vegetable is consumed. The treatment is made hypodermically, the dosage ranges from 2 to 15 c.c.

Cugui-llere himself reports a large number of cases benefitted by the treatment, mostly sufferers from surgical tuberculosis, while Escocoz, at the International Congress at Lisbon, reported a number, 76, with a high percentage of recoveries from pulmonary tuberculosis.

The writer tried the serum in the treatment of six cases of surgical tuberculosis of varying duration and intensity, with the assistance of

Dr. Caraviam, who introduced the serum to the notice of American physicians, but while an early improvement was noticed in some cases, no definite or permanent result was achieved in any one of the series. The results obtained by the originators are almost miraculous, but it is strange that the agent should be powerless in the hands of others, and after nine years before the profession it should be so little known.

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### LUMBAR ANÆSTHESIA.

Gros, at the Prague Verein, gave a history of the method and *technique* of local anæsthesia, which he has practiced in the gynæcological wards during the last year. The total number was 615 operations under this form of anæsthesia; the liquid he kept stored in bottles, according to Höchst, as a 5 per cent. solution of "Novokain-Suprarenan." Half-an-hour before the injection a subcutaneous injection of 0.01 gramme of morphium muriatum and 0.0003 gramme of scopolimin hydrobrom, was used to dull the pain of the deeper injection.

Out of the 615 cases operated on 538 were completely anæsthetised, that is, 87.5 per cent., while 22, or 3.5 per cent., were imperfectly anæsthetised or suffered from pain which caused the suspension of the injection, and therefore he had to resort to inhalation narcosis, but 55, or 9 per cent., were quite refractory. Of these cases 450 were laparotomies; 388, or 86 per cent., were complete; 43, or 9.6 per cent., incomplete, and 19, or 4.2 per cent., complete failures. Of the 165 vaginal operations, 150, or 91 per cent., were complete; 12, or 7.2 per cent., incomplete, and 3, or 1.8 per cent., failures. It may be noted here that 100 of the cases were total extirpation of the uterus on account of carcinoma, 74 of myoma, and 37 for affections of the adnexa. The greatest number of failures was in the larger operations, such as laparotomy, and may have been partly due to a faulty *technique*, as it usually occurred after opening the peritoneum, when chloroform had to be resorted to. It may have been due to pressure in the abdomen influencing the diffusion of the drug. It is worthy of note that the greatest number of failures were met with in young persons; between the ages of 20 and 29 there were 105 cases with 7 failures, or 6.6 per cent.; between the ages of 30 and 39 there were 180 cases with 11, or 6.1 per cent. failures, while in a number of 204 between the ages of 40 and 49 only 3 cases, or 1.4 per cent. were met with; in 93 cases between the ages of 50 and 59 only 1 or 1.07 failed; and in 25 cases between 60 and 80 not one failed.

The after effects were more frequently observed in the young, as 10 per cent. complained of headache, but strange to relate the more nervous suffered least in this respect. One case was followed by paralysis

of the abducens nerve, but recovered within two months. In two cases immediately following one another infection had been imported probably through the imperfect sterilisation of the salt solution which sometimes had been substituted by a soda solution in which the instruments had been boiled. Since then the sterilisation has been carried out without any addition of soda. One of these cases died from diffuse purulent cerebral meningitis, the fluid of which contained bacteria coli. The other case had all the typical symptoms of meningitis; by lumbar puncture a cloudy liquor was extracted whose sediment was purulent; in the intracellular matter were found fine rods, but no pathogenic bacilli could be identified. The puncture was repeated four times, and upwards of 80 c.cm. were extracted. On the twelfth day the fever was high, but after this rapidly fell, and the patient finally recovered. No other bad effects were observed from the spinal anæsthesia.—*Medical Press and Circular.*

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#### LUMBAR PUNCTURE.

Tapping of the cephalo-rachidian liquid in the lumbar region is frequently practised to-day to establish the diagnosis of several affections. By this method also, different therapeutic and anæsthetic agents are introduced into the medullary canal. The chief indications of lumbar puncture are, consequently, threefold: anæsthesia, diagnosis, and treatment.

Intra-rachidian injection of anæsthetic agents has been, and is still, says Prof. Tuffier, a point of much discussion.

Many surgeons have rejected it altogether. It seems, however, that this method is capable of rendering service to the surgeon deprived of competent assistance, as frequently occurs in the country, and certain patients with heart disease in whom general anæsthesia is counter-indicated.

Amongst the surgeons who practice this regional anæsthetic, some employ cocaine, while others, the majority, prefer stovaine.

The patient is prepared as for a simple lumbar puncture, and the needle being adjusted to Luer's syringe of two cubic centimetres, 2, 3, 4, or 5 tenths of a centimetre cube of a solution of stovaine at 10 per cent. (the dose varying according to the importance of the operation) are aspirated. The syringe containing the solution is separated from the needle and laid on a clean compress, while the needle is used for the puncture between the fourth and fifth vertebræ. About two drachms and a half of the rachidian liquid are drawn and the syringe fixed on the needle with great gentleness so that its position should not be disturbed. If the little manipulation be well done, the pressure of the rachidian

liquid will push back the piston, which is immediately arrested in its course by the operator; the liquid mixes with the solution of stovain, becoming of milky appearance. Gently and progressively the piston is pushed down to the end, when the syringe is withdrawn and the little wound closed with collodion.

Anæsthesia is obtained in about ten minutes after the injection; a sensation of pins and needles is felt in the feet in about three minutes and a certain impotence in the lower limbs which soon becomes complete.

The amount of stovain to be injected depends on the region to be operated; the minimum dose (2 centigr.) for the perineum; the maximum for the inferior portion of the abdomen, while a medium dose is sufficient for the lower limbs. The anæsthesia lasts half-an-hour or more.

For amputation of the leg or thigh, four-tenths of the syringe are necessary, and for inguinal hernia, appendicitis, enterostomy, five-tenths will be required. Certain precautions are necessary to observe in this method of producing anæsthesia.

The patient should be placed in the lateral decubitus and left for five minutes in this position after the injection, where the operation is to be practised on one or the other side of the body. In weakly persons, the injection should be preceded by an injection of caffeine or strychnine, and particularly in cases of intestinal occlusion or strangulated hernia. After the operation the patient must lie on his back without a pillow.

Rarely is rachi-anæsthesia unsuccessful, but if, after waiting a quarter-of-an-hour, the anæsthesia is incomplete, some error has been made in the introduction of the needle; the stovaine has been injected into the cellular tissues or the muscle. In such a case, the operation must be performed again.

When proper precautions are taken, accidents following this method are rare. They consist in pallor of the face and cold sweats and sometimes vomiting, retention of urine (rather frequent), headache, especially when a sufficient quantity of cephalo-rachidian liquid has not been previously drawn off, while six cases of sudden death have been reported, all of which were in elderly patients who had received large doses of stovaine.

As means of diagnosis, lumbar puncture finds its indication in numerous affections, to confirm, by examination of the cephalo-rachidian liquid, diagnosis of obscure cases.

The macroscopic aspect of the liquid in its normal condition is absolutely clear as water, in pathological conditions it is cloudy, purulent or hæmorrhagic.

Cloudy or purulent indicates acute meningitis. Hence each time that a patient presents symptoms of acute meningitis lumbar puncture is indicated. When hæmorrhage is perceived in the liquid it may mean

blood effused in the subarachnoid space, but it may also originate from the puncture itself, and a distinction is necessary. If the presence of the blood is due to a wound of a vein by the needle, the liquid is red at the beginning and then pales down; if on the contrary the liquid is frankly hæmorrhagic, it is of a brownish or greenish yellow, and not red.

The presence of blood, when confirmed, may be met with in a large number of affections, but it cannot be regarded as an absolute pathognomonic symptom. However, in traumatism of the cranium, it may indicate intra-meningeal hæmorrhage due in many instances to fracture of the skull, and in any case it is a proof that the traumatism is grave.

From a chemical point of view, the cephalo-rachidian liquid is characterised by abundance of chlorides and by traces of albumen. An increase of the latter is, however, an indication of tuberculous meningitis, while the existence of pus denotes acute meningitis. Where ataxy or softening of the brain is suspected, the existence of lymphostytosis will confirm the diagnosis.

Lumbar puncture has been also employed in the treatment of several affections. For the simple purpose of evacuation, the puncture has rendered great services in fracture of the skull by diminishing compression produced by blood effused in the folds of the arachnoid; the coma disappears, consciousness returns, and the headache is relieved by extracting five drachms of the liquid.

Puncture followed by injection of therapeutic agents has been employed with best success in the treatment of cerebro-spinal meningitis. The serum injected may be that of Roux, Flexner, or Wasserman, and the quantity to be used for a child is one ounce, repeated every day for four or five days; two ounces for an adult. About five drachms of the rachidian liquid should be withdrawn before each operation. Other agents have been introduced into the medullary canal such as anti-tetanic serum, collargol, etc., but without great success.—*Medical Press and Circular*.

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## GYNÆCOLOGY AND ABDOMINAL SURGERY.

Under the charge of S. M. HAY, M.D., C.M., Gynæcologist to the Toronto Western Hospital, and Consulting Surgeon, Toronto Orthopedic Hospital.

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### CARCINOMA OF THE UTERUS, WITH METASTASES IN THE LUNGS AND PLEURAL CAVITIES.

Dr. H. Offergeld, Frankfurt, *Archiv. f. Gynækologie*, bd. 87, hft. 2, declares that the lungs are a favorite seat for metastases in the case of cancer of the uterus, while the pleural cavities are but rarely involved.

## FREQUENCY OF METASTASES IN THE PLEURA.

Sibley, in the Middlesex Hospital, found the condition in two out of forty-four cases of cancer of the uterus.

Dittrich, in Prague, found two cases in sixty cases of cancer of uterus.

Béquerel, in the Salpêtrière, in Paris, reports one in fifty-one cases.

Bzau and Dybowski found in Virchow's material of 262 cases, three cases with secondary involvement of pleura.

Albers-Schönberg, in Hamburg, found metastases of the pleura in eleven out of 564 cases.

Buday, in Klausenburg, in two out of 158 cases.

## FREQUENCY OF METASTASES IN LUNGS.

Wagner found them in 6 per cent. of his cases.

Albers-Schönberg in 5.1 per cent. of his cases.

Sänger v. Herff, in 7 per cent. of his cases.

From his examination of the literature, Offergeld found 118 individual cases, in which secondary involvement existed in the lungs, in the presence of cancer of the uterus.

These metastases may take place early, when the primary uterine growth is still very small, even where the neighboring lymphatics are still uninvolved. The usual location for the secondary pulmonary growths is in the central portion of the lower lobes. The lesion is most frequently bilatreal.

The metastases take place both through the circulatory and the lymphatic systems.

## SUMMARY.

1. Cancer of the pleura is very rare in primary cancer of the uterus.
2. Cancer of the pleura is found only in advanced cases of cancer of the uterus, and especially in cancer of the cervix.
3. Cancer of the pleura secondary to cancer of the uterus, arises only through the lymphatics and then only after passing through the pulmonary and bronchial lymph glands.
4. The clinical symptoms are indefinite.
5. Metastases in the lungs, in cancer of the uterus, are relatively frequent (5-7 per cent.).
6. Such metastases in the lungs are found relatively early.
7. These pulmonary metastases are usually bilateral and are found especially in the central zones of the lower lobes.
8. They arise chiefly through the circulatory system.
9. Carcinomatous Lymphangitis is very infrequent in the lungs, in the case of primary carcinoma of the uterus.—*Surgery, Gynæcology and Obstetrics*, May, 1909.

## POSTOPERATIVE DILATATION OF THE STOMACH.

That acute dilatation of the stomach, not necessarily in extreme degree, is fairly common, we believe to be true from our own experience. The patients with persistent distension, persistent nausea and vomiting, with the peritonitic facies and the thready pulse of a diffuse infection are often allowed to die because the case is believed to be one of peritonitic ileus for the reason that the customary methods of treating the latter do not prove effective. Enemata are followed by the passage of flatus usually in considerable amounts. Cathartics given by mouth are either vomited at once or they fail to produce the expected results. Liquids given by mouth are retained in part or whole for many hours, deluding the surgeon into the belief that nourishment is being absorbed. If, however, the stomach tube is used the amount of fluid that is obtained may be appalling. Again and again the stomach must be washed out until nausea ceases and until the stomach regains its normal size. Following repeated lavage the distension, the facies and the thready pulse disappear, and at once it is clear that one is dealing not with the dreaded peritonitic ileus, but with an over-distended, paralyzed stomach.

More and more at our clinic are we induced to employ lavage when nausea or vomiting hesitate to disappear spontaneously, or if there is any distension that is not entirely relieved by enemata or rectal tube.—John C. Munro in *The St. Paul Medical Journal*—(*American Journal of Surgery*, October, 1909).

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## LARYNGOLOGY AND RHINOLOGY.

Under the charge of FERRY G. GOLDSMITH, M.D., C.M., Fellow of the Laryngological and Rhinological Society of Britain; Assistant Laryngologist and Rhinologist, Toronto General Hospital.

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### RECENT PROGRESS IN LARYNGOLOGY AND RHINOLOGY.

In the *Boston Medical and Surgical Journal*, Aug. 12, 1909, Coolidge and Kerr have given a very interesting summary of some of the more recent procedures in this department of medicine. (The reviewer has had the advantage of using it as a key in an endeavor also to point out some of the more recent advances.)

*Tonsil Surgery.* The removal of the faucial tonsils has up until a year or so ago been by the use of various amputating devices which were only able to remove a portion of the gland. For many years the question whether tonsils should be removed or not has met different answers, but during the last year or two there appears to have been

an outburst of operation fervor which is probably reaching its height, as it cannot increase indefinitely from lack of material. The more recent advance is along the line of removing the entire gland rather than only the part. There is no other place in the body where only part of a diseased gland is left (leaving out of consideration the thyroid). Why, therefore, should one perform a partial removal, tonsillotomy in place of a complete enucleation—tonsillectomy.

Various measures are employed to reach the space behind the capsule of the gland after which it is easily stripped from its bed. Blunt and sharp dissectors have their advocates. Matthews has recently described a method of finger dissection which has also been brought forward by Richards. Generally speaking, after having freed the tonsil from the pillars and the superior constriction, the operation is finished by a snare or small guillotine. Scissors and punch are favored by many.

The majority of cases in children are performed by general anaesthesia—ether or chloroform. West, Beck, Tydings, and others, use injections in and around the tonsil, of cocaine and adrenalin. (The reviewer uses almost entirely a 3% sol. of quinine hydrochlorate and Beck's tonsil syringe, and sees no reason to return to cocaine solution.) Freer says "tonsillotomy with the tonsillitome or snare, cautery dissection and the attempt to cause shrinkage of the tonsils by slitting the crypts are timid and unreliable methods which should be abandoned."

The question of hemorrhage is of considerable importance. Most writers seem to have less hemorrhage with complete than with partial operation. (The reviewer has had more hemorrhage with the former operation but does not allow this to weigh in deciding as to which operation to perform, as he invariably enucleates the gland in all cases except young children.) Pynchon insists that gentle massage to the tonsillar cavity after enucleation is very desirable as it conduces to early healing and less scarring.

*Frontal Sinus.* There appears to be a more conservative feeling coming over the profession in regard to external operation. The value of x-ray pictures when *properly made and intelligently interpreted* is unquestionable. More persistent efforts are being made to cure these cases by intra-nasal measures or at any rate to so modify the symptoms that there does not remain the necessity for any external disfiguring operation.

*Maxillary Antrum.* It has always been a difficult matter to say what cases are adapted for treatment by lavage, and which by operation measure. Time or intra-nasal conditions do not always point the correct method. If the teeth are at fault they should be attended to, but alveolar drainage is only adopted in few instances. A paper by Logan Turner (*B.M.J.*, Oct 10, 1908), based upon a series of cases, aims to

try to determine whether there are means at our disposal to say at the outset whether lavage is likely to be sufficient or a radical operation to be advised. His conclusions are as follows: In patients of advanced years a conservation treatment is the one of choice, lavage because of its simple nature and avoidance of shock. The presence of nasal polypi does not make the radical operation imperative, as success has followed lavage and removal of the polypi. Polypi, however, points towards some of the sinus as being involved, usually the ethmoid. Antral suppuration of one year's duration is usually successfully treated by lavage alone.

Sufficient cytological and bacteriological data is not at present available to determine before treatment is commenced in what cases of this class lavage may prove a failure. If the suppuration be of longer duration than one year, lavage may be used if the staphylococci are predominant organisms. When in the same class of case the streptococcus is the virulent organism, or when the streptococcus is associated with the presence of squamous epithelium and lymphocytes, the radical operation should be advised and practised. When lavage is decided upon it should be by intra-nasal means rather than by the route. Turner favors in the radical operation, entering the antrum through the canine and subsequently draining through the nose. (Caldwell-Tuc). This tendency is, however, to make a longer opening into the antrum from the nose, and have the patient wash it himself. This is all that is needed in most cases of uncomplicated antral suppuration. Beck of Chicago uses a 33% Bismuth paste introduced by a special syringe into the antrum. He found it of distinct value, and the reviewer can very heartily endorse its value in antrum suppuration.

*Ethmoid.* The great difficulty in dealing with ethmoidal suppuration has been to reach all the suppurating foci. Various punch forceps have been devised and repeated operations found necessary. Ballenger (Chicago) has devised a special instrument by which the middle turbinal and ethmoidal cells may be removed in one piece. It is a very heroic method, but Ballenger says he has used this method over two hundred times without a fatality.

*Sphenoid.* There has been nothing of importance to record in this series other than the value from a diagnostic point of the use of the x-rays photograph. The close connection between diseases of the optic nerve and suppuration in the sphenoidal sinus and posterior ethmoidal cells has received a good deal of study by Grant, Thompson, Onida and Toeb. Many cases are reported of intra-ocular conditions clearing up on treatment directed to the sphenoidal sinus and posterior ethmoidal cells.

*Atrophic Rhinitis.* The view that this is a disease with a definite pathological entity seems to be gaining ground. Many consider with

Grunwald that there is always some purulent focus to be found in some of the sinuses, but one is not always able to find this spot. Steiner believes that atrophy of the membrane with fetid crusts may arise from four causes—congenital defect, mechanically, empyema of a sinus and from syphilis. Frere argues that the disease is the result of hereditary syphilis of which snuffles is the first stage. Sohanherin (*Arch fus Laryngal XX.*, p. 474) applied the Wasserman test to seventeen cases of atrophic rhinitis. In no single case was there a positive reaction. The only new therapeutic advance, if it is an advance, has been the use of the fresh lactic acid bacillus. An emulsion is used as a nasal spray by Curtis of New York who reports some interesting improvements.

*Nasal Deformities.* Rhinologists are gradually paying more attention to the various deformities of the external nose, and many papers have appeared which have added to the little store we have of operations for this class of cases. Beck and Roe have both taken up the subject and have illustrated their article with excellent photographs. Smith speaks highly of paraffin intra-nasally, the sub-mucous resection appears to be the operation of choice in septal deviations. In children, however, care must be taken in removing any of the nasal framework before development has been completed.

Recently Carter of New York has published a series of cases in which he has successfully treated cases of some recent and old fractures of the nasal framework. He mobilises all the offending fragments and by means of a special splint applied over the nose he is able to anchor the fragments into the desired position and retain them there until they become fixed.

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#### CASE OF THE MAGLIGNANT DISEASE OF THE TONSIL.

H. J. Davis, M.D., (*Proceedings Royal Society of Medicine*, vol. II., No. 3) presented this case at the December meeting.

Patient was aged 40, complained of earache and dysphagia of two months' duration. It had first appeared to be a simple tonsillar hypertrophy, and the gland was removed with guillotine.

The portion removed was very hard and ulcerated posteriorly, and microscopic examination showed typical squamous-celled epithelioma. With a laryngeal mirror fungation was observed extending on to the lateral pharyngeal wall. The tongue was free, the larynx not involved, and no glands could be found.

The patient was advised to have the growth removed by external operation. In the discussion which followed this course was commended.

## AMERICAN PROCTOLOGICAL SOCIETY.

## "INTESTINAL AUTO-INTOXICATION: ITS TREATMENT BY IRRIGATION."

By WM. L. DICKINSON, M.D., Saginaw, Mich.

During normal digestion, there are present in the intestine peptones, crystalline bodies, aromatic substances and ptomaines, which are toxic, but changed into less toxic bodies and eliminated by the stools. Whenever their number is very great, relief is obtained by a profuse intercurrent diarrhœa, while the remaining toxic bodies, having been acted upon partially by the digestive mucosa, are changed in the liver, then enter the circulation, and being further changed by the antitoxic glands, finally are eliminated through the skin, kidneys and lungs.

Many patients have suffered for years, and perhaps the greater part of their lives from constipation, and the condition has been aggravated as they have grown older and more sedentary in their habits.

There are well marked symptoms in the auto-intoxicated. Among the prominent are: A drawn expression; sunken eyes; frequently the so-called liver spots; often the patient is pot-bellied and the skin is dry and harsh; it is quite common to have the bowels greatly distended by gases, shortly after meals, necessitating the loosening of the clothing; the breath is frequently very offensive; the odor of the stools is sickening, while the stools are constipated, hard, lumpy, and of small caliber or semi-liquid and mushy, and upon examination mucus and membranes are found. Patients are often unable to concentrate their thoughts, and there is loss of memory. There is great fatigue, and depression of spirits. Pruritus, urticaria, eczema or furnunculosis caused by intestinal auto-intoxication may be present.

These are not all the symptoms that may arise from intestinal auto-intoxication, but they are sufficient to emphasize the importance of the subject, and the necessity of having the intestinal discharges examined by a competent person before and during the treatment of the patient. An examination of the urine to determine the amount of indican present in cases of intestinal auto-intoxication can be made by any physician, but there are times when a laboratory examination must be made by an expert.

The treatment must of necessity begin with careful attention to the kind and amount of food taken. Vegetables should largely replace meats, and in fact the patient will gain faster if meat is not partaken of at all. There should be a liberal use of water internally,—drinking between meals two to three quarts of water daily.

The treatment is not simple and is one that requires attention and generally a long time. The routine method is the administration of calomel gr. 1/10 and podophyllin gr. 1/24, repeated every hour for eight or ten doses, followed with rochelle salt one half ounce in six ounces of hot water every two hours until the stools are watery. The colon should be distended with warm water containing half an ounce of soda sulphate to the quart. The patient should be in the knee-chest position. The water should flow slowly, fully distending the bowels, but not causing pain. This washing out of the bowel should be done daily for about one week and the urine should be examined again for indican, and if it is found present, the indication is that there is need of another course of the calomel and podophyllin. The bowel should be made aseptic by the use of sulphocarbolate of zinc gr. x to one quart of water used by enemata retaining as much of it as possible.

The treatment is to keep the intestine as clean as possible.

“PERIRECTAL ABSCESS.”

By J. A. MACMILLAN, M.D., Detroit, Mich.

Who called attention to the fact that in a large proportion of cases of perirectal abscesses, the bacillus tuberculosis is present, and that next in importance, as an etiologic factor, is the genococcus. A diagnosis is most difficult when the abscess is located above the levator ani. In this location it is frequently found to be complicated with some disease of one or more of the pelvic organs. In this condition it is sometimes necessary to make an abdominal incision both for exploratory purposes and to rectify the condition. In the treatment of the perirectal abscess, however, the drainage should always be from below.

“DISEASE OF THE COLON DUE TO EXTRA-INTESTINAL CAUSES, WITH SPECIAL REFERENCE TO MEMBRANOUS COLITIS:—ILLUSTRATIVE CASES.”

By A. B. COOKE, M.D., Nashville, Tenn.

The intimate functional relations existing between the several viscera of digestion, which is recognized by all, was pointed out, but the writer stated that the anatomic relations of the alimentary tube and the frequency with which they are to be looked to for the explanation of many of its pathologic conditions, have not received the serious consideration their importance demands. He also called special attention to certain familiar diseases of the colon, which are often found to exist primarily because of these relations, and the mechanical irritation growing out of them.

Perhaps, the most conspicuous of which, was cited *membranous colitis*. The writer recalled the great divergence of opinion that has always prevailed as to the true nature and pathology of this malady, and

notwithstanding the conclusions of such authorities as Osler, Tyson, Hemmeter and others, that the disease is a secretion neurosis; he takes the contrary view held by many other equally careful and competent clinicians, who hold that there are always pathological lesions that bear directly upon the colon, either from without, as by pressure from other misplaced organs, or by adhesions, or by some local irritant from within to account for these cases.

For present purposes the term membranous colitis is limited to that peculiar affection, which is characterized by the periodic discharge of mucus with membranes or casts from the bowel, and of which fecal stasis is always a prominent feature. With reference to this type of colitis, Dr. Cook stated unequivocally that he had never seen a case in which he failed to find some gross pathologic condition of one, or more abdominal organs as well as of the mucosa itself; and furthermore, that the etiologic relation between the two has been clearly established in a number of cases by the prompt and permanent disappearance of the bowel trouble upon correction of the extra-intestinal condition, after all other methods of treatment had failed. From this experience he had been led to conclude that the primary causes of this particular variety of colitis belongs in the main, if not exclusively, to a special class, viz., those which act mechanically. Most noteworthy in the list of such causes are enteroposis, right movable kidney, peritoneal adhesions and extra-intestinal growths which occasion continuous pressure upon some portion of the colon.

He then discussed each of these causes in detail and supported his argument by the enumeration of well-illustrated cases.

“NECESSITY FOR ROUTINE EXAMINATION OF THE RECTUM IN INTESTINAL DISEASES: ILLUSTRATIVE CASES.”

By DWIGHT HENDERSON MURRAY, M.D., Syracuse, N.Y.

Dr. Murray's paper was one of special interest to the general practitioner, and emphasized the necessity for rectal and colonic examinations in all cases of protracted diseases of the digestive tract, whether special symptoms are directed to the rectum and colon or not.

In many cases of gastro-intestinal disturbance the real cause may be found in the rectum or colon, if sought, though the patient gives no symptoms of such rectal trouble. These are amenable to local treatment.

A thorough examination, including rectal and bacteriological examination of the stools, should be made in every chronic intestinal case before beginning treatment. He advised that physicians should not treat patients who refuse to allow the necessary examination.

He reported illustrative cases, including so-called intestinal indigestion and dyspepsia, chronic diarrhoea, cancer of the sigmoid, and internal hemorrhoids.

A case of internal hemorrhoids where the attending physician had entirely neglected to examine the rectum, had been treated by lavage seven months, for so-called dyspepsia and dilation of the stomach with out benefit, and was told that a gastro-enterostomy was the only hope of cure. After an operation for radical removal of the internal hemorrhoids he was cured of his dyspepsia. A careful diagnosis would have saved this patient years of suffering.

The patient's life in one instance (possibly) and certainly the general reputation of the medical profession in all of the cases would have been better had the patients been carefully examined.

This neglect was found to be true not only of the physicians in this country, but of physicians in Europe, who had treated some of the cases in the list reported.

The author made a plea not only for local, but bacteriological examination, claiming that every case of diarrhoea, continuing for a longer time than is sufficient for nature to eliminate the irritating material that may be causing it, is due to a more serious disease.

There are many local conditions that cause a chronic diarrhoea which would be eliminated by a simple operation or local treatment. When allowed to become chronic while depending upon oral medication, frequently the time when a cure could be effected, had passed, and chronic invalidism or death may result.

“SIR CHARLES BALL'S OPERATION FOR INTERNAL HEMORRHOIDS,”

Was the title of a paper read by G. W. Combs, M.D., Indianapolis, Ind., in which he briefly described the operation advised by Mr. Ball for the removal of internal hemorrhoids which consists: (1) of making a curved incision opposite the pile being treated, terminating in the mucous membrane on either side of the pile, the greatest convexity not including more than one-third of the revoluted anal ring; (2) of bluntly dissecting the pile from the external sphincter, the dissection being carried upward until healthy mucous membrane is reached; (3) of crushing the pedicle in a powerful clamp; (4) of passing a heavy silk ligature subcutaneously in the remaining two-thirds of the revoluted anal ring and through the crushed mucous membrane pedicle, one part of which is constricted in a first tying and the whole of it in a second; (5) of tying the ligature very tightly, thus bringing the remaining two-thirds of the revoluted anal ring up into position, maintaining it there until union takes place and constricting the pedicle so that sloughing will occur.

The results obtained by the writer have not been so favorable as those that should follow the procedure as indicated by the author.

The following are the writer's conclusions :

1. The post-operative pain is greater than after the usual ligature or clamp and cautery method.
2. The duration of the healing period is not shortened because of the sloughing of the ligature from either the skin or pedicle before union takes place, leaving the wounds to heal by granulation.
3. There is a necessity for unusual watchfulness that all ligatures may be removed as they slough.
4. Failing to secure primary union, skin-tabs frequently remain for subsequent removal.
5. No time is saved by this modification of the ligature operation.
6. There is danger of secondary haemorrhage from an early tearing off of the pedicle by traction.

“THE TECHNIC OF THE INJECTION TREATMENT FOR HEMORRHOIDS,”

was the title of the paper by Dr. Edwin A. Hamilton, of Columbus, Ohio, who stated that the injection treatment does not have a wide application; as its indiscriminate use is followed by embolus, abscess and other complications; and relapses are prone to occur except in cases especially adapted to this method. The instruments needed are a cone-shaped anal speculum with one broad fenestrum and a special copper-tipped long needle of large calibre with an outside barrel which may be screwed to the needle proper to regulate the depth to which it may be inserted. The solution is 10 per cent. carbolic acid, 90 per cent. oil of sweet almonds. Neither water nor glycerine is used in the solution, as they cause pain. When the sphincter is normal or hypertrophied, the hemorrhoids are never strained outside of the rectum and treated there, but are allowed to protrude through the fenestrum of the speculum and attended to in their normal location. In cases where the sphincter is dilated and the hemorrhoids are easily replaced, they may be treated outside, but under no other conditions. From four to eight drops are injected in a hemorrhoid, only one injection being made at one treatment. The patient rests in the recumbent posture for several minutes. No application or dressing is applied. The bowels are moved after the second day. Subsequent treatments may be administered at intervals of five days.

“THE TEST DIET; NITROGEN AND SULPHATE PARTITIONS, AS AN AID TO DIAGNOSIS IN INTESTINAL DISTURBANCES.”

By JEROME M. LYNCH, M.D., New York City, N.Y.

Who stated that the subject of test-diet, as suggested by Professor Schmidt, is one well worthy of study. If, after a proctoscopic examina-

tion of the rectum and sigmoid,—and an examination of the stomach contents, a case is still obscure, the test-diet should be given, and an examination of the feces and a thorough examination of the urine, with nitrogen and sulphate partitions, be made. Otherwise, one cannot conscientiously say he has exhausted all the resources at his command.

These tests, he admitted, are not always conclusive, but in most cases they are of great help; often, a positive solution of doubtful problems.

Of twenty-five cases under observation during the last six months, he found three of especial interest. Case 1 was referred for treatment on account of moderate diarrhœa, with prolapsing and bleeding internal hemorrhoids. The stomach had been previously examined with negative results. Proctoscopic examination, except for hemorrhoidal condition was negative. Put on test-diet. The specimen of feces examined had a somewhat pasty consistency, a light yellow color, normal odor and showed no microscopic admixture. Microscopic examination showed the usual amount of striped muscle fiber, carbohydrate food remnants and granular detritus, with an excess of free fat and fatty acids. The starch was properly digested; bacterial flora, not excessive; reaction, neutral. Sublimate test, negative. Fermentation test, negative. The specimen showed evidence of deficient bile admixture.

The analysis of a twenty-four hour specimen of urine showed the specimen to contain no albumen and no renal elements, with a normal daily amount of urine, a normal specific gravity and a normal daily excretion of urea. The sulphate ratio as well as the ratio of the urea and uric acid was somewhat depressed, with the presence of a marked excess of indican.

Analysis of this report disclosed at once the cause of the diarrhœa, namely,—deficiency of bile with excess of fatty fluids and depressing of sulphate ratio, causing auto-intoxication.

The other two cases were equally interesting:

Relative to the determination of the clinical significance of faulty sulphate and nitrogen partition, the writer stated that the relative increase in ethereal sulphate may be due to one of several causes, among which were mentioned,—stasis in the bowel, ingestion of decomposing nitrogenous food, improper digestion of food in the stomach and upper intestine, by diminution or absence of hydrochloric acid and bile, the result of excessive or faulty bacterial fermentation in the lower portion of the small intestine and the upper portion of the large intestine. This process may exist without an actual toxemia, and an actual toxemia may exist without this particular putrefactive process; but they are usually associated.

Excess of ethereal sulphate is usually associated with an excess of endoxyl sulphate, though not always. Without means of estimating the amount of the actual products of toxemia, the relative excess of ethereal sulphates is used as a guide, although subject to errors, as are other guides.

Fault in the nitrogen partition would seem to justify the inference that the hepatic function is disturbed. The decrease in the relative amount of urea nitrogen probably indicated the degree of the fault. With this decrease, there is a relative increase in the amount of one or more of the other forms of nitrogen in the urine. In the severe toxemias of pregnancy, pneumonia, etc., this is chiefly in ammonia nitrogen and creatinin nitrogen; in digestive disturbances the increase in the so-called extractive nitrogen, and in lithemic cases and in those of cyclic vomiting, headache, or albuminuria, in the purin nitrogen as well, particularly during the acute attack. In cases of enteritis or colitis, owing to the destruction of cells, the purin nitrogen is often increased.

Faulty nitrogen partition may exist without a toxemia but a hepatotoxemia without a faulty nitrogen partition is practically unknown. Acidosis frequently accompanies a faulty nitrogen partition; but it would seem an evidence of the toxemia rather than of the fault in hepatic function, though this is disputed by some.

“MULTIPLE ADENOMATA OF THE RECTUM.”

By JAMES P. TUTTLE, M.D., New York City.

Who stated that the distinction between multiple adenomata and polypi is more marked clinically, than histologically. Pendunculated adenomata or polypi may exist in varying numbers without constituting a true multiple adenomata. Age and its relation to the two types; distinction between the two types in proportion to the number of growths; the relative frequency of the growths in different portions of the bowel; growths found largely in the sulci and not in the mucous folds of the bowel. What is the probability of malignant metamorphosis when not interfered with? The tendency to recurrence, in malignant form, after surgical measures? Results of internal and local medication; results of functional rest to the parts. Does radical operation furnish the best hope for the patient, in view of clinical experience?

“SURGICAL TREATMENT OF DIARRHŒA AND A DESCRIPTION OF A NEW CECOTOMY WHICH PERMITS FREE IRRIGATION OF BOTH THE SMALL AND LARGE INTESTINE.”

By SAMUEL GOODWIN GANT, M.D., LL.D., New York City, N.Y.

In this article attention was first called to the frequency of occurrence of chronic diarrhœa and the simplest and most reliable methods

were briefly outlined of diagnosing ulcerative lesions of the colon inducing diarrhœa and also the relative frequency was mention between gastric and hepatic diarrhœa and those caused by local disease of the large intestine. The author then proceeded to make the following points :

*First* : That acute attacks of diarrhœa could sometimes be controlled by diet, rest and internal medication, and, further, that the frequency of the evacuations could occasionally be diminished by these therapeutic measures in chronic diarrhœa but that a cure of the latter could be accomplished only in rare instances in this way.

*Second* : That the treatment of chronic ulcerative colitis by internal medication should be abandoned because it is harmful in many ways and utterly unreliable in so far as a cure of the diarrhœa is concerned.

*Third* : That *direct bowel treatment* by lavage or medicated irrigation introduced through the anus or from above through the appendix or cecum, is the only rational treatment for diarrhœa due to ulcerative lesions of the colon.

*Fourth* : That operative procedures are contradicted except in cases where, for any reason, the colon tube cannot be introduced sufficiently high, to insure thorough washing out of the entire large bowel and when operative procedures are declined.

*Fifth* : That the surgical treatment of chronic diarrhœa gives universal satisfaction and that he recommended appendicostomy and cecostomy for the relief of this ailment with the same confidence that he did appendectomy for appendicitis.

*Sixth* : The relative values of *resection, intestinal exclusion, colostomy, appendicostomy, simple cecostomy, and cecostomy* with an arrangement for irrigating the small intestine, (Gant's operation), in the treatment of chronic diarrhœa, were fully discussed. The results of his experience show that appendicostomy and cecostomy could be performed most quickly, where the least dangerous, give the best results and were less often followed by unpleasant sequellæ than the other procedures.

The method as used by Weir, and as advised by Tuttle, is practically free from danger, and the author believes is not more hazardous than appendicostomy and the after-effects are not at all unpleasant to the patient in the ways and degrees that a colostomy must be. He sees no great danger of hernia or wound infection if proper precautions are taken in dressing the same. By this method one may practice almost continuous irrigation of an inflamed colon and dectum with no special degree of pain or discomfort to the patient,—the appendix being used as a nozzle, directing the solution into the colon.

He does not advise appendicostomy except in a small percentage of cases, mostly chronic ones, but in these, he insists that it is a most valuable aid to treatment and that the operation itself is practically free from

danger, as is appendectomy when the appendix is not the seat of infection.

The author concludes his article by stating that in all cases requiring appendicostomy we should not permit the stump to close before the expiration of one year. He has been forced to reopen an appendical stump three months after closure and resume irrigations. This was accomplished in his office, but it may become a difficult matter to find the lumen of a closed appendix.

“PRIMARY GONORRHEA OF THE RECTUM IN THE MALE.”

By ALFRED J. ZOBEL, M.D., San Francisco, Cal.

The writer stated that a review of the literature for the past five years showed very little to have been written on the subject of rectal gonorrhoea, and the cases reported have been rectal gonorrhoea in the female and for the most part secondary to an infection of the genital tract.

It was also stated that gonorrhoea of the rectum in the male is almost always the result of sodomistic practices, and when so, can be considered of the primary type. The condition has been rather rare in this country but since the influx of foreigners from those countries where unnatural practices are common, more cases are now seen.

The cases reported by the writer were seen in the rectal clinic at the San Francisco Polyclinic and were in American born boys of 16, 18 and 20 year of age, respectively. They belonged to the tramp class and were of a rather low order of intelligence. They were ignorant of their true condition and came to the Clinic with a self-made diagnosis of “piles.” When made aware of the true nature of their trouble it had a markedly depressing effect upon them, which in one case, after a few weeks, developed into a condition resembling neurasthenia which often accompanies a chronic posterior urethritis.

The symptoms complained of, briefly summarized, were,—all complained of such soreness about anus and rectum that they did not care to stand; while walking was an effort and caused great pain. At the time of bowel movement they suffered such excruciating pain that they hesitated to pass their feces, and had become quite constipated. Two were annoyed by discharge from the anus, while one was unaware of its presence, although it was found on examination. In one, the discharge was streaked with blood, and bleeding was noticed at the time of defecation. One complained of an itching sensation about an inch up from the anal aperture, and had severe pain on the drawing in of the anal sphincters. Their appearance was feverish, worried and haggard, and they felt weak, ill and distressed.

It was impossible to make a digital or instrumental examination at the first visit on account of the severely acute pain caused thereby.

Therefore, whenever there is the least suspicion of the possibility of a specific inflammation of the anus and rectum, the case should be treated as if it actually exists, and the ultimate diagnosis left to the future. When the acute symptoms have subsided under treatment, there can be seen excoriations and fissures about the anal orifice and in the canal, with marked redness and infiltration of the mucous membrane of the anus and rectum, together with the presence of a purulent secretion. Examination of this secretion shows the presence of the gonococcus.

The author believes that gonorrhoea of the rectum in the male is a much more common condition than is suspected by the general profession. Many of the latter even do not know that such a condition could exist.

The treatment is directed towards keeping the parts clean; relieving the severe rectal symptoms; reducing the inflammatory exudates; keeping the fecal movement soft; healing the ulcerations and destroying the infective agent.

The author further brings out the important point, which he deems worthy of consideration, that there seem to be no reason why complications, such as gonorrhoeal arthritis or an endocarditis could not arise. While so far as he is aware, no cases of an endocarditis or an arthritis resulting from rectal gonorrhoea have been reported, yet it would be well for the internist to bear in mind that an examination of the rectum might furnish the clue in a baffling case, where the etiological factor is missing.

#### "OPERATION FOR ANAL PRURITUS."

By THOS. CHAS. MARTIN, M.D., of Washington, D.C.

The use of a solution of cocaine and adrenalin secures local anesthesia and a dry visible field. Radiating incisions do not endanger the nutrition of the parts. Corrugation of the flaps may be effaced by traction of their margins. A skin-tag may be removed within an elliptic incision, which by suture may be given a linear form. Radiating wounds require no suture, coaptate automatically when the patient is in extension, and heal by first intension.

Officers elected for the ensuing year: President, Dwight H. Murray, M.D., Syracuse, N.Y.; Vice-President, T. Chittenden Hill, M.D., Boston, Mass.; Secretary-Treasurer, Lewis H. Adler, Jr., M.D., Philadelphia, Pa.

Executive Council: Geo. B. Evans, M.D., Dayton, Ohio, Chairman; Dwight H. Murray, M.D., Syracuse, N.Y.; Louis J. Hirschman, M.D., Detroit, Mich.; Lewis H. Adler, Jr., M.D., Philadelphia, Pa.

The place of meeting for 1910 is St. Louis, Mo. Headquarters: Planters Hotel. June 6th and 7th, 1910.

The following were elected fellows of the Society: Dr. Chas. S. Gilman, 419 Boylston St., Boston, Mass.; Dr. Donley C. Hawley, Burlington, Vt., and Dr. Frank C. Yeomans, 19 E. 45th St., New York City, N.Y.

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## ALBERTA MEDICAL ASSOCIATION.

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### THE ALBERTA MEDICAL ASSOCIATION ON DOMINION REGISTRATION.

Dec. 1st, 1909.

*To the President and Members of the Central Alberta Medical Association.*

Sirs,—Your committee on Medical Registration appointed at the November meeting beg to submit the following report:—

1. The Canada Medical Act passed in 1902 (Chapter 137, Revised Statutes of Canada) provides for a Medical Council of Canada whose purposes shall be:

(a) To establish a qualification in medicine acceptable in all the Provinces of Canada.

(b) To establish a medical register for Canada.

(c) To determine and fix the requisites for registration.

(d) To establish and maintain a board of examiners to grant certificates of qualification.

(e) To establish such a status of the medical profession in Canada as shall enable Canadian practitioners to register under the Imperial Medical Acts for the United Kingdom.

(f) To obtain the enactment with the consent and at the instance of the Medical Councils of the various Provinces of Canada of such provincial legislation as is necessary to this Act and to effect the foregoing purposes.

2. The Canada Medical Act provides that the said Medical Councils shall be composed of:

(a) One member for each Province appointed by the Governor-in-Council.

(b) A number of members of each Province, fixed according to the number of medical practitioners of the province as follows:

For the first 1 to 150—one member.

For the first 151 to 500—two members.

For the first 501 to 1100—three members.

For the first 1101 to 1700—four members.

For the first 1701 to 2300—five members, etc.

Of such members one to be elected by the Provincial Medical Council and the others by the registered medical practitioners of the Province.

(c) One member from each university or medical college or school on whose graduates a university regularly confers its degree.

(d) Three members elected by the practitioners of any particular and distinct school of practice of medicine recognized by the Laws of the province wherein they practise.

Every member of the said Medical Council shall reside in the province which he represents, be duly registered in that Province, and also be duly registered under this Act. The term of office of members shall be four years except that every member elected by a Provincial Medical Council shall remain in office only during the term of the Council electing him.

3. The Canada Medical Act provides that "No province shall be represented upon the Council either by appointed or elected members until the legislature of the province has enacted in effect that registration by the Council shall be accepted as equivalent to registration for the like purpose under the laws of the province; and when all the provinces shall have legislated in effect as aforesaid, it shall be lawful to appoint and elect in the manner aforesaid the members of the Council. (2 E. VII., c. 20, s. 6.)"

4. The Province of Alberta has enacted the necessary legislation to obtain representation on the Medical Council of Canada.

5. The Canada Medical Act, however, is not in force because not all the provinces of Canada have enacted the necessary legislation.

6. The Canadian Medical Association at its 1909 meeting in Winnipeg, inaugurated and endorsed a movement to have the Canada Medical Act amended as to make it effective on the participation of five or more provinces.

7. In pursuance of this purpose a conference of representatives from the various Provinces met Dr. Roddick in Montreal on the 16th ult., to formulate proposed amendments to the Canada Medical Act. This conference arrived at an arrangement satisfactory to those there present, and the amending of the Canada Medical Act necessary to give it effect at an early date will in all likelihood be obtained during the current session of the Dominion Legislature.

8. We are informed that the chief changes in the Canada Medical Act thus proposed are:—

(a) To make this Act effective on the consent of five or more Provinces instead of *all*.

(b) To require only the final examination of practitioners who have been licensed before the Act goes into effect.

(c) To reduce the membership of the Canada Medical Council from about forty-three to about twenty-two.

(d) To provide for the acceptance of the examinations of the provincial medical councils instead of an examination by the Canada Medical Council.

9. Your committee are also informed that the granting of the license to practise dentistry—which is really a special branch of surgery—is at present on a basis in Canada essentially similar to that proposed by the Canada Medical Act for the license to practise medicine. This demonstrates the practicability of the latter.

10. We believe that the intention of the Canada Medical Act is to unify and nationalize the medical profession in Canada. *At present the Canadian practitioner is non-existent.* There are only provincial medical practitioners.

11. The Canada Medical Act will create a basis for a national department of public health in Canada to administer wise and comprehensive laws for the conservation and protection of the health of the people, than which there is no greater national resource.

13. Your committee therefore most heartily commend the provisions of the Canada Medical Act and such amendments to it as are necessary to its becoming effective as agreed upon by the accredited representatives of the several provincial medical professions in Canada.

Respectfully submitted,

(S'nd.) J. PARK,

Chairman.

This report was unanimously adopted by the Association at its regular monthly meeting in December.

Edmonton, Alta.,  
Dec. 8, '09.

D. G. REVELL,  
Sec'y. C.A.M.A.

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## PERSONAL AND NEWS ITEMS.

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### ONTARIO.

Dr. G. R. McDonagh, of Toronto, is recovering from an attack of pneumonia.

Dr. John L. Davison, Toronto, was recently operated upon for an attack of appendicitis. He is doing well.

Dr. Rupert Michell, who was with Captain Shackleton in his South Pole Expedition, was visiting Toronto friends.

Dr. Bryans, of Toronto, was again successful in his election contest for the Board of Education.

Dr. and Mrs. J. A. McArthur, of Ottawa, have been holidaying at Fortress Monroe in Virginia.

Dr. Kemp, 39 Avenue Road, Toronto, has returned from the Pacific Coast, very much improved in health.

There occurred a fire in the Hamilton Hospital, on 23 January. It was extinguished and there was no serious loss.

In Toronto the deaths last year were: Scarlet fever, 77; diphtheria, 191; measles, 70; whooping cough, 30; typhoid fever, 79; and tuberculosis, 293.

The City Architect has issued a permit for the erection of a four-storey addition to St. Michael's Hospital on Bond Street, Toronto, north of the present building, to cost \$180,000.

The senate of Toronto University, for the first time in its annals, has cancelled the degrees conferred upon one of the graduates of the university. On Saturday it was decided to cancel the degrees of M.B. and M.D. conferred upon Dr. Pollard when he graduated. Dr. Pollard is now serving a term in Kingston Penitentiary.

Toronto expended last year on the various hospitals \$156,580. The Toronto General received \$31,716.28; St. Michael's, \$18,421.60; Grace, \$5,124; The Western, \$7,009.50; The Convalescent, \$593.50; St. John's, \$607.60; Gravenhurst Sanitarium, \$6,587.70; Weston Sanitarium, \$14,622.06; Hospital for Incurables, \$8,922.05.

The Isolation Hospital of Toronto is badly in need of additional accommodation. Many scarlet fever patients cannot be admitted because of lack of room for them. There is a new wing being added and the Medical Health Officer hopes that the work of construction may be pushed on with all possible speed.

At the recent Municipal Elections in London, the subject of compulsory vaccination of the school children was fought out. The result was that the Board of Education was instructed to repeal the rule requiring compulsory vaccination. This is a more retrograde step in the matter of preventive medicine.

The sewage disposal bill that is likely to come before the Ontario Legislature this session provides that: "No person shall throw or deposit, or cause or permit to be thrown or deposited, any sewage, offal, or refuse animal or vegetable matter of any kind whatsoever, into any river, stream, or other water, any part of which is navigable or flows into any navigable water."

*The Bulletin of the Ontario Hospitals for the Insane* comes out in a much enlarged form. It is announced that in future the *Bulletin* will be edited in Toronto, and that its appearance will be more regular in future. The present number contains much interesting matter, though

most of the articles are from the pen of Dr. Ernest Jones and reprinted from other journals. This does not lessen their value, however,

Among the matters that came before the Toronto Civic Legislation and Reception Committee was the proposed application for legislation to fix a standard for milk. Legislation will be sought to give the city power to appropriate \$12,000 for an addition to the casual ward of the House of Industry. The Dominion Government may be asked to amend the act with reference to the inspection of gas meters, etc., with a view to providing for more satisfactory tests of meters than obtainable at present.

In 1909 there were 1,564 cases of scarlet fever reported to the Medical Health Officer of Toronto, as against 1,418 in 1908. He does not regard this increase last year as alarming, in view of the fact that there was considerable territory added to the city by annexation. Last year the diphtheria cases reported to the Medical Health Officer totalled 1,292, as against 1,294 in 1908. There were 331 typhoid fever cases in 1909. In 1908 the typhoid fever cases totalled 201.

Three hundred and forty-seven patients in the advanced stage of tuberculosis cared for in the past twelve months was the story told in the report of Dr. W. J. Dobbie, physician-in-chief of the Toronto Free Hospital for Consumptives and King Edward Sanitarium for Consumptives, at the fifth annual meeting of the Board of Trustees of these two institutions. Since the Toronto Free Hospital was opened in 1904, eight hundred and eighteen patients have been cared for, and from the date of opening of the King Edward Sanitarium in 1907 an additional one hundred and forty-seven, or, in round figures, one thousand patients have found treatment in these two institutions, so prettily situated near the Humber.

#### QUEBEC.

The Alexandra Hospital, of Montreal, made an appeal some time ago for \$100,000. So far \$30,000 have been received.

The December issue of the Montreal *Medical Journal* came to hand a week on in January. This brings its news rather late into the field.

The number of cases in Montreal in the recent outbreak of typhoid fever has totalled over 2,000.

Dr. Oscar Klotz, who has been Prof. Adami's assistant for some years, has been appointed to the chair of Pathology in Pittsburg University.

Dr. Robert Seigneur of Chambly, Que., who died some weeks ago, bequeathed \$20,000 to the Hospital for Incurables in Montreal, \$2,000 for the Chambly convent, and \$1,500 for the hospital in the same place.

Arrangements have been made for the erection of an emergency hospital in Montreal for the accommodation of typhoid fever patients.

When completed it will accommodate 100 to 150 patients. It is expected that the hospital will be completed on Tuesday next.

From statistics completed at the City Hall, Montreal, it was shown that there were no less than 226 new cases of typhoid in that city in the last week of December. The deaths numbered thirteen. What is still more startling is that since the beginning of the year there have been thirteen new cases and six deaths. Despite this, it is declared that the disease is scarcely typhoid, and that the situation is exaggerated.

Montreal is having a hard time over the typhoid fever epidemic. There should be an awakening of the public conscience as a result of this. An emergency hospital for typhoid fever cases has been established. The scheme to establish a filtration plant has been approved of by the water commissioners, and an effort will be made to sterilize the water. The Finance Committee of the Montreal Council voted \$15,000 to the Emergency Hospital, and Lord Strathcona cabled \$25,000. If the cause of the disease could be removed he will subscribe \$100,000. The Citizen's Committee has collected about \$25,000.

#### WESTERN PROVINCES.

Dr. Prowse, of Winnipeg, has returned from California where he was recuperating from an attack of pneumonia.

In Saskatchewan there is to be a Minister of Health, a deputy called a Commissioner of Health, and an Advisory Board of four medical men.

At Regina, Sask., Lieut.-Governor Forget presented, on 6th January, the diplomas to the nurses graduating from the General Hospital of that city.

A proposition was submitted to the City Council of Winnipeg, asking that a by-law be submitted to the ratepayers to endorse the raising of \$350,000 for hospital extensions and improvements, with the alternative of devoting the sum to municipalizing the present General Hospital.

#### BRITISH COLUMBIA.

The Home Hospital in Nelson, owned and operated by Miss Desbrisay and Miss Ida Morris, has been acquired by the directors of the General Hospital as the first step towards the erection of a new building. The Home has been very successful during its seven years' existence, over 1,500 patients having been admitted during that period, and the institution always had the medical contract for Kootenay C.P.R. employes, the "boys" sticking loyally. The Home Hospital, through amalgamation, will result in the erection of a fine new modern building next spring.

## FROM ABROAD.

Prof. A. Crum Brown, so well known to Edinburgh medical men for many years, was recently presented by his old pupils with his portrait.

It would appear that there is every likelihood that there will be a Bureau of Health and a Minister of Health for the United States.

In Britain the revenue from the consumption of spirits has decreased by the sum of \$9,050,000 during the past nine months.

The New South Wales Branch of the British Medical Association has undertaken to erect in Sydney a building for its use to cost £24,000.

Dr. E Hastings Tweedy, Master of the Rotunda Hospital, has been elected to the position of gynæcologist and obstetrician to Dr. Steevens' Hospital, Dublin.

Sir John Batty-Tuke has decided to withdraw from the British House of Commons. He was a valuable member in the interest of medical education and reform.

At a recent meeting of the General Medical Council of Great Britain, the application of Prince Edward Island asking for medical reciprocity was up for consideration.

By command of the King, the Convalescent Home for Officers at Osborne is now equally open to officers of the territorial forces with officers of the army and navy and special reserves.

Dr. James Whiteford, of Greenock, Scotland, who has completed 50 years in practice, was entertained by many of his friends and patients a short time ago and presented with a purse of \$4,550.

The British Oaths Bill, passed during the recent session, abolished the dirty and insanitary custom of kissing the book. Oaths are taken by holding the book in the right hand.

Dr. W. B. Ransom, a very distinguished consulting and hospital physician of Nottingham, died recently. He was an extensive contributor to medical literature.

An examination of 100 students of Talane College, New Orleans, revealed the unpleasant fact that one-third of them were infected with the hookworm parasite.

The infant mortality in England and Wales under 1 year to each 1,000 births was for 1904, 145; for 1905, 128; for 1906, 132; for 1907, 118; for 1908, 121.

In Britain the decline in the birth-rate is a matter of much concern. It is observed that the decline is most marked among the provident and better educated persons, while the birth-rate keeps among the poorer, unprovident, and lower classes.

Sir Alfred Jones, who did so much for the Liverpool School of Tropical Medicine, died suddenly a few weeks ago. He was a great man

and a true empire builder. His loss will be felt throughout the entire world.

The December meeting of the King Edward Hospital Fund Committee distributed for the year \$750,000 among the various hospitals. The Prince of Wales presided and continues to take an active interest in the work.

Quite recently London has lost two of her best known surgeons, Mr. Marcus Gaun, the well-known ophthalmic surgeon, and Mr. C. R. B. Keetley, a general surgeon. The former was attached to the Royal Ophthalmic Hospital and the latter to West London Hospital.

Mr. Herbert Gladstone stated recently that he thought the patent medicine question one of sufficient importance to the appointment of a commission to enquire into the advisability of compelling the publication of the formulæ on the labels.

The work of the Royal Society's Commission on sleeping sickness has shown that the *glossina palpalis* remains infective for a period of two years after the people have left the district. This throws a new light on the difficulty of stamping out the disease.

In Victoria, Australia, in every 200 births 11 were illegitimate. In most of the illegitimate births the mothers were feeble-minded. It is suggested that a farm colony be established for the mentally defective persons.

The International American Congress of Medicine and Hygiene of 1910, in commemoration of the first centenary of the May revolution of 1810, under the patronage of His Excellency, the President of the Argentine Republic, will be held May 25th in Buenos Ayres, Argentine Republic.

Sir Victor Horsley in a recent address stated the enormous advance made in temperance, in medical inspection of schools, etc. The teaching of hygiene to school children, and the means of carrying these reforms into effect were almost wholly due to the efforts of the medical profession.

At the Medical Society meeting of Berlin, Dr. H. Newmann stated in his paper on diabetes and pregnancy that dialectic maidens should not marry, that married diabetics should avoid conception, and if they did conceive they should be allowed to go on to term as it was too dangerous to interfere with such cases.

The subject of the administration of general anaesthetic has been much discussed of late in Britain. It is now proposed to ask for legislation to the effect that no one but a qualified medical practitioner shall be permitted to administer an anaesthetic, and that all colleges must give instructions on anaesthesia.

The Infant Mortality in Prussia per 1,000 births was last year 157 in the cities and 166 in the rural parts. The average from 1886 to 1890

was 210 in cities and 187 in the county. From 1896 to 1900 the rate was 195 and 185. From 1901 to 1905 it was 181 and 178. This goes to show a considerable decline in the death rate.

Duke Karl, of Bavaria, died a few weeks ago. He was a brother of the ill-fated Empress of Austria, and father of the future Queens of Bavaria and the Belgians. He was 70 years old. He studied medicine and conducted a private hospital where he performed some 500 cataract operations. He was a learned contributor on medical and scientific subjects.

At a recent meeting of public vaccinators held in Liverpool, Dr. Monckton Copeman stated that the reason vaccination protected against smallpox was that it was really derived from that disease. Whereupon Mr. Lupton asked in the House why persons should be subjected to smallpox against the terms of the Act of 1867. One would think that such questions could not be asked at this late date in science.

The College of Physicians of Philadelphia recently entered into the occupancy of its new building. This is now a very venerable medical association. It has acquired a site, a splendid building and a library of 100,000 volumes. This goes to prove that the acquiring of a library helps to make a medical society successful. There is an auditorium with seating capacity for 800.

In Australia the hospitals have their difficulties. The Melbourne Hospital was some £4,000 behind. The Alfred Hospital had gone back £3,000, the women's hospital was in financial straits. The Foundling Hospital was short of funds, and many other charities were seriously crippled. The government last year gave £1,316,306, and private donors £383,654.

An unknown donor has placed in the custody of Yale University the sum of \$100,000 as a prize for an absolute cure for tuberculosis. The prize is open to the world. The trustees have asked Drs. E. L. Trudeau, W. H. Welch, L. F. Flick, Simon Flexner, and Herman Biggs to become members of the advisory board. The interest is to be used in the investigation of cures; but the principal sum to go only to the one who may succeed in discovering an absolute cure.

The *British Medical Journal*, in commenting on the United States game of football, where 30 were killed and 216 severely injured during the past season, remarks: "Surely the murderous character of the game could be mitigated without in any way spoiling the *gandum certaminis* of the players. A manly sport should not be allowed to be degraded into a brutal fight in which the deliberate maiming of opponents is part of the game."

The number of marriages registered in England and Wales during 1908 was 264,940, which was equal to a rate of 14.9 persons married

per 1,000 of the population, estimated at 35,348,780 persons in the middle of the year. Comparing the marriage-rate in 1908 with that in 1876-80, after correction for variations in the proportion to total population and in the age constitution of the marriageable population, there appears to be a decline of 15.4 per cent. The mean age at marriage continues to rise, almost equally in the two sexes.

The Stamps and License Bill of the Cape Legislature, South Africa, called forth a lively discussion. Premier, Hon. J. X. Merriman, had charge of the bill, and mercilessly scored some of the secret remedies on the market that were sold for a high price and contained nothing of merit. In the case of a certain cure for tuberculosis the ingredients were about 5 cents and sold for \$12.50. There was nothing in the preparation that had any value in tuberculosis. It is quite evident that the Cape Government is bound to place restrictions on secret remedies.

The Royal College of Surgeons have made some alterations in its regulations for the admission of women students to the college museum in order that they may have the same opportunities for the purpose of study as men. Women holding other medical or surgical qualifications than students are now admitted to the museum every day, while students may enter after application to the secretary accompanied by a recommendation from the dean. A number of women students, encouraged by the recent action of the Royal College of Surgeons, have entered for the examinations of the conjoint board of the college, and also for the examinations for diplomas in public health, granted by the Royal College.

The 940,383 births registered in England and Wales last year were equal to a rate of 26.5 per 1,000, which slightly exceeded the rate in the previous year, but was 1.6 per 1,000 lower than the average for the ten years 1898-1907. There is no present indication of any real check in the decline of the birth-rate, the slight rise in the rate for 1908 being possibly due to a temporary recovery in the marriage-rate during the years 1905-7. Since 1876-80, when the birth-rate in this country was at its highest, there has been an almost continuous decline, the total fall being 8.82 per 1,000, of which 8.20 is due to a decreased rate of legitimate births, and 0.62 to a decreased rate of illegitimate births; these figures, however, do not fully represent the decline in *fertility*, because the ratio of women aged 14-45 years to the total population has increased.

The number of deaths registered in England and Wales during 1908 was 520,456, corresponding to a rate of 14.7 per 1,000; this rate was 1.7 per 1,000 below the average rate for the ten years 1898-1907, and was the lowest death-rate on record. The proportion of deaths among children under 1 year of age to registered births was equal to 120 per

1,000; this rate is slightly above that recorded for 1907, but is 22 per 1,000 less than the average for the ten years 1898-1907. Comparison of the death-rates of each sex at several ages in 1908 with the average rates in 1876-1880 shows that the mortality of males has decreased by 25.2 per cent., and that of females by 26.7 per cent. This improvement, however, is very unequally spread over the several ages, being much greater in both sexes up to 35 years than at the later ages. Of the 520,456 deaths the causes of 476,359 were certified by registered medical practitioners, inquests were held in 36,620 cases, while for the remaining 7,477 deaths the causes were uncertified.

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## OBITUARY.

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JAMES H. RICHARDSON, M.D., M.R.C.S., ENG.

As the bells were tolling out the hour of midnight, 15th January, Dr. James H. Richardson, the first graduate in medicine at the University of Toronto and Professor of Anatomy there for half a century, passed peacefully away at his home, 36 St. Joseph street. He was one of Toronto's grand old medical men. A host of his old students, many of whom occupy high places in their profession in this city and elsewhere, paid their last tributes to his memory on Tuesday, 18th, when interment took place at the family plot in the Necropolis. The lectures at the Medical School were cancelled for that afternoon.

Born in 1823 at Presquile Point, Northumberland county, Dr. Richardson was 86 years old at the time of his death, which was due entirely to old age. When a child of three he came to this city with his father, the late Bishop Richardson of the Reformed Episcopal Church, a patriotic Canadian, who lost an arm in the attack on Oswego during the war of 1812. The deceased, though a youth at the time, retained a most intimate recollection of the stirring times of 1837 and following years. and his memoranda on this was always a source of great interest to his many friends in this city. An ardent military enthusiast himself, Dr. Richardson was in his day one of the best rifle shots in the city, and was surgeon of the old "Merchants' Company" before that militia organization was merged with the Grenadiers in March, 1862. His chief recreations were fishing, and, in his earlier days, shooting. It is claimed by his friends that he has fished every stream between the head of Lake Superior and Cape Breton.

Dr. Richardson first studied medicine in 1841, with Dr. Rolph, in Rochester. He attended the first course of medical lectures given at the old "King's College" here. There was only one other student, and,

as this man was not a very regular attendant, the deceased received his diploma first. Then, crossing the Atlantic, he entered Guy's Hospital, London, Eng., in 1841. Remaining there for several years he was present at the first demonstration of ether as an anæsthetic in the British capital. In 1847 he returned here and commenced practice.

In 1850 he succeeded Dr. Sullivan as Professor of Anatomy in the then newly constituted faculty of medicine at the University of Toronto. Three years later, when these lectures were cancelled, he accepted a similar chair at the Toronto School of Medicine, Gerrard and Sackville streets. Upon the restoration of the faculty at the University he returned, and resigned only in 1902. About the year 1859 he was appointed surgeon at Toronto jail. This position he resigned only a year ago, on the completion of an occupancy of fifty years.

During his long term of teaching at the University, Dr. Richardson endeared himself to an army of students, whose number includes physicians and surgeons to-day ranking high as practitioners. On April 15, 1903, a number of these tendered him a dinner as a token of their esteem, and this was very largely attended. This event also marked the presentation of his portrait to the University of Toronto.

Dr. J. H. Richardson was a masterful teacher. He clothed his subject in the garb of living attractiveness. It can be said of him that "he knew his work." The most minute detail of anatomy was as familiar to him as the most ordinary structure. This was one of the reasons for the very high esteem in which he was held by his students. But he was a man of transparent honesty and the highest integrity, and it must be said that his influence among the students was very great and ever for good. He was a very widely read man, and full of information which he used in a most effective manner for the benefit of his classes. To get an hour with him in conversation was an enjoyment never to be forgotten—and many of these we had. He was a brilliant narrator of the rich fund of story he possessed of the many stirring events he passed through in the early days of this country.

In the words of Emerson, "while he is no longer with us as a companion his memory remains with as a guide."

Dr. Richardson is survived by four sons, Robert and Charles, Winnipeg; George, an engineer working on the construction of the Grand Trunk Pacific, and Dr. W. A. Richardson, who has charge of the medical work of the same railroad at the Yellowhead Pass. Three daughters, Mrs. Ross Sutherland, and the widow of the late Dr. Sutherland, both of Winnipeg, and Mrs. W. Freeland of St. Joseph street, this city, also survive.

His life was gentle, and the elements  
So mixed in him, that nature might stand up  
And say to all the world, "this was a man!"

## WILLIAM C. BEAMAN, M.D.

Dr. Wm. C. Beaman, one of the leading physicians of Ottawa, died rather unexpectedly 30th December past. He had been a sufferer for several years, but trips to Europe and South Africa, it was thought, had restored his health. He was taken suddenly ill in bed in the morning, and died in a few moments.

Dr. Beaman was born near Ottawa and graduated at Queen's. He was a member of the City Council and Board of Health for four years, being first elected in 1901.

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## G. F. CLELAND, M.D.

The death took place 3rd January at his home, 331 Broadview avenue, of Dr. G. F. Cleland, one of the best known and most highly-respected medical practitioners in East Toronto. Dr. Cleland had been in poor health for some time, and hoping to recuperate went south to Ashville, N.C. There, however, he grew worse, and returned to Toronto on Sunday before Christmas. Dr. Cleland, who was the son of the late Rev. Wm. Cleland, came to Riverdale when quite a young practitioner, fully twenty-five years ago, and worked up a very large practice. He was loved and respected by all his patients and the whole community of East Toronto, and indeed was looked upon throughout the district as another "Dr. Maclure." He was a Past Master of Orient Masonic Lodge. In religion he was a Presbyterian, being a member of St. John's Church.

Dr. Cleland is survived by his widow, a daughter of the late ex-Alderman Blong, and by two daughters, living at home.

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## UZZIEL OGDEN, M.D.

Dr. Uzziel Ogden, a well-known Toronto physician, died at his home in Rosedale about 1 o'clock of 4th January, at the age of 82 years. About five years ago he was stricken with paralysis, but had been in active practice until that time.

Dr. Ogden was born in the township of Toronto, and educated at the district school. He studied medicine under the late Hon. John Rolph, M.D., and was licensed by the Medical Board, U.C., in 1849. Subsequently he took the degree of M.D. at Victoria University, Cobourg. In 1853 he began to practise in Toronto. In 1855 he joined the Faculty of the Toronto School of Medicine, where he occupied the chair

of materia medica and therapeutics, and later that of midwifery and diseases of women and children. Later he became professor of gynaecology in the Medical Faculty of the University of Toronto. The *Canadian Practitioner* was originated and carried on by him for some years.

There are many medical practitioners throughout the country who heard with much regret of his death. He was a painstaking and conscientious lecturer. He never appeared before his class with his subject in an unprepared condition. His method of teaching was very practical. He gave his class what he felt would be of value and use in the battle with disease. His teachings on obstetrics were conservative and sound.

He was married three times; first in 1852, to Miss Nelles, of Mount Pleasant, and secondly, in 1884, to Miss Caroline See, of Prescott. He leaves one daughter, Miss Annie L. Ogden, Rosedale, Toronto.

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## BOOK REVIEWS.

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### SURGICAL DIAGNOSIS.

**Surgical Diagnosis.** By Daniel N. Eisendrath, M.D., Professor of Surgery in the Medical Department of the University of Illinois, (College of Physicians and Surgeons). Second revised edition. Octavo of 885 pages, with 574 original illustrations, 25 in colors. Philadelphia and London: W. B. Saunders Company, 1909. Cloth, \$6.50 net; half Morocco, \$8.00 net. Canadian Agents: The J. F. Hartz Co., Ltd., Toronto.

In the present work the author devotes nearly 900 pages to this subject of surgical diagnosis. This is the second edition, the first appearing about two years ago. The author has spared no pains to keep his work up to date. The subject matter is good and the illustrations are numerous and excellent. The publishers have done their share well. This volume is a very worthy one to add to any medical library and will well repay the labors of frequently consulting its pages. It is a book to be often used.

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### DR. TAYLOR'S MEDICAL ACCOUNT BOOK.

**The Physician's Pocket Account Book,** by J. J. Taylor, M.D., bound in full leather, 24 pages of practical instructions for Physicians, 216 pages of accounts. Price, \$1 per copy; published by The Medical Council, 4105 Walnut St., Phila., Pa.

This book is without a doubt the most complete and at the same time simple and thoroughly efficient account book that has ever been

devised. Furthermore, it is absolutely legal and can be presented in any court of justice. It does not make use of any hieroglyphics, but everything is entered in plain language, and any judge can understand it.

The book contains 24 pages of business instructions for physicians, which have been found very useful and correct in a long and varied practice, under the headings of "Importance of a due bill," "Fees," "Billing and collecting," "Cautions," "Statute of limitations," "Form for wills," "Dying declarations," "Saving and investing," "Instant treatment of poisoning," etc. It also contains an average fee bill which has been found to work out correctly in practice.

The book contains 216 pages for accounts, of which eight pages are devoted to alphabetic index, 146 pages are devoted to regular accounts, 32 pages to short accounts, 24 pages to cash accounts, and eight pages to birth, death, and vaccination records.

This book has the advantage that entries can be made in a fraction of a minute, right upon the spot, thus insuring that none will be omitted on account of procrastination. The book being always in the physician's pocket, it is always up to date, never requiring any posting, and when he meets a debtor on the road who inquires about his account, he can inform him at a moment's notice and thus collect what the debtor has to pay at that time, instead of putting off an answer until some convenient season and thus missing that payment.

This book is so convenient, useful and legal that an eminent Philadelphia judge, who has tried hundreds of cases in which physicians' accounts were involved has stated that "In the light of my recent examination of the law, I can say that the form of book which you have gotten together is as convenient and accurate as could well be devised."

The price of this book is only \$1, and physicians will find its purchase the greatest investment they ever made. Sample pages will be sent free upon request.

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#### TEXT-BOOK OF MODERN MATERIA MEDICA AND THERAPEUTICS.

Text-book of Modern Materia Medica and Therapeutics. By A. A. Stevens, M.D., Professor of Therapeutics and Clinical Medicine, Woman's Medical College, Philadelphia. Fifth revised edition. Octavo of 675 pages. Philadelphia and London: W. B. Saunders Company, 1909. Cloth, \$3.50 net. Canadian Agents: The J. F. Hartz Co., Ltd., Toronto.

This work consists of two parts. The first is devoted to Materia Medica, and the second to Applied Therapeutics. Upwards of 500 pages are devoted to the first part and about 170 to the second part. The con-

tents of the book are worked out in the well known and careful style of the author. There is an introductory chapter of general considerations containing excellent suggestions. Drugs are discussed in groups according to some leading action, as circulatory stimulants, respiratory stimulants, spinal cord depressants, etc. There are many very suggestive prescriptions scattered throughout the book. The section on applied therapeutics is all that the most exacting could wish.

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#### DR. MUTHU ON TUBERCULOSIS.

*Pulmonary, Tuberculosis and Sanatorium Treatment, a record of ten years' observation and work in open-air Sanatoria, by C. Muthu, M.D., M.R.C.S., Eng., L.R.C.P., Lond.; Associate of King's College, London; Physician Mendip Hills Sanatorium, Wells, Somerset; Late Physician Inglewood Sanatorium, Isle of Wight, etc. London: Baillière, Tindall and Cox, 1910. Price, 3s. 6d.*

The literature on tuberculosis is rapidly increasing, but it can well stand the addition of so excellent a work as this one. The author divides his remarks under three headings: First, the scientific dealing with the disease; second, the open-air treatment, and third, the social aspects of the disease. We can recommend this volume very highly. It is well written, and the material in it is well balanced. The book is well illustrated.

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#### ABORTION.

*The prevention and treatment of abortion, by Frederick J. Taussing, A.B., M.D. Lecturer on Gynæcology, Medical Department, Washington University; Obstetrician to the St. Louis Maternity Hospital; Gynæcologist to the St. Louis Skin and Cancer Hospital; Fellow of the American Gynæcological Society, and American Association of Anatomists. Fifty-nine illustrations, St. Louis: C. V. Mosley Company, 715 Metropolitan Building. Price, \$2, 1910.*

In part I of this volume the subject of abortion is considered on general lines, dealing with its frequency anatomy, pathology, etiology, clinical course, and diagnosis. The second part deals with prevention, and the third part with treatment. The author enters into the discussion of every phase of the subject with much care. Nothing is omitted that would tend to throw light upon the matter under consideration. The section of the book devoted to treatment is particularly good. Here we have passed under review the after treatment, operative indications, the instruments required, operative technique, complications, retained placenta, sepsis, perforation, missed abortion, mole pregnancy, and ther-

apeutic abortion. Under the head of therapeutic abortion he mentions the pathological conditions due to pregnancy, maternal diseases aggravated by pregnancy, and extreme contraction of the birth canal. Among the indications for the induction of abortion the author discusses incarceration of the pregnant uterus, acute hydramnios, hyperemesis, diseases of the heart and kidneys, and tuberculosis. The book is well illustrated and is well worthy of careful study.

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### CHILD'S EPITOME OF DISEASES OF WOMEN.

An Epitome of Diseases of Women. By Charles Gardner Child, Jr., M.D., (Yale), Clinical Professor of Gynæcology, New York Polyclinic Medical School and Hospital. 12mo, 210 pages, with 101 engravings. Cloth, \$1.00 net. Lea & Febiger, Publishers, Philadelphia and New York, 1909. (Lea's Series of Medical Epitomes. Edited by Victor C. Pedersen, M.D., New York).

It is more difficult to cover the essentials of a large subject, than to expand it in detail. To do either, an author must be master of his department. The small book requires more careful discrimination as to what is of major importance. These obvious principles are well exemplified in Child's *Gynæcology*. It surveys the field in excellent perspective, and the student possessing himself of the knowledge offered in its pages, will have an excellent foundation on which to build his grasp of details in such a way that he will have a good command of both the principles and practice. To the practitioner it will be serviceable for quick reference. This small volume has been prepared by by one who has had a large experience and is well able to state a case in brief form without losing in clearness.

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### BIOGRAPHIC CLINICS.

Essays concerning the influence of Visual Function, Pathologic and Physiologic, upon the Health of Patients, by George M. Gould, M.D., formerly Editor of *American Medicine*, Author of various Medical Dictionaries, "Borderland Studies," "The Meaning and the Method of life," "Righthandness," etc. Philadelphia: P. Blakiston's Son & Company, 1012 Walnut St. 1909. Price \$1, net.

Dr. George M. Gould has rendered a real service to medical science. It may turn out that he has pushed his views too far, nevertheless, they have merit, and are sure to stimulate thought and discussion. It is rare, indeed, to pick any writings on medical subjects that are more interesting than those from the pen of Dr. Gould. He is a man of convictions and states these in no uncertain manner. It is with much pleasure that we can recommend these volumes on Biographic Clinics to our readers. The

muscular and nervous mechanism is very closely related to the central nervous system. Strain on the ocular muscles is capable of causing most distressing symptoms. This is now admitted. It then becomes a matter of observation to find on the extent of the harm. Dr. Gould is a sort of pathfinder in this field of medicine. The recti muscles strain to overcome an exophoria or an esophoria, and the ciliary muscles spasm to correct a myopia or a hypermetropia. When one adds the many worries of astigmatism it becomes apparent that eye-strain is a serious matter.

If Dr. Gould can show how to arrange the light in our schools, tell us how the text-books should be printed, and the number of hours children ought to study so as avoid developing a race of myopes, he will confer on humanity one of the greatest blessings that has ever come from any great reformer.

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#### PHYSICAL EXAMINATION OF SURGICAL CASES.

By G. Stanley Ryerson, M.D., C.M., Demonstrator in Surgery, University of Toronto; Junior Surgeon, Toronto General Hospital and Hospital for Sick Children, Toronto. The University Press, Toronto.

This very neat pamphlet of 42 pages should be in the pocket of every student. He should constantly refer to its pages until he has transferred its contents from his pocket to his memory. The scheme of the instruction is excellent, and the guidance for diagnosis is laid down in brief but clear language. We are sure that the students will find this a very useful help, and will enable them to read with greater ease the larger works on surgery.

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#### ANTIPYRINE, ACETANILIDE AND PHENACITIN.

By Uriel S. Boone, Ph.G., M.D., formerly Professor of Minor Surgery and Pharmacology, and Assistant to the Chair of Histology, Pathology, and Bacteriology, College of Physicians and Surgeons, St. Louis, Mo. Respectfully dedicated to the Medical Profession of the United States. Price, 25 cents.

This pamphlet is the outcome of the author having sent a circular letter to all the hospitals and sanatoria in the United States asking for information regarding the three drugs dealt with in this report. The answers are collated and speak for themselves. The work is certainly original and deserves careful consideration. It appears from the answers that there is no fear of addiction being acquired, and that the risk of death from their use is almost nil.

The main tenor of the pamphlet goes to show that the statements which have been made regarding the evils resulting from the use of headache powders, etc., have been very much exaggerated. The author disclaims all intentions except those of collecting information from the hospitals, and their medical heads, and giving the results of his labors to the medical profession. Assuming that this has been genuinely done this pamphlet is a valuable addition to our knowledge of these drugs. As such we welcome it and recommend it. The hospitals and their answers are given.

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### EXAMINATION OF URINE.

A Manual for Students and Practitioners by G. A. De Santos Saxe, M.D., Instructor in Genito-Urinary Surgery, New York Post-Graduate Medical School and Hospital, etc., etc. Second Edition, revised, with text illustrations and colored plates, a number of them original. Philadelphia and London: W. B. Saunders Company, 1909.

Here we have a very complete manual of urinary analysis. The book is well illustrated. The instructions regarding the microscopic examination is reliable and full. We can recommend this book as a very suitable one for every day use in the doctor's office. The latest and most reliable tests are given. In all important instances the clinical significance is pointed out. The author deserving much credit for his efforts to give the profession so useful a guide on this subject.

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### SURGERY—ITS PRINCIPLES AND PRACTICE—VOLUME V.

In five volumes. By 66 eminent surgeons. Edited by W. W. Keen, M.D., LL.D., Hon. F.R.C.S., Eng. and Edin., Emeritus Professor of the Principles of Surgery and of Clinical Surgery, Jefferson Medical College, Philadelphia. Volume V. Octavo of 1,274 pages, with 500 illustrations, 45 in colors. Philadelphia and London: W. B. Saunders Company, 1909. Per volume, cloth, \$7.00 net; half Morocco, \$8.00 net. Canadian agents, The J. F. Hartz Co., Ltd.

This volume completes the work, Dr. Keen has labored long and hard to bring out a truly magnificent work on Surgery; and he has succeeded. He has secured the assistance of a large corps of eminent surgeons to aid him in making these five volumes what they really are—among the finest in the English language. We hope that this work will meet with the reception it merits, for it ought to find a place in the library of everyone who makes any pretensions to being a surgeon. This volume deals with the vascular system, Gynæcology, Anaesthesia, X-rays, operative and plastic work, infectious diseases, legal questions, Pathology, Hospital organization, etc., we feel that the four volumes that

have already appeared have made this work on surgery sufficiently well known to render any words of ours on this volume as hardly necessary. The contributors are well-known surgeons, and include the names of George E. Armstrong, Montreal, W. S. Brickham, New York; P. B. Bland, Philadelphia; H. L. Carson, Philadelphia; E. A. Codman, Boston; Wm. L. Coplin, Philadelphia; W. L. Estes, South Bethlehem; Jas. Fisher, Philadelphia; C. H. Frazier, Philadelphia; J. H. Gibson, Philadelphia; H. A. Hare, Philadelphia; K. G. Lennander, Sweden; C. H. Moys, Rochester, Minn.; R. Matas, New Orleans; E. E. Montgomery, Philadelphia; A. J. Ochsner, Chicago; J. B. Roberts, Philadelphia; J. P. Warbasse, New York; L. J. F. Lachrisson, Sweden. These names stand as the guarantors of the contents of this volume, which is a fitting end of a great undertaking. We congratulate the editor, Dr. W. W. Keen, and the publishers very heartily on the results of their efforts.

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#### TEXT-BOOK ON THE PATHOGENIC BACTERIA.

For Students of Medicine and Physicians. By Joseph McFarland, M.D., Professor of Pathology and Bacteriology in the Medico-Chirurgical College, Philadelphia. Sixth Revised Edition. Octavo of 709 pages, fully illustrated, a number in colors. Philadelphia and London: W. B. Saunders Company, 1909. Cloth, \$3.50 net. Canadian agents, The J. F. Hartz Co., Ltd., Toronto.

This edition of this very excellent work brings the subject of "Pathogenic Bacteria" up to date. We have long been familiar with this work, and have noticed with much pleasure the improvements in each edition as it made its appearance. The author has had a splendid training for the task he has set himself—the preparation of a reliable work on bacteria. He has also a clear style of expression. We can hardly imagine any more complete work than this one. With this volume in his possession the student and practitioner can feel satisfied that he has a safe guide.

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#### A TEXT-BOOK OF THE PRACTICE OF MEDICINE.

By James M. Anders, M.D., Ph.D., LL.D., Professor of the Theory and Practice of Medicine and of Clinical Medicine, Medico-Chirurgical College, Philadelphia. Ninth Revised Edition. Octavo of 1,326 pages, fully illustrated. Philadelphia and London: W. B. Saunders Company, 1909. Cloth, \$5.50 net; half Morocco, \$7.00 net. Canadian agents, The J. F. Hartz Co., Ltd., Toronto.

Dr. J. M. Anders knows what the student and practitioner requires, and he gives them that very thing. In this volume we have the happy medium between the short compend and the systems in several volumes. By the time a work reaches its ninth edition it has had its defects elim-

inated and its strong points accentuated. The more closely one examines this "Practice of Medicine" the more apparent does it become that the author has had the words "up-to-date" ever in his mind. For sane advice in the treatment of disease one may turn confidently to the pages of Anders Practice.

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## MISCELLANEOUS.

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### PATIENT PREVARICATORS.

E. S. McKEE, M.D., Cincinnati.

I T was Rudyard Kipling who said: "All patients are phenomenal liars where their own symptoms are concerned." You have all met the voluble patient, usually of the female sex, who can lie like an Oriental and yet tell nothing. They are afflicted with *suppressio veri*. Then we have the lying which goes with hysteria, the patient who will lie incessantly, and smile the lie she fears to speak, if such there be. The measureless liar is the morphine fiend, or better or worse, his cocaine confrère. Really few have to suffer from the plague of lies as does the doctor. He is lied to by his patients till he wishes this lie of life was over. He especially hates the long-drawn-out lie with subjunctive clauses and excursions into regions not even collateral. He prefers a quick lie for the quick, not the dead. The doctor, like God and good men, hates a liar. Some men even patients forget that it is absolutely and universally unlawful to lie. Here comes the man smelling of whiskey, wanting something to stop a pain in the stomach or a fainting tendency to which his florid face gives the lie—will tell lies of the first magnitude, solid, stately, epigrammatic. There is the policeman who wants a berth on an easy or agreeable beat. Some patients tell an untruth from ignorance or misconception, which is not a willful lie with an intent to deceive or defraud. Some liars will even tell the truth if it but better serves their end. Knowing them to be liars, their reputation makes their truth seem false. "Tell them I will not come to-day. Cannot is false. Shall Cæsar send a lie?"

Have you had the lady who wants to be sent to some fashionable health resort against the wishes of her husband? How she can lie! How she tries to make you lie for her! She makes her memory so sin that she even credits her own lies, so great an affinity hath fiction and belief. Her imaginary complaints become as real to her as that fiction of finance, the reduction of debt by borrowing. Have you not seen that patient who is morally and modishly sure that the colicky pain on the left of the umbil-

icus is appendicitis, just like Albert Edward's? Dr. Quintard not long ago wrote on this subject before the Société de Médecine d'Angeres. He deals with those people who approach the doctor with the deliberate intent to deceive him. There is the unmarried female—how lucky are the males!—who says she has undergone one operation for a tumor of the womb, but it has recurred, and she begs you to remove it. While you are dutiously doubting the tumor is removed by the obstetric art.

Great liars are those patients who belong to mutual benefit societies, life insurance and accident insurance. They seem to feel that they have a right to be sick and get a benefit, whether they must lie for it or not. In fact, there are so many varieties of patient liars that some doctors of large practice, who do not lie about the amount of their practice, are tempted to say in their hearts that all patients liars are. I sometimes feel like asking some of my patients to excuse the frankness founded on many years as a medical attendant, but that it is my honest belief that they would rather lie than tell the truth.

Untruthfulness is sometimes constitutional. It runs in families. Some lie because they cannot help it, some because they think it right, and some because they think it wrong. Charity leads to the belief that much lying is subconscious. Lying sometimes has its origin in an over-vivid imagination, in that wish to believe, which is the foundation of that faith which enables us to believe that which we know not to be true. This is possibly the explanation of the strange disregard of the truth in persons of otherwise unimpeachable character. Who has not, for instance, heard a doctor of otherwise irreproachable virtue, honest and truthful, who would lie like a trooper when it comes to talking about the amount of his practice. One would not feel so chagrined by being lied at by his patients were it not so many of the lies so barefaced that the doctor must conclude that the patient does him little credit for intelligence if he believes that he will believe them. Few of our patients probably realize the extent to which they lie. Some are conscious, others semi-conscious, others unconscious liars. Many lie to excite sympathy, others to escape work, to impose on charity, to pose as remarkable cases in journals and before societies, and others for the peculiar pleasure of deceiving. It is well known to experienced doctors that no reliance should be placed on what patients say about other doctors' patients or cases. This rule will save much unnecessary hard feeling the profession. The doctor should little heed what he hears, and go by the sense of sight and touch. Pediculosis may be found on the Governor and the garbage man. Polar purity does not prevent syphilis and gonorrhoea. Lawyers, too, sometimes tussle with the untruth, which has led to the saying among them, "truth will out, even in an affidavit."

You ask me who shall hang the liars? Shall the honest man do it? If so, then the liars are also foolish, and the fools of the world are a large

and influential majority. There are enough liars to bind and hang all the honest men. Lie and liar appear entirely too frequently in this article. Let us in the future say mythomania and mythomaniac.—*Eclectic Medical Journal*, August, 1909.

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#### BIRTHS, DEATHS AND MARRIAGES IN TORONTO.

Last year there were 7,839 births recorded at the City Clerk's office; 3,905 marriages, and 5,188 deaths, as against 7,945 births in 1908, 3,413 marriages, and 4,629 deaths. In 1905 there were 5,816 births, 3,060 marriages, and 3,915 deaths.

The deaths from contagious diseases last year were as follows: Tuberculosis, 293; diphtheria 191; scarlet fever, 77; measles, 70; typhoid fever, 79; whooping cough, 30. In 1908 the deaths from contagious diseases were as follows: Tuberculosis, 280; diphtheria, 159; typhoid fever, 64; scarlet fever, 47; whooping cough, 23; measles, 1.

In December, 1909, there were 620 births, 353 marriages, and 531 deaths, as against 831 births in December, 1908, 374 marriages, and 409 deaths. There were 33 deaths from tuberculosis in December, 1909, 20 diphtheria, 11 scarlet fever, 11 typhoid fever, 4 whooping cough, and 1 measles.

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#### MEDICAL, DENTAL AND DRUG EXCHANGE.

The Canadian Medical Exchange wishes us to say that this season of the year is probably the best of any for physicians desiring to sell their practices, to offer them, as the Exchange has a great many more *bona fide* buyers registered with them, who are looking for a location, than they have practices to offer, and Dr. Hamill who has conducted this important department of medical affairs for many years, would be glad to have the opportunity of opening up negotiations with physicians desiring to sell. The list of his offers will be found in the advertising columns of this journal, the completion of which changes each month. The address is 75 Yonge St., Toronto.

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#### THE GAGE SCHOLARSHIP IN TUBERCULOSIS.

Mr. W. J. Gage has made an offer to the University of Toronto of five scholarships to the value of \$100 each, and gold and silver medals, carrying a cash payment of \$50 each, to be competed for by fourth and

fifth year graduates in medicine. The scholarships and medals are to be given for the early diagnosis and treatment of tuberculosis.

All students competing in these examinations will be required to spend at least one week at the Muskoka Free Hospital for Consumptives, where clinics will be given in the diagnosing and treatment of tuberculosis, and where ample opportunity will be afforded students in the use of a well-equipped laboratory. This new attempt to emphasize the diagnosing and treatment of tuberculosis in medical schools, so that the disease may be detected in its incipient stage, would seem to go a long way to assist in a successful warfare against what was at one time looked upon as a scourge.

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#### ROBERT MARCUS GUNN, M.A.M.B., F.R.C.S.

The many friends and former pupils of Marcus Gunn, in this country, will learn with sincere regret of his death, on Dec. 5th, at the comparatively early age of fifty-nine, in London. Gunn's career was a very distinguished one and at the time of his death he was certainly the leading oculist in England. A Netherlandshire man, he came to London and after a six years' tenure of the house surgeons of the Moorfields Eye Hospital began private practice, in which he was eminently successful and was at the time of his death the senior surgeon at Moorfields. Among other appointments he held those of Arris and Gale lecturer at the Royal College of Surgeons of England, and Bowman lecturer to the Ophthalmological Society of Great Britain. Gunn did much original work on the comparative anatomy and embryology of the eye and on the physiology of vision, and was a frequent contributor to the *Journal of Anatomy*, the Royal London Ophthalmic Hospital Reports and articles in the *Encyclopedia of Medicine*.

G. S. R.

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#### MEDICAL PREPARATIONS, ETC.

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##### THE AFTER CARE OF OPERATIVE CASES.

It is a fact well established by hematologists, and well known to the surgeon, that a large majority of surgical diseases, requiring operative interference, are preceded, accompanied or followed by hemolytic changes. In addition to the more or less devitalizing effect of the original condition which brings the patient to the operating table, the necessary anæsthesia, if at all prolonged, reduces the hemoglobin percentage and

the shock incident to the operation contributes, to a certain extent, to the surgical anemia. Hemorrhages, suppuration or sepsis, precedent to the use of the knife, of course intensifies the post-operative chlor-anemia and renders more than ever necessary the employment of hematogenic measures during surgical convalescence. Judicious but generous feeding is of prime importance in such cases and sedulous attention should therefore be paid to the patient's dietetic requirements. Feeding, alone, however, will not hasten recovery as rapidly as a judicious combination of feeding with a hematinic reconstituent such as Pepto-Mangan (Gude). Except in cases in which it is not permissible to introduce food or medicine through the mouth, this palatable, readily tolerable and promptly absorbable organic combination of iron and manganese is distinctly indicated in preference to other blood building agents, because it is agreeable, non-irritant and free from constipating effect. Its hematinic, appetizing and general reconstituent properties are quickly evidenced subjectively, by a general feeling of well-being; objectively, by increased color of skin and mucous membrane, and hematologically, by a progressive increase in the number of erythrocytes and percentage of hemoglobin.

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#### EXTRACT OF CORPUS LUTEM IN DISTURBANCES OF ARTIFICIAL AND PHYSIOLOGIC MENOPAUSE.

Morley, in the November number of the *Journal of the Michigan State Medical Society*, reports his results in 18 cases. This report is a continuation of the one that appeared in the August number of the *Detroit Medical Journal*. The author used an extract made from the corpora lutea of beef ovaries rather than an extract of the entire ovary, as the consensus of opinion seems to be that the internal secretion of the ovary is produced by the yellow body. The extract is given in five grain doses, three times a day, one half to one hour before meals. His results may be summed up as follows:

Five were cured, 12 were improved and one obtained no relief. Included in the 12 cases that were improved are grouped those that are still taking the extract. A permanent cure may result in a few of the cases under treatment. Of the 18 cases, 14 suffered from disturbances of operative or artificial and four from those of natural or physiological menopause. While the results obtained in so small a group of cases do not warrant the drawing of any definite conclusions, still, the author thinks that the results are favorable enough to justify a continuance of the treatment in other cases, where there is a disturbance incident to artificial or physiological menopause.