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OF  
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# INDEX TO VOLUME XXVII

## January

### ORIGINAL CONTRIBUTIONS.

|   |    |
|---|----|
| Sarcoma of the Nose, with Presentation of Cases. By J. Price-Brown .....        | 1  |
| Artificial Light and its Effects Upon the Eye. By James M. MacCallum, M.D. .... | 21 |
| School Hygiene .....  | 30 |

### EDITORIALS.

|   |    |
|---|----|
| The Statutory Membership of the College of Physicians and Surgeons of Ontario ..... | 33 |
| Medicinal Treatment of Subacute and Chronic Gout .....                              | 37 |
| Why are not Toronto Schools Medically Inspected? .....                              | 39 |
| Special Meeting of the Ontario Medical Council .....                                | 42 |
| Further Accessions to our Staff .....   | 44 |
| A Suffragist Entertained by the Woman's Medical Alumni .....                        | 45 |
| Editorial Notes .....   | 46 |
| Correspondence .....  | 52 |

### SOCIETY PROCEEDINGS.

|                               |    |
|-------------------------------|----|
| The Academy of Medicine ..... | 65 |
|-------------------------------|----|

### NEWS OF THE MONTH.

|   |    |
|---|----|
| Retirement of Miss Snively After 25 Years of Splendid Service ..... | 60 |
| Was Vote Legal by the Doctors? ..                                   | 61 |
| Canadian Women Doctors .....  | 62 |
| Items .....   | 63 |

### PHYSICIAN'S LIBRARY.

|   |    |
|---|----|
| A System of Ophthalmic Therapeutics. By Casey A. Wood, M.D. ....  | 66 |
| Soured Milk and Pure Cultures of Lactic Acid Bacilli in the Treatment of Disease. By George Hirschel, M.D. .... | 67 |
| Clinical Memoranda for General Practitioners. By Alex. Theodore Brand, M.D. ....                                | 68 |
| Text-Book of Modern Materia Medica and Therapeutics. By A. A. Stevens, M.D. ....                                | 68 |

## February

### ORIGINAL CONTRIBUTIONS.

|   |    |
|---|----|
| The Radical Mastoid Operation and its Technique. By D. J. Gibb Wishart, M.D. ....               | 69 |
| Medicine Versus a Criminal Act. By John Hunter, M.B., Toronto .....                             | 77 |
| The Stimulant Group. By William F. Vaughn, M.D., Chicago .....                                  | 82 |
| The Indeterminate Sentence and Parole System. By Dr. J. T. Gilmour, Warden Central Prison ..... | 86 |
| Society Proceedings .....   | 89 |
| Abstract .....  | 91 |

### EDITORIALS.

|  |     |
|--|-----|
| The Colon Tube .....   | 93  |
| Laymen Rival Doctors in the Campaign Against Tuberculosis .. | 94  |
| Copper in Vegetables .....                                   | 97  |
| "Call it Six Days." .....                                    | 99  |
| Editorial Notes .....  | 102 |
| Personal .....   | 110 |

### OBITUARY.

|  |     |
|--|-----|
| The Death of Dr. James H. Richardson ..... | 111 |
| Death of Dr. Uzziel Ogden .....            | 114 |
| Death of Dr. G. F. Cleland .....           | 115 |

### NEWS OF THE MONTH.

|   |     |
|---|-----|
| The Clifton Springs Sanitarium ..                 | 116 |
| The Peters' Scholarship .....                     | 117 |
| The Borderland Between Medicine and Surgery ..... | 118 |
| Items of Interest .....                           | 118 |

### BOOK REVIEWS.

|   |     |
|---|-----|
| Northern Lights. By Sir Gilbert Parker .....                          | 119 |
| Diseases of the Pharynx and Larynx. By Dr. E. J. Moure .....          | 119 |
| Hydrotherapy. By William H. Diefenbach, M.D. ....                     | 120 |
| Quain's Elements of Anatomy. By E. A. Schaffer and J. Symington ..... | 121 |
| Practical Microscopy. By F. Shillington Scates, M.A., B.C. ....       | 121 |

|  |     |
|--|-----|
| Formulaire des Medications Nouvelles pour 1909. Par le Dr. H. Gillet .....                         | 122 |
| The Relation of Medicine to Philosophy. By Dr. R. O. Moon ..                                       | 123 |
| Manual of the Diseases of the Eye. By Charles H. May, M.D. ....                                    | 123 |
| Outlines of Bacteriology. By David Ellis, Ph.D., D.Sc. ....  | 124 |
| Clinical Studies for Nurses. By Charlotte A. Aikens .....  | 126 |
| The Practical Medicine Series. Edited by Joseph B. De Lee .....                                    | 126 |
| A System of Ophthalmic Therapeutics. Edited and chiefly written by Casey A. Wood, M.D. ....        | 126 |
| A Text-Book of Physiological Chemistry. By John H. Long .....                                      | 126 |
| High Frequency Currents. By H. Evelyn Crook, M.D. ....   | 127 |
| Legal Medicine and Toxicology. By R. L. Emerson .....  | 127 |
| The Morphia Habit and its Voluntary Renunciation. By Oscar Jennings, M.D. ....                     | 128 |
| The Practical Medicine Series. Edited by Gustavus P. Head, M.D. ....                               | 129 |
| Medical Libraries .....  | 129 |
| Clinical Examination of the Urine and Urinary Diagnosis. By J. Bergen Ogden, M.D. ....             | 130 |
| Surgical Diagnosis. By Daniel Eisendrath, A.B., M.D. ....  | 130 |
| Dietetics for Nurses. By Julius Friedenwald, M.D. ....   | 131 |
| Congenital Dislocation of the Hip Joint. By J. Jackson Clarke ..                                   | 131 |
| Insomnia and Nerve Strain. By Henry S. Upson, M.D. ....  | 132 |
| A Manual of Venereal Diseases. By Officers of Royal Army Medical Corps .....                       | 133 |
| Diseases of the Male Generative Organs. By Edred M. Corner ..                                      | 133 |
| Auscultation and Percussion. By Samuel Gee, F.R.C.P. ....  | 134 |
| The Open-Air or Sanatorium Treatment of Pulmonary Tuberculosis. By F. Rufenacht Walters, M.D. .... | 134 |
| The Practical Medicine Series. Edited by George F. Butler, M.D. ....                               | 135 |
| Aids to Microscopic Diagnosis. By E. Blake Knox .....  | 136 |

*March*

**ORIGINAL CONTRIBUTIONS.**

The Borderland of Medicine and Surgery. By Maurice H. Richardson, M.D. . . . . 137  
 Radium Therapy. By Herbert A. Bruce, M.D., F.R.C.S. . . . . 166  
 Public Health in the West . . . . . 174

**EDITORIALS.**

The Expenses of the Faculty of Medicine of the University of Toronto . . . . . 177  
 Forced Feeding in Tuberculosis . . . . . 180  
 The Slaughter of the Innocents . . . . . 182  
 The New Toronto General Hospital. . . . . 184  
 Editorial Notes . . . . . 191

**THE PHYSICIAN'S LIBRARY.**

Physical Examination of Surgical Cases. By E. Stanley Ryerson, M.D., C.M. . . . . 197

The Treatment of Diseases in Children. By G. A. Sutherland, M.D., F.R.C.P. . . . . 197  
 Pulmonary Tuberculosis and Sanatorium Treatment. By C. Muthu, M.D., M.R.C.S. . . . . 198  
 The Physician's Pocket Account Book. By J. J. Taylor, M.D. . . . . 198  
 A Text-Book of Obstetrics. By Barton Cooke Hirst, M.D. . . . . 199  
 Principles of Hygiene. By D. H. Bergy, M.D. . . . . 193  
 A Manual of Midwifery. By Henry Jellett, B.A., M.D. . . . . 200  
 The Skin Affections of Childhood. By H. G. Adamson, M.D. . . . . 202  
 The Practical Medicine Series. . . . . 202  
 A Text-Book on the Practice of Gynecology. By W. Easterly Ashton, M.D., LL.D. . . . . 203  
 Practical Anesthetics. By H. Edmund G. Boyle, M.R.C.S. . . . . 204  
 A Manual of Normal Histology and Organography. By Chas. Hill, Ph.D., M.D. . . . . 204

*April*

**ORIGINAL CONTRIBUTIONS.**

Treatment of Hernia in Children. By Chas. B. Shuttleworth, M.D. 205

**EDITORIALS.**

The Winter March of the Royal Canadian Horse Artillery . . . . . 210  
 Are Fomites Productive of Contagious Diseases? . . . . . 214  
 The Galvano-Cautery in the Treatment of Malignant Growths . . . . . 216  
 How Long will it be Before the College of Physicians and Surgeons is Bankrupt? . . . . . 219  
 The Rabies Outbreak . . . . . 222  
 The Downey Tuberculosis Bill . . . . . 226  
 Amendments to the Ontario Medical Act, Proposed by the Academy of Medicine . . . . . 228  
 Editorial Notes . . . . . 229  
 Personal . . . . . 237  
 Correspondence . . . . . 238

**NEWS OF THE MONTH.**

The Canadian Hospital Association . . . . . 242  
 Dr. Luther Gulick, of New York, on Medical Inspection of Schools. . . . . 242  
 McGill University Faculty of Medicine . . . . . 244

**THE PHYSICIAN'S LIBRARY.**

The Sexual Question. By August Forel . . . . . 245  
 Fifth Annual Report of the Henry Phlipps Institute for the Study, Treatment and Prevention of Tuberculosis . . . . . 246  
 The Practice of Surgery. By the late Walter George Spencer. . . . . 247  
 The Practical Medicine Series, Edited by Drs. E. C. Dudley and C Von Bachellet . . . . . 248  
 Manual of Operative Surgery. By John Fairbairn Binnie . . . . . 249  
 Studies in Tuberculosis. By Henry Clarke . . . . . 249  
 La Cure Radicale de la Hernie Inguinale . . . . . 250  
 Dose-Book and Prescription-Writing. By E. Q. Thornton . . . . . 250  
 Medical Diagnosis. By Charles Lyman Green, M.D. . . . . 251  
 A Synopsis of Surgery. By Ernest W. Hey Groves, M.D. . . . . 252

A Compend of Histology. By Henry Erdmann Radascu, M.D. . . . . 252  
 The Prevention and Treatment of Abortion. By Frederick T. Taussig, A.B., M.D. . . . . 253  
 Prostatic Enlargement. By Cuthbert S. Wallace, M.B., B.S. . . . . 254  
 Surgery of the Brain and Spinal Cord. By Prof. Fedor Krause. . . . . 254  
 Examination of the Urine. By G. A. De Santos Saxe, M.D. . . . . 255  
 An English Handbook to the Paris Medical School. By A. A. Warden, M.D. . . . . 256  
 Living Anatomy and Pathology. By Thomas Morgan Potch, M.D. . . . . 256  
 Modern Astronomy. By Herbert Hall Turner, F.R.S. . . . . 257  
 Medical Lectures and Clinical Aphorisms. Samuel Gee, M.D. . . . . 257  
 A Practical Guide to the Administration of Anesthetics. By R. J. Probyn-Williams, M.D. . . . . 258  
 Ophthalmic Surgery. By Charles H. Beard, M.D. . . . . 258  
 A Text-Book Upon the Pathogenic Bacteria. By Joseph McFarland, M.D. . . . . 259  
 Text-Book of Medical and Pharmaceutical Chemistry. By Elias H. Bartley . . . . . 259  
 Biographic Clinics. By George M. Gould, M.D. . . . . 260  
 Atlas of External Diseases of the Eye. By Dr. Richard Greeff. . . . . 260  
 Electricity for General Practice. By F. Stewart Povah and F. Davidson . . . . . 260  
 Treasures of Truth. By George F. Butler . . . . . 261  
 Surgery. Its Principles and Practice. Edited by W. W. Keen, M.D. . . . . 261  
 A Text-Book of Physiology. By William H. Howell, Ph.D., M.D. . . . . 262  
 A Handbook of the Diseases of the Nose, Throat and Ear. By Eugene S. Yonge, M.D. . . . . 263  
 A Text-Book of the Practice of Medicine. By James M. Anderson, M.D., Ph.D., LL.D. . . . . 263  
 The Practical Medicine Series, Edited by W. L. Baum, M.D., Harold N. Moyer, M.D. . . . . 264  
 Exercise in Education and Medicine By R. Tait McKenzie, M.D. 264

|  |     |
|--|-----|
| Dorland's American Illustrated Medical Dictionary, By W. A. Newman Dorland, M.D. ....          | 265 |
| Clinical Lectures and Addresses on Surgery, By C. B. Lockwood ..                               | 266 |
| Practical Points in the use of X-ray and High-Frequency Currents. By Aspinwall Judd, M.D. .... | 267 |
| Oxford Medical Publications, By Edred M. Corner, M.A. ....                                     | 268 |

|  |     |
|--|-----|
| Nervous and Mental Diseases. By Hugh T. Patrick and Charles L. Mix .....             | 269 |
| Medical Gynecology. By Samuel Wyllis Bandler, M.D. ....                              | 269 |
| Surgical Emergencies. By Percy Sargent, M.A. ....                                    | 270 |
| Age Incidence, Sex and Comparative Frequency in Disease. By James Grant Andrew ..... | 271 |

## May

### ORIGINAL CONTRIBUTIONS.

|   |     |
|---|-----|
| Electrocardiography and Electro-phonography as Aids in Clinical Diagnosis. By Lewellys F. Barker, M.D. .... | 273 |
| Nursing People of Moderate Means and the Poorer Classes. By John N. Elliott Brown .....                     | 287 |
| A Test for the Diagnosis of General Paralysis of the Insane. By George W. Ross, Jr., M.D., Toronto .....    | 297 |

### EDITORIALS.

|   |     |
|---|-----|
| A Vegetarian Diet Useful in Gout and Bright's Disease .....   | 305 |
| The Paper Milk Bottle .....   | 307 |
| The Causes of Appendicitis .....  | 309 |
| "We All Think That Is Not As It Should Be" .....  | 312 |
| An Impertinence .....   | 316 |
| The Retiring Medical Health Officer. The Academy of Medicine Elections. "Toronto Jail a Health Resort" .... | 318 |
| Editorial Notes .....   | 321 |
| Personals .....   | 325 |

### ORIGINAL CONTRIBUTIONS.

|  |     |
|--|-----|
| The Differential Diagnosis of Cerebellar Tumours. By Ernest Jones, M.D. .... | 341 |
| Gallstones. By Dr. J. M. Rogers, Ingersoll, Ont. ....                        | 350 |

### SOCIETY PROCEEDINGS.

|   |     |
|---|-----|
| The Canadian Medical Association. ....          | 359 |
| The American Medical Editor's Association ..... | 364 |

### EDITORIALS.

|   |     |
|---|-----|
| Hemorrhagic Diseases of the New Born .....  | 367 |
| The Orphanages of Ontario .....   | 370 |
| The Hospitals of Ontario .....  | 373 |
| Why are the Autos of Physicians "held up" daily by the Police? ..                               | 375 |
| A Little Embarrassing, Don't you Know? .....  | 379 |
| Four Thousand a Year for a Medical Health Officer. Ten Thousand a Year for a City Counsel. .... | 382 |
| Dr. Charles Hodgetts Joins the Federal Service .....  | 383 |
| Editorial Notes .....   | 384 |
| Personals .....   | 389 |
| Correspondence .....  | 390 |

### SELECTED ARTICLES.

|                                   |     |
|-----------------------------------|-----|
| Romance of a Gold-Headed Cane ... | 327 |
|-----------------------------------|-----|

### CORRESPONDENCE.

|  |     |
|--|-----|
| The 1910 Meeting of the British Medical Association .....      | 332 |
| Who Has Treated Progressive Muscular Atrophy Successfully? ... | 333 |

### NEWS OF THE MONTH.

|   |     |
|---|-----|
| Opening of the New Tuberculosis Sanatorium at London, Ontario. .... | 334 |
| Canadian Medical Association .....                                  | 336 |
| The Canadian Association for the Prevention of Tuberculosis .....   | 337 |
| Presentation to the Academy of Medicine .....                       | 338 |

### THE PHYSICIAN'S LIBRARY.

|   |     |
|---|-----|
| Diagnostic Therapeutics. By Albert Abrams, A.M., M.D. (Heidelberg) .. | 339 |
| Handbook of Diseases of the Ear. By Richard Lake, F.R.C.S. ....       | 340 |

## June

### OBITUARY.

|   |     |
|---|-----|
| Death of Dr. John D. Wilson, of London, Ont. .... | 394 |
|---|-----|

### NEWS OF THE MONTH.

|  |     |
|--|-----|
| A Large Deputation of Medical Men Wait Upon the Board of Control .....   | 395 |
| The Academy of Medicine Elections. Annals of Medical Practice Purchased by the New England Medical Journal ..... | 395 |

### BOOK REVIEWS.

|  |     |
|--|-----|
| The Practice of Osteopathy. By Charles H. Murray .....                             | 397 |
| Emergency Surgery. By John W. Sluss, A.M., M.D. ....                               | 397 |
| Functional Nervous Disorders in Childhood. By Leonard G. Guthrie, M.A., M.D. ....  | 397 |
| Spondylotherapy. By Albert Abrams, A.M., M.D. ....                                 | 399 |
| Claims Arising from Results of Personal Injuries. By W. Edward Magruder, M.D. .... | 399 |
| Modern Surgery: General and Operative. By J. Chalmers DaCosta, M.D. ....           | 400 |
| Myomata of the Uterus. By Howard A. Kelly, M.D. ....                               | 401 |
| Diseases of the Nose. By Ernest B. Waggett, M.A., M.B. ....                        | 402 |
| Heart Disease and Thoracic Aneurysm. By L. J. Poynton, M.D. ....                   | 402 |
| Diseases of the Larynx. By Harold Barwell, M. B. ....                              | 403 |



EDWARD VII. THE PEACEMAKER

"I HAVE DONE MY DUTY"

Born, November 9th, 1841

Died, May 6th, 1910

Ascended The Throne January 22nd, 1901

To the end indeed, he did his duty. As a man, as a King, as an Englishman, he will go down in history as Edward the Greatest, the most tactful and the best beloved of Sovereigns.

His death is not the sorrow of a nation, but the grief of nations, for he was the universal friend and the lover of "Peace and good will to men."

As a Sovereign, towards his people he was sympathetic, tireless, and ever ready with a personal word of cheer in every work which might aid in the advancement of Medical Research or give relief to suffering humanity.

He came to the throne of England, as the shadow of war hung over it, he leaves it with a Benediction of Peace. He came to govern a people who welcomed him as his good Mother's Son, he left it as a Monarch worthy of the Crown of Empire, a name he had made for ever great.

Requiescat—Edward Rex Imperator

MAY SIXTH, NINETEEN TEN

W. A. Y.

## " In Memory of His Late Majesty "



On Sunday afternoon, May 15th, the University of Toronto held a service in Convocation Hall " In Memory of His Late Majesty King Edward VII."

Convocation Hall was suitably draped in Royal Purple. The attendance of both students and public was large and the service was entered into by all present with an unusual spirit of solemnity.

On the platform were Chancellor Meredith, President Falconer, Sir James Whitney, Sir Mortimer Clarke, the Provost of Trinity College, Dean Clarke, Dean Temple, Controller Spence, Controller Church, Members of the Faculties of Medicine, Arts, Theology and other prominent citizens. An orchestra of twenty pieces was present to conduct the sacred programme of music.

The order of the service was as follows :

|                      |   |  |   |                  |
|----------------------|---|--|---|------------------|
| ORCHESTRA            | - | Funeral March  | - | <i>Chopin</i>    |
| HYMN                 |   | " O God, Our Help in Ages Past "                     |   |                  |
| PRAYER               | - | The Reverend the Provost of Trinity College.         |   |                  |
| READING OF SCRIPTURE |   | The Reverend the Dean of Theology, Victoria College. |   |                  |
| HYMN                 | - | " Nearer My God to Thee "                            |   |                  |
| ADDRESS              | - | The President of the University.                     |   |                  |
| BENEDICTION          | - | The Provost of Trinity College.                      |   |                  |
| ORCHESTRA            | - | Eroica   | - | <i>Beethoven</i> |

GOD SAVE THE KING

W. A. V.

# The Canadian Journal of Medicine and Surgery

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## ❧ Original Contributions ❧

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### SARCOMA OF THE NOSE, WITH PRESENTATION OF CASES

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BY J. PRICE-BROWN.

Fellow of the American Laryngological Association, Toronto Academy of  
Medicine, etc.

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Western Hospital Clinic, Nov. 18, 1909. Discussions by Professors Wishart, Anderson and Primrose, of Toronto University, and others. Dr. A. A. MacDonald, Dean of the staff, in the chair.

*Ladies and Gentlemen:* It gives me great pleasure to preside at this particular meeting of the Clinical Society of the Toronto Western Hospital, as we are to have a communication from one of the members of our staff, showing the outcome of years of study and experience, and reporting results far in advance of the accepted theories of the day.

We have heard, from time to time, of the exceptional success obtained by Dr. Price-Brown, with his method of treating nasal sarcoma, but to-day he is to give us, not only step by step, the means by which the ends have been attained, but also the concrete results.

He has fortified his strong position by having had confirmation of the diagnosis by able clinicians, and pathologists, and

now he exhibits to you three patients, giving you the opportunity of judging the results for yourselves.

Whilst introducing Dr. Price-Brown, it is not the place of the chairman to say more than to congratulate him on his excellent work and to invite the closest examination and fullest criticism.

Dr. J. Price-Brown spoke as follows:

Fortunately for mankind sarcoma of the nose is a rare disease. Its malignancy has made it the dread of the surgeon as well as the patient. Medical treatment as a curative agent is acknowledged to be futile, and surgical treatment has been almost as unfortunate in its results.

To prove that this is the expression of modern thought I need only refer to the works of some of the leading writers of the day, men who are specialists, and, some of them, prominent teachers in the field of rhinology.

Lennox Browne, in his most recent edition upon diseases of the nose and throat said that when the sarcoma affects the upper region of the nose no operation is advisable; when the lower region is affected. Ollier's or Rouge's *may* be attempted. He does not say they *should* be.

Bosworth, after quoting a large number of cases in which operation had been done, says that it would appear that one half the cases are cured, but that the statement is not trustworthy, as many of them were reported from one to four months after operation, while in others time was altogether ignored, rendering the statistics unreliable.

Boylan reports ten cures out of seventeen cases, but nearly all of them were reported within a few months of operation.

Shurly, Porter, and Bliss each report two cases, none of which recovered.

Kyle says that prognosis is always grave. Early and complete removal is the only hope, and the only instruments he advocates in purely nasal sarcoma are the galvano-cautery and curette.

Richards, in his article upon nasal sarcoma, says when it affects the ethmoid, the only region he refers to, "that we are positively helpless, and can only watch the fatal issue." He had four cases, two children and two adults: all died.



Bishop says it is a rapidly fatal disease of less than a year's duration.

Coakley, in his issue of 1908, says if the sarcoma is small it may be removed at one sitting by the electro-cautery snare, or if large by several distinct operations, the base being always cauterised. Prognosis, he says, should always be guarded, as recurrence, when least looked for, is likely to follow.

And lastly, Packard, of Philadelphia, in his new text-book upon the nose, throat, and ear, only just published, says (I quote his own words): "The prognosis of sarcoma of the nose is extremely bad. If removed it has a strong tendency to early recurrence. The only satisfactory treatment is thorough extirpation of the neoplasm as early as possible. For this purpose it is generally necessary to perform an external operation, intranasal operations not affording sufficient room for thorough removal."

In the light of such a record from leading specialists of this new century it looks like temerity to say anything more. But the last word has not been said, nor will it be for many years to come; and I ask for a few minutes' earnest and candid consideration of the subject.

Six years ago I reported at the American Laryngological Association at Washington the history of three cases. All of them had exhibited the usual classical symptoms: continued obstructive growth, repeated hemorrhages, etc. All had been previously operated on by other men. All had been of long standing, and the diagnosis was in each case sustained by pathologists after careful examination of sections removed. Two of them were then reported as cured. The third still under treatment was reported as follows:

On Oct. 31, 1902, Mr. L. R. P., aged 21 years, presented himself at my office. On examination I found a large growth, which completely filled the left nasal cavity. It distended the nostril, flattening that side and producing partial frog-face. Posteriorly it filled the post-nasal cavity, pressing the soft palate downward, and rendering it rigid and immovable. The lower part of the left cheek was also protuberant and pendulous, although not diseased. The septum was pressed over to the right by the growth, so that nasal respiration was impossible.

The tumor was of a pinkish color, particularly at the posterior end, and was smooth, glistening and firm. The sense of smell was entirely absent.

Physically he was well nourished and of a plethoric color. There was neither glandular enlargement nor pain; but there was very great distress, accompanied by a full bursting sensation.

As the growth had been pronounced sarcoma after microscopical examination by a competent authority two and a half years ago, and as excision by external operation was said to be the only possible method of relief, and even that would be accompanied by great danger from hemorrhage; it was not without a good deal of trepidation, and thoroughly explaining the risk to the patient and friends, that I was willing to take charge of the case.

Careful examination impressed me with the fact that it was not an osteo-sarcoma; but that it had its origin in the soft parts, and that any existing affection of the bony framework would probably be in the form of absorption. The tumor, however, was so enormous, and the history so hemorrhagic, that I believed it to be inoperable by regular surgical excision.

Still my experience, from the history of the two cases already reported gave me confidence, and I was willing to attempt its removal by intranasal operative means; particularly as the patient and his immediate relatives were desirous that I should do so, after I had fully explained to them the risk.

The first attempt at treatment was on Nov. 13th, 1902, Dr. Wilson kindly assisting. The application of a solution of cocaine, followed by a 1 in 2,000 of adrenalin, rendered the anterior end of the tumor pallid. The idea was to remove several segments if possible by snare. It was found, however, that although the loop would slide in between the nasal wall and the side of the tumor, the latter was so round and dense that but slight hold could be obtained, and little else but mucous membrane came away. Still the hemorrhage was so severe that the nose had to be plugged tightly at once.

Several days elapsed before all the tampons could be removed, consequently, operating did not really commence until Nov. 18.

From that date until Feb. 2, when an operation under chloroform was done, of which I will speak later, I removed 12 pieces of the growth by means either of the snare or scissors: and operated upon it also 49 times with the electro-cautery. Before each cautery operation I sprayed the nasal cavity out with an alkaline solution, and then removed the sloughs occasioned by the previous operation with forceps. A large number of these I kept preserved in alcohol and here they are.

By the date mentioned, or ten weeks after commencement, the great body of the tumor had been removed. But there was still a large piece attached to the vault of the left side of the naso-pharynx and posterior end of the septum. I tried several times to get a loop upon it, but the patient could not bear my fingers behind the palate to adjust the snare.

The result was that on Feb. 2nd I decided to operate under general anesthesia. Dr. Gullen kindly administered chloroform. A mouth gag was inserted. I passed a screw snare through the nose to the naso-pharynx with the right hand, and with the fingers of the left in the naso-pharynx adjusted it in position around the base of the tumor. Dr. Gullen then turned the screw until the hold was secure, after which the screw was tightened by degrees until the growth was cut off and drawn into the nose. where it acted as a plug, the snare separating from it. The hemorrhage was excessively severe, and the gag being still in the patient's mouth, I pressed in behind the palate a number of large wads of absorbent cotton, completely filling the cavity and retaining pressure for some time with my hand.

Quarter of an hour later, after hemorrhage had ceased, the piece was pulled out of the nasal cavity with forceps. Here it is. When fresh it weighed nearly three drams, and, as you will notice, the base was nearly as large in every direction as the diameter of the tumor itself.

Between the time of this operation under chloroform and two and three-quarter years ago, I had many other electro-cautery operations upon parts of the tumor and regrowths. These have been chiefly in the posterior turbinal region. Since Feb. 1907, there has been no return whatever of the growth and he is one of the patients that I now show.

There is one point of interest in this case that it may be well

to touch upon, the attachment of the tumor. It was immensely sessile, as sarcoma of the nose usually is, and was attached to the whole length of the left inferior and middle turbinal regions and the posterior part of the vault above. The attachment extended over the upper part of the left palate bone, the body of the sphenoid, the inner surface of the internal plate of the pterygoid, and the posterior end of the vomer. The bone of the inferior turbinal had been entirely absorbed, and the greater part of the middle turbinal; also a portion of the face of the body of the sphenoid; for instead of the ordinary openings into the sphenoidal sinus, there is now a large perpendicular oval opening, which in all likelihood was made by pressure absorption.

To-day all three men are perfectly well and are following their usual vocations as bread-winners for their families in the city of Toronto. It is 14 years since the last operation on the first case, and it is 8 years since the last operation on the second case, and it is  $2\frac{3}{4}$  years since the last operation on the third case.

CASE 4.—In the December issue of *The Annals of Otolaryngology*, 1906, I reported my next case. The patient was a butcher, aged fifty-eight. His father died of cancer of the stomach at the age of seventy-two. On examination I found the left nasal passage from anterior to posterior naris filled with a dense growth which bled on being touched. Microscopical examination of a pathological specimen removed, indicated that it was a round-celled sarcoma. The growth was from the outer wall, the middle and inferior turbinals being involved and softened. In two weeks the tumor was entirely removed by electro-cautery operations. At the end of that time the nasal passage was cleared of all obstruction and there was complete restoration of normal breathing through the nostril.

His temperature when he first presented himself was  $99.4^{\circ}$  F., and it continued more or less elevated throughout the treatment, running between  $99^{\circ}$  and  $102^{\circ}$  F. As the operations drew to a close septic symptoms developed. He lingered about two months and then succumbed to the absorption of toxins from the site of the tumor and a diseased antrum. There was, however, no return of the sarcoma, nor even of inflammatory

vegetations, and both the patient and his friends were spared the horrible and repulsive deformity which usually attends death from this disease.

The following three cases were reported to the American Laryngological Association at Boston five months ago, two of them being still under treatment.

On April 1, 1909, Dr. Kerr, of Toronto, referred the first of these:

CASE 5.—Mr. C. C——, aged thirty-five. General health and family history good. Bachelor, and weaver by trade. For several months closure of the left nasal passage had been developing, resulting in complete stenosis, even of the right side. Taste and smell had been lost, and the voice had a thick nasal twang.

*Examination.*—Left nasal passage packed with a red, fleshy growth which bled on being touched. The tumor was sessile, being attached to the triangular cartilage in front and the vomer behind. It did not project into the naso-pharynx. I removed a section by knife and submitted it to two pathologists. Their report was:

"The microscopical examination, together with the clinical history, incline us to believe that the growth is a small, rounded-celled sarcoma.

"(Signed) GEO. H. CARVETH,  
"L. A. DAVIS."

Electro-cautery operations were at once commenced and repeated almost daily for two weeks, the passage being freed from sloughs before each succeeding operation. By that time the tumor was fully removed, the posterior portion of the cartilaginous septum and part of the vomer having been sacrificed to help to accomplish that end. The nasal passage was quite free, the breathing had become normal again, and the sense of smell had returned. This is another of the patients shown to-day. It is seven months since operation. No return.

CASE 6.—On April 9, 1909, Mr. W. S. ——, aged twenty, was referred by Dr. Nichol, of Cookstown. For more than two years he had suffered from a constantly increasing growth in the right nasal passage, with the loss of both taste and smell. Nine months ago, the stenosis having become complete, he was

referred to a surgeon. From then until now, at different times, segments of the growth have been removed, each operation being attended by excessive hemorrhage. As the tumor continued to increase in size he was finally brought to me by his family physician and placed in the Toronto Western Hospital for treatment.

I found complete occlusion of the right nasal passage extending low down into the naso-pharynx. The slightest touch caused bleeding, yet the hardness within the nasal passage was so dense that on first examination I thought it was partly due to a cartilaginous and bony ridge of the septum, which, after a free application of cocaine and adrenalin, I attempted to remove with a saw. But instead of cartilage and bone the instrument simply removed a mass of tissue, pathological examination of which brought out the following report:

"We find that this is an angeio-sarcoma, composed of small round cells in a fibrous reticulum, having in it large and numerous blood-vessels with thin walls. Myxomatous degeneration is found in places.

"(Signed) L. A. DAVIS,

"GEO. H. CARVETH."

Two days later the tampons were removed and electro-cautery operations commenced. While under treatment an acute pericapsular abscess of the left ankle formed, which, after being operated upon on both sides, healed. This interrupted the electro-cautery operations, and they were suspended from April 15 to 29, when they were resumed. The rule was to cleanse the nasal cavity each morning, removing all loose sloughs, to anaesthetise it with cocaine and adrenalin, and then to cauterise as much of the growth as was deemed advisable. This would be followed by an evening cleansing of the passage, the routine being carried out each day.

By May 18 the nasal passage was free right through to the posterior naris, and the post-nasal segment of the growth was freely incised with the cautery through the nose. On this day chloroform was administered, and a large portion of the balance of the tumor was removed through the mouth by means of a modified Lowenberg's forceps. The attachment was to the anterior part of the roof of the naso-pharynx, to the septum and to the upper side of the soft palate.

From then until the latter part of June I used the electro-cautery at least a score of times, burning away fragments of the growth and thoroughly cauterising the base of the pedicle. These were all done by means of a strong light through the nasal passage. Once, also I used the post-nasal curette. By this time the tumor was entirely removed. There were in all, besides saw, forceps and curette operations, forty-five applications of the electro-cautery knife. The spray used was one of simple albolene, and on going home the patient was instructed to continue to use it until the crust formation and catarrhal symptoms were over. He returned to his home in Muskoka five months ago. Two months later under my instruction he came back for examination. I found recurrence in the upper and back part of the passage in the ethmoidal region. For some days electro-cautery treatment was resumed, the growth was cleaned out completely and he again went home. Under orders he came back a month ago. But there was no return. He is now working in the lumber woods but will return at Christmas for another examination.

CASE 7.—On April 12, 1909, three days after receiving the last case, Dr. W. M. Brown, of Neustadt, brought to me Mr. E. W—, aged eighteen, for treatment. This case was similar to, though in some respects more serious than the one just described. For several years the left nasal cavity had been filled with a similar growth extending into the naso-pharynx. In the latter it was much larger than in the case of Mr. S—. During the last two years he had undergone many operations by snare, forceps, and cautery, each one being attended by violent hemorrhage.

*Examination.*—Breathing on either side impossible. Left passage filled by a growth which presented a red, globular form half an inch within the nostril. The right side narrow, and filled with pus. The post-pharynx was completely filled by a large globular mass.

The lad was placed in the Toronto Western Hospital.

The treatment was on similar lines to all those that had preceded it. In this case, however, there was no preliminary cutting away of a specimen for examination. This was deferred until later.

Daily cauterisations were at once commenced, the main object being to reduce the size of the tumor as safely and speedily as possible—*per vias naturales*. The attacks were made under cocaine and adrenalin upon the central part of the growth in the nostril, leaving the shrinking shell as a protection to the normal tissues. Consequently, although the sittings were long and tedious to the operator, they produced little pain in the patient. Little by little the heart was eaten out of the nasal portion of the tumor, and the naso-pharynx was reached. In the meantime I had discovered that the attachment was to the middle turbinal and upper end of the septum and adjoining naso-pharynx; and like the former case, there was also a wide adhesion to the soft palate.

On the thirtieth day of treatment chloroform was given, and the large body removed from the naso-pharynx with cutting forceps. Bleeding was so severe that post-nasal packing had to be done. Two days later this was removed. Then on examination I discovered a piece of the tumor still attached to the post-pharyngeal wall immediately behind the left posterior pillar. It had the appearance of a hard, misplaced uvula. Another segment was in the posterior part of the nasal cavity, and was attached to the middle turbinal, the posterior ethmoid cells, and the summit of the septum. These, together with many other spots, were removed by electro-cautery, the operative treatment being still necessary for several weeks.

On removal of the post-nasal portion of the tumor a pathological examination was made by Professor Anderson, of the University of Toronto, who gave the following report:

"I have examined the specimen of tissue from the naso-pharynx and consider the condition to be that of myxo-sarcoma. The myxomatous tissue, forming a considerable part of the growth, is exceedingly vascular; the vessels as a rule have poorly developed walls. In different areas of the growth there are masses of small round cells. The condition I believe is one of sarcomatous transformation of a myxomatous tissue.

"(Signed) H. B. ANDERSON."

This case, like the preceding one, made an excellent recovery. The affected passage became perfectly free, every vestige of the



growth that could be seen being removed, and he went home in the middle of June.

In August, two months later, however, upon my request, his doctor examined him again. The boy was strong, heavier than ever in his life, felt perfectly well, and could breathe through his nose with the greatest freedom; but the examination proved that the growth was re-forming, and he was sent back at once to me for treatment.

I found the growth had already reached a large size, filling the upper and back part of the left nasal cavity, but not extending into the naso-pharynx. The attachment was to the vault and upper-end of the posterior choana. It was richly supplied with blood and took a number of successive electro-cautery operations to remove it. These operations were continued for several weeks, as occasion demanded. I showed this patient and also Case 6 to the Academy of Medicine a month ago. There had been no operations on him for more than 2 months and there have been none since. The lad now feels quite well, and in order to have him under regular observation and operative treatment, with the hope of completely eradicating all tendency to the return of the disease, I secured a situation for him. He is one of the patients shown.

These seven cases were all private patients. They were all males, their ages being respectively eighteen, twenty, twenty, twenty-one, thirty-five, fifty and fifty-eight years.

In every case the disease was unilateral so far as the nose was concerned, but occupying the whole vault when involving the naso-pharynx. Two occurred on the right side, five on the left. Every case but one had been previously operated on before it was referred to me, and in every case the diagnosis was confirmed by microscopical examinations by skilled pathologists.

Three out of the seven have permanently recovered—that is, after intervals of fourteen, seven, and two and three-quarter years, there has been no return. The fourth died from toxemic poisoning. The fifth has had no return in seven months, the sixth no return in the last two months, the seventh no return in the last two months—that is, out of the first four cases, there was a recovery of 75 per cent. and a death-rate of 25 per cent.

We may consider the last three too soon to be reported positively upon as cures.

I present this paper as a report upon research work, not in pathology, but in operative treatment, in one of the most dangerous, most repulsive, and most baffling of diseases that a human being can be afflicted with; and in doing so I want to draw your attention to the fact that among the names of the scientific men that I have mentioned whose text-books are in our hands, those that speak most hopefully with regard to the treatment of this disease are the ones who advocate, above all other methods, the use of the electro-cautery knife or snare. But they speak on general principles, giving few, if any, records of cases.

While this fact is an encouraging note, I can claim without danger of contradiction that I am the first to evolve a systematic method of treatment, carrying it out through a long series of cases and a long series of years, with a uniformly successful result.

My own experience has emphasized the following points, some of which I have never seen mentioned.

(1) In sarcoma of the nose the usual site of origin is in the soft tissues and not in the bony framework which supports them.

(2) That the origin is in the form of a pedicle, which rapidly becomes sessile.

(3) That as the sarcomatous mass enlarges and presses upon the surrounding mucosa, abrasions take place, which are quickly transformed into adhesions; and these adhesions in time will become almost co-extensive with the disease itself.

(4) That these adhesions never attain the vitality and virile power possessed by the pedicle. Hence, when once thoroughly destroyed recurrence does not take place upon the site of the adhesion.

(5) Recrudescence, however, frequently does occur in the region of the pedicle; and in view of this contingency this region should be kept under regular observation and control.

(6) When the nasal passage is filled with the sarcomatous growth any attempt to discover the site of adhesions will at once produce hemorrhage. Hence, intra-nasal removal by the knife should not be attempted; but as gradual and systematic dis-

section out by the cautery knife, except in extreme cases, is always available, it should not only be encouraged but should be insisted upon.

In closing, it may be as well to note that extensive granulation-tissue as well as tertiary syphilis may either of them be mistaken for sarcoma. But the answer in the cases I have reported would be: First, that the growths were larger and harder than those produced by granulation; and secondly, that they were removed and the patients cured by operative measures only, without resorting to specific treatment—something which it is impossible to accomplish in tertiary syphilis by surgery alone. Hence both these conditions may be ruled out of the question.

#### DISCUSSION.

Dr. WISHART.—The opening of the discussion upon such a remarkable series of cases as those just presented by Dr. Price-Brown is a somewhat difficult task, for while every praise must be given to Dr. Brown for what is really a unique record in nasal sarcoma, it still must be confessed that rhinologists are not at all agreed either as to the diagnosis or the prognosis.

Dr. Price-Brown has quoted rather largely from American authors but he might have mentioned also such British authors as McBride, Lack, and Tilley, who are quite as decided in their conclusions that "no treatment other than surgical holds out any hope of success" in sarcoma of the nose. Voltolini it is true refers to electrolysis, but its curative effects are spoken of as "nil."

Cases of nasal sarcoma are by no means rare. In 1902, Gibb, of Philadelphia, published a synopsis of 111 cases culled from the literature. Most cases end fatally, and the demand for curative treatment is urgent, but even in the face of these cases of Dr. Price-Brown, stretching over a period of 15 years without a death, I am unaware that any rhinologist has seriously adopted the procedure which he advocates.

The question is one of diagnosis. The differentiation between a round celled sarcoma, and a syphiloma is exceedingly difficult as Professor Anderson will tell you, and it is also a fact that different portions of the same growth may present wholly different appearances. In the article by Gibb above mentioned

It is affirmed that "unfortunately, the microscope is not infallible. Cases have occurred in which the microscopical diagnosis has been that of malignancy, when the subsequent course of the disease has proven this to be fallacious." Knight also remarks that "implicit faith in the microscope as a guide in diagnosis is not advisable, at least when applied to sarcoma."

It would appear that the very success obtained would according to these views disprove the correctness of the diagnosis. It must again be noted that in many of the cases sufficient time has not elapsed to establish cure.

Sarcoma of the nose is exceedingly erratic in its behavior, as is well demonstrated by a case published by Dr. Levy, of Denver, in 1906. The patient, a woman aged 73, mother to a physician, presented a tumor filling one nasal cavity, a section of which under the microscope was pronounced round celled sarcoma. The case was considered inoperable, Iodide of Potash administered for two months without result, and then Coley's fluid tried with a like result. The patient begging for some air, sufficient of the growth to give a fair passage was removed with the snare, and the cautery applied to the base. Four months later the growth had again become the size of an almond, which was again removed, and declared pathologically to be identical with the first specimen. Metastatic growths also developed on both legs. The nasal growth immediately reformed on a larger scale, the nose swelled and the patient was sent home to die. One year later, no further treatment being applied, the nose was found to be quite clear, the scar of the cautery was plainly seen as a furrow, the breathing was good, and all the metastatic growths but two had disappeared. The original specimens were sent to Dr. Welsh, of Baltimore, who declared them to be unmistakably sarcoma. Three years from the first examination, the patient died from exhaustion, due to the rapid recurrence of the tumors in the legs, but the nose remained free to the end.

Dr. Price-Brown's cases are further peculiar in the growth being confined to the nasal cavities proper, whereas many of those reported by others involved the ethmoidal regions, and the antrum.

Dr. Price-Brown is to be congratulated upon the comfort

his treatment has afforded to his patients, even if the rhinologists have not yet seen their way to the belief that he has discovered a "specific" for nasal sarcoma, and we would urge the necessity for repeated microscopical examinations by acknowledged pathological authorities, and also for the prior exclusion of syphilis by appropriate treatment.

Dr. H. B. Anderson congratulated Dr. Price-Brown on the very interesting series of cases he had presented and the remarkably successful results he had obtained. These results, obtained in a condition ordinarily regarded as so hopeless, were worthy of the most careful consideration by the medical profession. The discussion naturally turned on the accuracy of the diagnosis of sarcoma. He quite agreed with Dr. Wishart as to the difficulty of drawing certain conclusions from microscopic examination alone. At times even the most expert pathologist might be in doubt or error, basing his opinion solely on the histological characteristics presented. In every doubtful case, the clinical features of the case should be considered in connection with the microscopic examination. Clinicians were too ready to accept as final the laboratory report. What impressed him most with the series of cases presented by Dr. Price-Brown, especially the first one, was the fact that the clinical course and microscopic findings were completely in accord.

The growth itself was large and involved the tissues widely. It presented the gross appearances of sarcoma, it had recurred after previous removal by operation and presented the microscopic characters of a sarcoma. He cited cases of tumors pronounced by the most expert pathologists as sarcomatous, which had subsequently disappeared, and referred to a remarkable case coming under his own observation. The case cited by Dr. Wishart, of the sarcomatous tumor of the nose which had completely disappeared and the subsequent development of a metastasis in the leg, to his mind rather strengthened Dr. Price-Brown's position as indicating the possibility of local disappearance. Referring to the case which he had himself examined for Dr. Price-Brown, he stated that he had come to the conclusion that the condition was sarcomatous after a careful examination and with due regard to the difficulties presented by tissues of this sort. Of the more recent cases presented in Dr. Price-

Brown's series, sufficient time had not elapsed to warrant conclusions as to the ultimate results. Under any circumstances one could hardly hope that in cases of sarcoma of the nasopharynx in general that such uniformly successful results could be obtained as those reported. But if the treatment advocated by Dr. Price-Brown was successful in eradicating even an increased percentage of such growths, it was a great step in advance, and he was to be congratulated on his achievement.

Doctor Primrose congratulated Doctor Price-Brown on the results he had obtained in the treatment of the cases he had described.

The question had been raised as to the nature of the tumors removed and the difficulty which often arises in recognizing true sarcomatous new growth. One can recall instances of tumors which presented the clinical appearances of sarcomatous development, and on removal of a portion of such a growth for microscopic examination, the pathologists have considered its nature that of a sarcoma, and yet subsequently one has been surprised to learn of its disappearance without operative interference. These instances are rare, but they have occurred in the past; with improved technique and a wider knowledge of the life history of these growths, both from the clinical and pathological standpoint, the possibility of error is less than formerly.

At the present time there is a great deal of interest taken in the study of the spontaneous disappearance of malignant growths. Even in cases of chorion epithelioma, than which no more malignant tumor appears, spontaneous disappearance has been recorded several times. It has been hoped that by studying the conditions under which spontaneous disappearance of malignant growths take place some clue might be obtained to some more efficient method of treating such cases. In the cases which Dr. Price-Brown has described, Dr. Primrose would like to ask if there is any possible advantage claimed by Dr. Brown in the use of the electro-cautery which might result favorably in the prevention of the recurrence of these growths; how was it that Dr. Brown, by the use of his method, should obtain such good results when other surgeons have failed who had carried out what were apparently equally radical methods of dealing with sarcomatous growth?

Whatever the explanation may be as to the nature of the growth, or the special method of removal, Dr. Brown is certainly to be congratulated on what we must concede to be brilliant results.

Dr. John Hunter—Dr. Price-Brown has written a new chapter in the treatment of sarcoma. His method is thoroughly radical without the destruction, or removal, of normal tissues.

It is a subject for congratulation, that a Canadian, and a member of the staff of the Western Hospital, has originated and carried out successfully a method of removal of sarcoma of the nose from a series of patients who, from all clinical and microscopical evidence, were doomed. This new method of treating sarcoma seems to be not only scientific, but thoroughly rational, notwithstanding the gloomy pessimism permeating the quotations made from the literature on this subject. The future will doubtless prove that whenever this method is resolutely followed the prognosis, in cases of sarcoma within the nares, will be equally as favorable as when this disease is found in any other part of the body, where a radical operation can be performed successfully.

Dr. W. J. Wilson said he was very much interested in Dr. Price-Brown's cases, especially as he had seen the one of seven years' standing at the beginning of his treatment. The case at that time looked hopeless.

The case where the antrum had been diseased and where death resulted from sepsis was also of interest, as for many years previous he had been Dr. Wilson's patient, as also was his father, who, at death, showed on post mortem a cancer of the stomach, which had given no symptoms and had not been diagnosed. The argument put forth by Dr. Wishart that cases may occasionally recover spontaneously, and that the pathologists may have been mistaken in their diagnosis, would hardly hold for such a list as Dr. Price-Brown presents. That argument would make it appear that where the patient died the pathologist was right, but where he recovered it must have been either syphilis or tuberculosis.

Dr. Price-Brown's reply. Mr. Dean, ladies and gentlemen. While I thank you for your cordial attention and for examination and discussion of the cases presented, I desire particularly

to thank the University men for taking such an active part in the consideration of my paper, and for their approval of the results shown, no matter how much they may question the correctness of diagnosis.

After quoting English authors, Dr. Wishart, in expressing their views, says: "It would appear that the very success obtained, according to these views, disproves the correctness of diagnosis."

My answer is that case 1 was first seen by the leading laryngologist of Hamilton. It was diagnosed by him clinically and pathologically as sarcoma. After consultation with other surgeons it was decided that the only hope of recovery would be by radical operation. This was declined. The youth was then taken to a Boston hospital, and part of the growth taken away intranasally, followed by a rapid recurrence. He then came under my care. For the third time microscopical examination pronounced the disease to be sarcoma. The growth filled the right nostril and naso-pharynx, and the hemorrhages from it were exceedingly severe. In this case there has been no return in fourteen years.

Case 3, eight years ago, was placed in Dr. Wishart's hands for treatment. Microscopically and clinically he pronounced the disease to be sarcoma. Radical operation was arranged to be done at the General Hospital. This was declined. Later on he was referred to me. Microscopical examination of a section I removed confirmed the diagnosis. The history of this case already reported states that the last operation was two and three-quarter years ago. There is no return. Surely Dr. Wishart cannot doubt the correctness of diagnosis in either of these cases.

Case 2 was a working man aged 50, father of a large, healthy family. There could be no suspicion of syphilis in his case. He had no specific treatment. No return after seven years.

These facts should dispose of the first three cases.

In reply to the remark that my paper confines itself to nasal cases, my answer is that it accords implicitly with its title. I neither profess nor believe that antral sarcoma can be cured by electro-cautery operations, as in these cases there is always extensive bone involvement. Still, the fact that fimbriated ex



tremities of sarcomatous tissue may extend into the maxillary antrum or sphenoid sinus, so long as they have no attachment within the cavities, does not affect the possibilities of removal by electro-cautery methods. In case 3, the anterior wall of the sphenoid sinus was absorbed and sarcomatous fimbriae partly filled the cavity. In case 6 a similar condition existed in reference to the right maxillary antrum.

I fully approve of Knight's opinion, as quoted by Dr. Wishart, that: "Implicit faith in the microscope as a guide to diagnosis is not advisable." But when the microscopic findings fully endorse the clinical history, I agree with the majority of specialists in approval of the diagnosis. In reference to the three most recent cases, I agree with Dr. Anderson in the belief that sufficient time has not elapsed to warrant a positively favorable prognosis. But when we consider that in one of these there has been no return since the operative treatment was finished seven months ago, and that the man feels perfectly well to-day, the outlook is a hopeful one.

In reference to the other two, Nos. 6 and 7, although over two months has elapsed since either of them were operated on, no recurrence has taken place. Yet regrowth may occur at any time, and each patient will need assiduous watching for months to come—possibly, as in the case of No. 3, even for years, until final eradication has been accomplished. One remarkable thing about all cases of nasal sarcoma is, judging purely by my own personal experience, that these patients are not only willing, but anxious, to have the operation repeated as frequently, and for as long a period, as the operator deems necessary.

In answer to Dr. Anderson's remark that: "Under any circumstances one could hardly hope that in cases of sarcoma in the naso-pharynx such uniformly successful results as those reported could be obtained." I may say that in each of cases 1 and 3, the origin of the sarcoma was in the naso-pharynx. Both cases cured. In cases 6 and 7 the origin was also in the naso-pharynx. Both cured for the present but under observation.

Dr. Primrose's remarks upon the spontaneous disappearance of malignant growths I highly appreciate. It seems to me that this accords with the method of destruction that I advocate.

the operations being confined almost entirely to the removal of the new growth.

In answer to Dr. Primrose's question as to a possible advantage which removal by electro-cautery may have in preventing recurrence of the sarcoma, I may say that I am very glad that the question has been asked. It opens up a new field of enquiry, and I believe the answer awaits us. Sarcoma of the nose is an intensely hemorrhagic disease. The blood vessels and blood spaces contained therein possess no contractile power. Hence, when cut by knife or cautery they bleed profusely at once. The heat of the electric knife, however, coagulates the fibrin in the external adjacent tissues, and stops the bleeding, putting an end to both exosmose and endosmose, so that while checking the flow of blood, it also checks the absorption of cell life, and is a strong barrier against the local extension of the disease. You ask what proof have I to corroborate such a statement? Simply this, that, notwithstanding the intensely hemorrhagic nature of the nasal sarcoma, yet I never, after an electro-cautery operation, leave a tampon in the nose to prevent hemorrhage, no matter whether I operate ten times or twenty times or fifty times in the one nasal cavity. The patients whom you have seen to-day will all tell you the same story.

Of course, when operating you must always be guided by good judgment and personal experience, and never operate too much at one time. Also, while cauterizing, a sudden gush of blood may call for immediate packing with absorbent cotton at the site of the blood flow. But in a few seconds or minutes the flow ceases and the wool can at once be gently removed. And there will be no return of the bleeding. This process may be repeated as long as operations are required.

In closing, some of the speakers have fancied that I have mistaken tertiary syphilis or gumma for sarcoma. While doing so, they have not contradicted my statement that every experienced surgeon knows that you cannot cure a large, pronounced syphaloma by operation only, but must combine with it a course of specific treatment. Yet my cases have had no specific treatment. Not having any history of syphilis, they have been treated by operation only; and while the early ones are entirely cured, the more recent ones are at least temporarily well and seemingly free from the disease.

## ARTIFICIAL LIGHT AND ITS EFFECTS UPON THE EYE\*

BY JAMES M. MACCALLUM, M.D.

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So much work is done by artificial light, and so much complaint made of its injurious effect on the eyes, that it is well to consider the question of artificial lights and illumination. Experience teaches us that our eyes tire much more quickly in doing any given amount of work by artificial light than by daylight. Assuming the bodily conditions to be constant, this must be due to a difference either in the amount, or in the quality of the light, or to some faulty arrangement of the light. Light is not a physical quantity, but is the physiological effect exerted on the human eye by certain radiations. The physicist defines light as a form of energy. There are many forms of energy, as electric energy, heat energy, radiant energy, and all convertible into each other. Radiant energy is a vibratory motion of a hypothetical medium, the ether. Radiant energy can be derived from heat energy by raising a body to a high temperature. From the heated incandescent lamp filament, for example, the heat energy issues as radiations of different frequencies, *i.e.*, of different wave lengths. The waves of light are transverse, while those of sound are longitudinal.

We are all familiar with low and with high notes, and know that they are due to less or greater frequency of vibration of the sound waves. We easily appreciate the fact that there may be notes of such slowness of vibration, or of such frequency, that the human ear cannot perceive them. Just as the human ear perceives as sound only certain frequencies of sound wave, so also only certain frequencies of light waves are perceived as light by the eye. Frequencies, lower as well as higher, are invisible. The invisible rays of lower frequencies are called infra red or heat rays. The rays of higher frequency are known as ultra-violet, chemical or actinic rays. Of these three kinds of rays given off from every light source, only the visible rays and the invisible ultra-violet affect the eye and demand consideration.

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\*A paper read before the Ontario Medical Association, June, '09.

The eye is a physical organ not a mere camera. It has become habituated to, and adapted to, light coming obliquely from above, and resents strong illumination, natural or artificial, from any other direction. Bright sunlight, because of its reflection, as well as because of its intensity, is not desirable. But the general properties of sunlight must be sought in ordinary artificial illumination, namely steadiness, absence of pronounced color, downward oblique direction, wide and strong diffusion, freedom from sharp and black shadows.

The ideal light is the diffused light of a room with good window surface looking to the north. The direct sunlight being excluded, the candle power ranges from 5 or 6 near the window to a half candle or less in the darker parts. One never tries to make a room as bright as by daylight; one is content if the desk upon which he is working or the book which he is reading is sufficiently illuminated. The important thing is not the amount of visible rays coming from the source of light, but the amount of light which reaches the object seen; *not the light, but the illumination from the light.* The light as regards its candle power may be ample, but it may be so placed, or so arranged, as not to give sufficient illumination.

Of equal importance is the amount of light which reaches the eye from the illuminated object. This varies with the widening or contraction of the pupil. The eye automatically adjusts itself to the intensity of the light. If there is in the field of vision a source of high intrinsic brilliancy, the eye protects itself by contracting the pupil, and thus receives much less light. If the source of light is taken out of the field the pupil dilates, and more light is actually sent into the eye, although only the same amount strikes the illuminated object; that is to say, a *higher physiological efficiency is obtained. More light may reach the eye, even though much less reaches the illuminated object.* To put it in other words, the candle power may be lessened, and yet by proper management a larger amount of light is made to enter the eye.

The eye is evidently protecting itself not against light, but against the energy of radiation. The energy of radiation, however, is chiefly in the ultra-red end of the spectrum, so that it is the red and yellow rays chiefly which cause the pupil to contract.

The great drawback to all artificial lights is their excessive

brightness. *The immediate artificial source of light must not be too bright in itself, if it is to diffuse sufficient light. If a brilliant light falls upon the retina, the visual purple is exhausted and there results an after image more or less persistent. The eye shifts itself about to get away from the brilliant light, and protects itself by contracting the pupil. The pupil may be so contracted that the rest of the field may be dimmed so much as to interfere with proper vision, quite aside from the fatigue caused by the bright light wandering over the retina as the eye is shifted. To protect the eye from the direct effect of the intense light either a shade is put over the light, to throw its rays downwards—or else a ground glass, which diffuses as well as modifies the intensity of the light.*

The intrinsic brightness of the light is not of much importance optically but physiologically it is of the greatest significance. The injurious effects to the eye increase with the brightness of the naked light, and with the area of the source of light. "No matter what the area may be, the intrinsic brightness per square centimetre of that area cannot safely exceed .75 Hefner candle."

Only candles, flat kerosene, and flat gas burners fall within the limit of safety. The tubular central draft kerosene lamp, now so popular, acetylene, and all incandescent gas lamps should be inclosed in ground glass or matt globes. Incandescent electric lights are still brighter, and their brightness increases with their candle power. The most dazzling of all artificial lights, with the exception of the electric arc light, are the new metallic filament (Tungsten) lamps and the Nernst lamp.

The limit of intrinsic brightness of .75 Hefner candle per square centimetre of illuminating surface is exceeded by round kerosene burner 5 times, Auer incandescent gas light 8 times, Carbon filament 100 times, New Metallic filament 270 times, Nernst lamp 550 times, electric arc 4,000 times.

The striking thing here is the astonishing difference between the electric light and the ordinary flame illumination. The very great intrinsic brightness of the incandescent light is a menace to the eye. If these powerful lights used in offices and houses can be concealed and the light reflected from walls, ceilings, etc., that should be done. If this cannot be done, they should be inclosed in globes so as to appear as uniformly luminous surfaces. The

globes should be made of a kind of glass that absorbs the ultra-violet rays.

Brilliant light direct or reflected should be kept out of the eye, and upon the objects to be illuminated. The proper place for the illuminant is outside of the field of vision. If it cannot be put so, its intrinsic brilliancy should be lessened by diffusion. This is the reason for indirect lighting. Even though a great amount of light is thrown on an object in a room, if the eye is fatigued by seeing the source of light, very little light will enter the eye.

In general terms the iris adjusts itself with reference to the brightest light it has to encounter, so that if there is in the field of vision a source of light of great intrinsic brilliancy, the working illumination may be highly unsatisfactory. This principle coupled with retinal fatigue explains how one is unable to see beyond a brilliant light, *e.g.*, the search light of an automobile. If when reading by artificial light correctly placed another bright source of light is placed so that its rays fall directly on the eye, the print at once seems to become dimmer.

It is often asked why moving pictures are so tiring to the eyes. It is not merely the movement. It is due to the flickering of the arc lamp on the alternating current. Even with fixed objects the flickering of the arc lamp is visible at 40 to 45 cycles. By moving a pencil or the finger quickly when strongly illuminated, these fluctuations are easily detected even at 60 cycles. It is not so well known that ordinary electric lamps on an alternating circuit distress the eye by flickering. A 16-c.p. lamp at 100 to 120 volts shows flickering at about 30 cycles per second; at 25 cycles the flickering is very annoying to the eyes; at 20 cycles it is most intolerable. If one looks directly at the light the filament is so dazzling that the fluctuations of the lamp are not noticed. A low frequency lamp may appear to be quite steady and yet distress the eye.

Seeing takes place by the recognition of differences in color and in intensity. Differences in intensity include shadows. Shadows are essential in seeing. We must have some shadows. If there are no shadows there is an appearance of flatness which distresses the eye accustomed to perceive form and position by shadow. If there are no shadows we depend on binocular vision to locate form and position, and we feel at once the strain.

When there are no shadows the illumination must be nearly equal from all directions. If the illumination be strong enough from any particular direction to be convenient for work requiring close attention of mind and eye then (if there are no shadows) equally strong light will enter the eye from directions altogether unwonted. This is objectionable, for the eye, as we all know, dislikes crosslights.

In some cases shadows are objectionable, *e.g.*, if the shadows are very dark, for then the eyes are tired by trying to see in the shadow. In other cases shadows are necessary for clear distinction. A room with white walls is not as agreeable as one with darker walls. There seems to be too much light. Yet there cannot be too much light, for there is not nearly as much light as there is in the daytime out of doors. There is too large a percentage of diffused light. The intensity of the diffused light is too great as compared with the directed light. The shadows are lost and the eye is tired.

Illumination is general or local (concentrated). We obtain our illumination, either by first, direct, or second, indirect lighting. The rays from the source of light pass directly to the illuminated object, or indirectly either by passing to a reflecting surface, thence to the object, or by passing through a refracting body to the object, as the frosted incandescent lamp globe, or the opal globe of the arc lamp.

Of course a good deal of light is wasted by reflection and refraction. Indirect lighting by reflection or refraction is done by a reflector, or a holophane, or frosted globe, or by reflecting the light from the ceilings and walls. White walls, of course, give the highest efficiency of reflected light.

In the school-room or concert hall general illumination is needed, for they demand a uniform fairly high intensity of light.

In the house the problem is to get sufficient directed light (from windows), and sufficiently low diffused lighting (reflected from the walls), to give the best vision. But at night, with the electric light, or the gas light, sending out light in all directions, the amount of diffused light is much greater than in the day time, and the directed light much less. This strong diffused light is not comfortable to the eye. For this reason the walls are shaded, so that a great lot of light (about 3-4) is absorbed. The

object should be to give sufficient directed lighting on the dining or reading table, and only so much diffused lighting as is compatible with the amount of direct used. The quality of the light must also vary according to the colors and shades used in the room.

On the desks of an office there is needed a moderate general illumination, and a far more intense local illumination, thus avoiding dense shadows and dark corners. A very intense general illumination would do in this case, but is not economical, and the glare is blinding.

The old rule for reading and writing is that the light should come obliquely over the left shoulder. By receiving the light from this direction direct light is kept out of the eyes. Any light regularly reflected is generally out of the way. The eye catches then only diffused light from the paper before it, and if the light comes from the left (for a righthanded person), the shadow of the hand and arm does not interfere with vision. If work, requiring both hands is being done, the best illumination is had by directing it downwards and slightly from the front, care being taken to avoid strong direct reflection into the eye.

Avoid glare direct or reflected, and get strong diffused light from the object illuminated.

What amount of illumination is needed?

For ordinary reading and writing an intensity of a candle foot is needed. With ordinary type set solid or with the smaller types (diamond), two candle feet is often needed. The quality of the ink and paper are, of course, important factors. Highly glazed paper is said to reflect 80 per cent. of the light. At 1-10 or 2-10 of a candle foot, reading is hard, and there is the tendency to bring the reading close, straining the accommodation.

This minimum of one candle foot should be doubled for really effective lighting. For much fine detail and work on colored materials not less than 5 candle feet should be provided. This also may be doubled for the finest mechanical work, such as engraving, watch repairing, and similar delicate operations. For such cases the more light the better, provided the source of light and direct undiffused reflections from it be kept out of the eyes.

Practically all methods of lighting are based upon incandescence. Incandescence means that the temperature of the



heated body is raised to such an extent that some of the radiations from it become visible as light. The higher the temperature the more radiations visible as light, and the more ultra-violet rays. The problem is to reach as high a temperature as possible. In the gas flame and the coal oil lamp this temperature—that of combustion—is rather limited. In the incandescent carbon filament lamp it is limited by self destruction of the incandescent body. The temperature of the gas flame may be increased by increasing the rapidity of combustion, hence the flat slit instead of the round flame, giving a larger surface to the flame. It has also been increased by using a gas of higher chemical energy, viz., acetylene. (The acetylene flame is white, ordinary gas is yellow).

By increasing the energy input (voltage), we increase the temperature of the carbon filament, but at the same time we more rapidly destroy it. Replacing the carbon filament by some more refractory material (osmium, tantalum, tungsten), permits of the temperature being raised still higher.

The oxides of the refractory earths, thorium, cerium, etc., used in the Auer (Welsbach) gas mantle give an abnormally large amount of visible rays, making them very efficient incandescent bodies.

Sunlight is practically not very rich in ultra-violet rays, as they are absorbed rapidly by our atmosphere, and at the same time a considerable portion of them is lost by multiple reflection before reaching our eyes.

Some of the ultra-violet rays of many artificial illuminants are absorbed by the glass globe surrounding the source of light. The glass of ordinary spectacles also absorbs some of them. Only the very short waves—shorter than 300 micro-millimetres are so absorbed; and these are the least dangerous, because they penetrate least into the human body. The most efficient, and therefore the most dangerous ultra-violet rays are those between 300 and 400 micro-millimetres in wave length. Ordinary lamp glass and spectacle glass do not absorb these rays at all.

Ordinary protective spectacles and eye-glasses allow these (blue) ultra-violet rays to enter the eye. Smoke gray spectacles reduce their intensity, but do not extinguish them entirely—but at the same time they diminish the total illumination.

The percentage of ultra-violet rays has increased greatly with the increased temperature and intensity of our artificial lights.

The ordinary arc lamp which is, from the intensity of its heat, the richest in ultra-violet rays, is not used for ordinary household or office illumination, so that it need not be considered. It is very problematical whether the other varieties of electric lights have sufficient heat to be worth considering as to their ultra-violet rays. It is with them chiefly a question of intrinsic brightness.

Patients with asthenopia often complain of the effect of gas light upon their eyes. Any room lit by gaslight should be well ventilated, for two gas burners to illuminate an ordinary room will throw off as much carbon as ten people.

Aside from its effect on the air, the average gas light is arranged to illuminate the ceiling rather than the room. Even when properly arranged the gas is very apt to flicker, either because of the varying pressure or from defect in the tip. This irritates the eye, because the constantly varying illumination demands a constantly varying pupil and accommodation. The ideal light is steady, does not flicker and does not give off too much heat. The asthenopic eye is intolerant of heat.

The students' or table gas lamp is easier on the eyes, probably merely because of being arranged both as to position and as to shade, so as to give better illumination than the ordinary gas light.

Time and again patients remark that they find the Auer light softer and less trying than the ordinary carbon filament electric lamp. It is easier on the eye because it does not exceed, to the same extent as the electric lamp, the standard of intrinsic brightness—.75 Hefner candle per square centimetre of illuminating surface. It has not so many ultra-violet rays, and to many eyes its bluish-white or greenish-white color is more pleasing than the yellow of the carbon filament lamp. Some eyes seem to react more to one color than to another.

The electric lamp has the great advantage over all others of not in any way affecting the air of the room, and of practically not heating the room, for we do not need to consider the electric arc lamp with its intense heat, and its disagreeable hissing sound, due to the heating and cooling of the air.

The ordinary carbon filament lamp is capable of only giving a certain candle power. It cannot be used on currents of very

high voltage (thus increasing its incandescence (like the arc lamp). The life of the carbon filament is very limited. Carbon can scarcely be melted, yet it volatilises very easily at a high heat. This volatilised carbon deposits itself on the glass globe, blackening the lamp and lessening its candle power. One starts off with 16 candle power, but very soon it is far from that, and one is having insufficient illumination. With this volatilisation the filament soon becomes thinner and breaks.

A great objection to the plain carbon filament lamp is that the filament is placed in such a way as to throw a band of light and then a shadow, another band and another shadow, so that as the eye passes over the page it passes from light to dark, light to dark and must accommodate itself to each. It really is the same thing as a flickering oil or gaslight.

To obviate this, and to protect from the excessive intensity of the filament the bulb is frosted. While this is done at the expense of diminished directed light, it, in the way already pointed out, practically results in increased illumination.

The advance made by the incandescent gas mantle has necessitated improvement in the carbon filament. The electric light with tungsten filament will inevitably supersede the carbon. It gives, roughly, 50-c.p. for the same expenditure of electric energy as a carbon filament of 16-c.p. Its candle power does not vary to the same extent. its life is longer, its filaments are so arranged that the band of light from one fuses with that of another, so that there are no alternate bands of light and shadow. Its intrinsic brightness is much greater, and hence it needs still more to be frosted, so as to diffuse the light.

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|  | <h2>School Hygiene</h2> |  |
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The educational world moves on in the direction of the medical inspection of schools. The Commission of Education for the United States, the Hon. Elmer Ellsworth Brown has just issued Vol. I of his annual report for the year ended June 30, 1909 from the Government Printing Office at Washington. Education for Health is sympathetically treated in the Report and the Commission speaks first of all of the International Congress on Tuberculosis as a means of Education, then of the establishment of a Department of Preventive Medicine Hygiene in Harvard, so that men may be prepared to serve on Boards of Health, investigate epidemics, etc. During the year Medical Inspection of Schools has been provided for by enactment in Louisiana, Colorado, Indiana, Ohio and New Jersey, and traveling physicians have been appointed for the first time in the Alaska School Service, whose duty it is to treat the sick amongst the Eskimos and Indians and teach them how to live in a healthy way.

Open air schools for tuberculosis children have been established in Boston, Brooklin, Providence, New York, Pittsburg, Chicago, etc. The commission also mentions the work of Drs. Gulick and Ayres of the Russell Sage Foundation, on Medical Inspection of Schools and refers to the approach of the Third Congress of School Hygiene, in Paris, August 2-7, 1910.

The regulations for the St. Louis Medical School Inspectors, which are admirable, are given in full in another part of the report and finally the report of the British Royal Commission on the Feeble-Minded, is ably reviewed so far as it refers to children. The review concludes thus: "One conclusion stands out with marked distinction, namely the importance of such adjustments of the public provision for education as shall meet the capacities and conditions of defective children without detriment to the great mass of children who are of normal health and capacity."

ABSTRACT

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**Uniformity of Vital Statistics.**—J. N. Hurty, Indianapolis (*Journal A. M. A.*, December 12), insists on the importance of correct vital statistics and their uniformity in the different States. This can be secured by following the principles laid down in the circulars issued by the Bureau of the Census, and more especially the one entitled "Legislative Requirements for Registration of Vital Statistics," which, he says, should be incorporated in all laws enacted for the purpose. The greatest difficulty experienced in Indiana in collecting accurate mortality statistics has been in the use of indefinite terms for the causes of death; the difficulty in securing reports of all deaths is not so great, as this can be enforced by law. The securing of records of births is obviously more difficult than the securing of death records, and in neither case can absolute accuracy be secured. Promptness in the report is extremely desirable, and Hurty thinks that the ten-day period allowed in the bill of the Committee on Vital Statistics should be changed to one day. The post-office address of the mother is also very desirable, as it is to her that it is usually necessary to appeal for the name of the child. For these and some other reasons, some additions have been made to the recommended blank form, by the Indiana State Board of Health. One of these was added for sanitary reasons only, viz., Were precautions taken against ophthalmia neonatorum, which he thinks is justifiable on a birth certificate, though it might be criticised from a purely statistical point of view. The form of letter sent to mothers asking for the name of the child is reproduced in full. Only occasionally does it fail to receive an answer, and it also presents the opportunity of sending, without an additional cost, a leaflet on the proper care of children. It is also found that in other ways it has the missionary effect intended.

# The Canadian Journal of Medicine and Surgery

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THE STATUTORY MEMBERSHIP OF THE COLLEGE OF  
PHYSICIANS AND SURGEONS OF ONTARIO

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UNDER the provisions of the Ontario Medical Act, Section 6 (1) provides that the Council shall be composed of the following persons:

“(a) 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, 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.

(b) Five members to be duly elected by the licensed practitioners in Homœopathy, who have been registered under this Act, or under the provi-

sions in that behalf of any Acts mentioned in Section 3 of this Act.

(c) Seventeen members, to be elected in the manner hereinafter provided, from amongst and by the registered members of the profession, other than those mentioned in the preceding clauses of this Section.

(2) 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."

At a regular meeting of the Ontario Medical Council, held December 9th, 1909, a report of the Legislative Committee was presented, which advised a change in the wording of Section 6 (1) (a) of the Ontario Medical Act, and showed that sub-section 2 of the same section was, and had been, violated. The committee reported that, in its opinion, the University of Toronto, Queen's University, Kingston, and the Western University, London, were the only educational institutions entitled to representation in the Council. At present there are eight collegiate representatives in that body, viz.: Dr. Britton, University of Toronto; Dr. Ryan, University of Queen's College; Dr. Moorehouse, Western University; Dr. Starr, University of Victoria College; Dr. A. J. Johnson, University of Trinity College; Hon. Dr. Sullivan, Royal College of Physicians and Surgeons; Dr. J. A. Temple, Trinity Medical College, and Sir James Grant, M.D., Ottawa University. In accordance with the wording of clause (a), Sec-



tion 6, of the Ontario Medical Act, the five last-mentioned gentlemen are still qualified to sit as members of the Council; in the opinion of the Legislative Committee, they should be legislated out of existence as members of the Ontario Medical Council. After this recommendation had been discussed in Council, it was referred back to the Legislative Committee for further consideration.

Of course, there is no reason why clerical accuracy should not characterize the wording of the Ontario Medical Act. Then, why was this clause not amended by the Legislature many years ago? Why perpetuate an absurdity, by continuing to grant representation in the Ontario Medical Council to Universities and Colleges, which do not, and will not, support a medical faculty? Should the University of Trinity College pull her neck out of the yoke and resuscitate her medical faculty, a place could be found her for one representative in the Ontario Medical Council. Now she has two there, although she has no medical faculty.

It may be that the seventeen territorial representatives in the Council think that eight collegiate representatives are too many. It may be, that even five collegiate representatives would be too many; but if the University of Toronto were allowed to have three representatives, the Queen's University and College of Kingston one representative, and the Western University of London one representative, the representation in the Council of all other colleges being abolished, the proportion between collegiate

and territorial representatives would seem fair enough, and the teaching bodies would still preserve a sufficient influence. With five homœopathic representatives, as at present, such a Council, twenty-seven in number, ought to be large enough to transact the business of the College of Physicians and Surgeons of Ontario.

The Legislative Committee also expressed the opinion that no teacher, professor or lecturer of any of the bodies mentioned in clause (a), Section 6, of the Ontario Medical Act, should hold a seat on the Council except as a representative of the body to which he belongs, thus quoting the exact words of sub-section (2), Section 6, of the Act. Now, Dr. F. N. G. Starr sits as a collegiate representative in the Council, representing the University of Victoria College. As a professor, lecturer or teacher of the University of Toronto, he is not qualified to represent in the Council any other university or college except the body to which he belongs, viz., the University of Toronto. The University of Toronto is by the Act entitled to one representative on the Council, and it already has one, Dr. Britton. Hence it follows that Dr. F. N. G. Starr, who is a lecturer in Toronto University, has no *locus standi* as a member of the Ontario Medical Council.

Another member in the same position as Dr. Starr is Dr. J. A. Temple, an emeritus professor of the University of Toronto, who also represents Trinity Medical College in the Council.

In reference to both these gentlemen, it will be

evident that, in our opinion, they are hard hit. They ought to choose between the Council and the University of Toronto, at least, until the action of the Legislature so amends the Ontario Medical Act, that they can be legally permitted to serve in both these bodies at the same time.

J. J. C.

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#### MEDICINAL TREATMENT OF SUBACUTE AND CHRONIC GOUT

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As gouty subjects are more prone to suffer from the injurious effects of constipation, of even a slight degree, than are non-gouty individuals, purgatives should be combined with colchicum in the treatment of gout. From personal experience, we can recommend a pill made of half a grain of extract of colchicum, half a grain of podaphyllin, and two grains of extract of aloes, the dose to be repeated according to the requirements of the case. A milder remedy than colchicum is guaiacum resin, which may be given as an alterative to stimulate the metabolism of the liver, and relieve an engorged portal system. From five to ten grains of guaiacum should be given in cachets two or three times a day, according to its effect on the bowels, since guaiacum sometimes acts as a laxative. This method of giving powdered guaiacum in cachets is preferable to giving the tincture of guaiacum in a mixture, as in the latter form a nauseous medicine is produced and the precipitated resin tends to cling to the tongue and fauces of the patient. Free

diuresis should be produced by the drinking of sufficient quantities of pure water. The citrate of potassium or the bicarbonate of potassium may be also used with advantage as a diuretic to encourage the elimination of the toxic agents of gout. The potassium salt is converted into a carbonate in the kidneys, and serves to diminish the acidity of the urine, which is generally high in connection with the gouty paroxysm, while, at the same time, it increases the solvent power of the urine for the uric acid salts, and so assists in their elimination.

In cases of sluggish action of the liver, gastro-intestinal catarrh and torpor, gouty dyspepsia and other forms of irregular gout, in which there are no appreciable uratic deposits in the joints, the moderate use of mineral waters containing sodium salts is beneficial, owing to the action of these salts as hepatic and gastro-intestinal stimulants. As much cannot be said for lithia salts, which are very much used as remedies for gout. The principal objections to lithia are its toxicity and its depressing action on the heart. To offset these dangerous characteristics, it is used in such small doses, that any real therapeutic effect from it is open to serious doubt. The regular use of lithia as a curative for the gouty diathesis is not good practice.

In marked cases of the gouty diathesis, the joints, especially the joints of the hands and feet, become enlarged and tender owing to two causes: the deposition of sodium biurate in the cartilages and fibrous tissues of the affected joints, and a chronic inflam-

matory thickening of the fibrous tissues of these joints. For the reduction of this thickening, as well as for painful gout of the sole of the foot, and for gouty neuralgic affections, iodide of potassium may be administered internally in doses of ten grains three times a day, and this medication ought to be continued for a considerable time.

Plethora from high living and lack of exercise induces a rise of blood pressure, which, if long continued, causes an injurious strain on the arterial walls. Hence the necessity of a spare diet in gout, together with moderate exercise in the open air. The occasional use of the colchicum pill mentioned above, by eliminating toxins, will tend to prevent arterial disease and recurrence of gouty paroxysms. J. J. C.

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**WHY ARE NOT TORONTO SCHOOLS MEDICALLY  
INSPECTED ?**

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THE subject is not a new one. It has been under discussion for several years, so why has not Toronto medical inspection in its numerous Public Schools, we may again pause and ask one another. Not because there is no real necessity for it, not for lack of interest on the part of the National Council of Women, for, for years past, the earnest President of one of their branches has besieged the powers that be, voicing their request for proper medical inspection of the school children. They have brought concise and unanswerable arguments to show that it

must be sooner or later, and if later, and an epidemic "breaks out" among the children, they will know upon whose shoulders the blame and penalty should fall.

The representative medical body of the profession in Toronto, The Academy of Medicine, adopted recently the following resolution:

Resolved, 1. That the Academy of Medicine hereby recommend that medical inspection of schools be carried out in Toronto as an integral part of our school work and of the public health service.

2. That steps should be taken at once, so that on the re-opening of our schools in September, 1909, a beginning might be made in at least a few schools, for example, Elizabeth Street, McCaul Street and Hamilton Street Schools, in the older and more central portions of the city, where the school population is large, and the foreign-born and recently-emigrated citizens are numerous, and where there is much room for improvement in the housing conditions.

3. That as a beginning, two School Medical Officers (to give their whole time to the work) should be appointed, to act under the direction of the Medical Health Officer of Toronto, and that as many School Nurses as may be found necessary should also be appointed.

4. That copies of this abstract and report be forwarded to the Hon. the Minister of Education, His Worship the Mayor of Toronto, the Medical Health Officer of Toronto, the Board of Education, and the

Local Board of Health, and that at the same time we would respectfully draw their attention to the fact that Toronto is woefully behind in this matter, and that its rapid growth, and its large foreign population call for immediate action, so that a state of things unworthy of a metropolitan city like Toronto may no longer be permitted or perpetuated.

Again, upon being asked their views on the subject at issue, the candidates for aldermanic and other New Year honors express themselves before election as simply gushing to see every little school-child medically examined. We sincerely hope that such inspiration will not drop to zero—"when the man is made a hero." So far all things seem ready, only two obstacles perhaps in the way, one the expense, the other the Board of Education itself; surely the expense, if properly apportioned, cannot be enormous, especially when the Board are willing to smilingly use well on to half a million of the people's money to build a new Technical School. It seems almost to be a part of the qualification for office in America to be experts at "straining at gnats and swallowing camels."

On the other hand, the Board of Education may say that the Medical Health Officer is expected to inspect the schools. He has done the best he could, in having given the teachers lectures on Hygiene, etc., but good as far as it goes, it is not all that is necessary to maintain a clean Bill of Health. Teachers could not possibly be expected to obtain medical knowledge enough to diagnose disease by

listening to a few such lectures, when physicians (in the making) spend five years trying to fit themselves to even meekly offer an opinion. Again, teachers are not necessarily all believers in disease, perchance some are Christian Scientists. Our capable M. H. O. is not of that belief, and he carries around with him something, light though it may be, in the form of matter which he terms his body, in which his mind is stored, and as it takes time to "oscillate" this complete outfit from school to school, do his best, and he does, he cannot medically inspect the numerous schools of this city except by "absent" treatment.

All we need add is an R. S. V. P. to the Board of Education, for, "Seigneurs, the house is yours."

W. A. Y.

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#### **SPECIAL MEETING OF THE ONTARIO MEDICAL COUNCIL**

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ON December 7th a special meeting of the Council began which lasted until noon of the 10th, and surely it was an epoch-making meeting. One of the most important subjects that came up for discussion was the proposed amendments to the Roddick Bill, and these, with a number of suggestions that it is thought will tend to make the Bill more workable, passed the Council, and the Legislative Committee of the Council has been instructed to secure legislation enabling the Province of Ontario to participate in the advantage of the Canada Medical Act, otherwise known as the Roddick Bill. The Enabling Clause



will be based on a similar clause of the Medical Act of the Province of Alberta.

The Council had some unpleasant duties to perform, viz., the striking of the names of two members of the profession from the Register, and while the obligation was an exceedingly unpleasant one, the Council did not shrink from what appeared to be its full duty. There is a move on foot, too, to have the Medical Act altered so that the process of investigation will be more speedy, and in the event of a conviction before the criminal courts a registered member may be struck off on proof of such conviction only.

At the request of the Thunder Bay Medical Association, the Council will also seek legislation for the addition of a further territorial representative for the Port Arthur, Fort William and Rainy River district. This will, of course, to some extent, disturb the balance that has been more or less maintained between the appointed and the elected members.

There was also a determined effort made in the Council to dispense with the services of the representatives of certain colleges, and while we fully agree that there should be some alteration in the college representation, still we think the proper course to adopt would be to approach the Legislature and have the Medical Act amended.

During the last morning of the meeting, Doctor J. M. MacCallum made an inquiry regarding the question of expenses connected with the examiners, as he had discovered several apparent discrepancies,

more particularly with reference to mileage. For instance, where two examiners came from the same town, one of them seemed to travel nearly twice as far as the other, and it was felt that there should be some better method of checking over such expenditures than at present exists. We should think this was a matter for the auditor, and now that the members of the Council, have awakened to a sense of their responsibility, we would humbly suggest that some of the officials of the Council—and the auditor in particular—would awaken to the responsibility that rests upon him in checking over accounts. Whether rightly or wrongly, we take no little credit to ourselves for having assisted in the awakening.

W. A. Y.

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#### FURTHER ACCESSIONS TO OUR STAFF

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It affords us great pleasure to announce the names of three medical men of high attainments in the world of medical science who have united with the staff of collaborators of THE CANADIAN JOURNAL OF MEDICINE AND SURGERY:

Dr. Llewellys F. Barker, Professor of Medicine in Johns Hopkins University, the worthy successor of Professor William Osler, and also a son of whom Canada is justly proud;

Dr. J. G. Fitzgerald, Demonstrator of Pathology, University of Toronto; and

Dr. Harry B. Anderson, of St. Michael's Hospital, Toronto.

W. A. Y.

A SUFFRAGIST ENTERTAINED BY THE WOMAN'S  
MEDICAL ALUMNI

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THE Woman's Medical Alumni gave a luncheon and reception recently in honor of that brainy woman and suffragist who recently visited Toronto (from England), Mrs. Snowdon.

It speaks strongly for the cause of womanhood suffrage that in the realm of medical science man has welcomed woman as a confrere in the profession, and no one has ever yet heard the idea mooted to give her a *limited* license to practice. It's a shame not to give a woman anything she asks worthily and nicely for. For one universal reason, just to see the exquisite smile and the flutter of angel wings. It is enough to make a mere man say things that sound like Tom Hood—about bits of "Heaven upon this earth below."

W. A. Y.

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|  | <b>Editorial Notes</b> |  |
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**The Rockefeller Hookworm Commission—**

A commission to carry on a campaign of education for the eradication of hookworm disease has been recently established by John D. Rockefeller, president of the Standard Oil Company, of the United States. A prominent member of this commission will be Dr. Stiles, chief of the Division of Medical Zoology in the Hygienic Laboratory at Washington. Last month we alluded in an editorial note to the scientific performances of Dr. Stiles, Dr. Smith, of Atlanta, and Dr. Looss, relative to hook-worm disease, so that further mention of that aspect of the question need not be made. Dr. Stiles has also shown the advisability of adopting certain practical methods, which would tend to rid the Southern States of this widely diffused disease. He recommends provisions for the enlightenment of the poorer classes of the people as to the ways in which this disease may be acquired, the inculcation of health maxims, and instructions, which, if carried into effect, would protect them from its invasion, together with information as to the employment of suitable remedies for the cure of the disease.

The diagnosis of a disease of pandemic proportions having been made it remained to obtain an agency potent enough to secure its eradication. The Public Health Service of the United States has neither the legal authority nor the necessary funds to carry into effect the programme designed by Dr. Stiles. Mr. Rockefeller proved himself to be the Atlas of the occasion, by establishing a commission to deal with the hookworm disease and providing adequate funds to support the commission.

His achievement, which is unique in the history of medicine.

will find its fulfilment in the rescue of millions of people in the Southern States from hookworm disease and its sequels, thereby restoring them to wage-earning usefulness and raising the standard of health and wealth in that portion of the United States. Besides, the well equipped Rockefeller commission will be placed in a position to do excellent work for medical science and may, incidentally, help to rob socialism of a weapon, by showing that gold that buys health can never be ill spent.

#### **The Migration of Consumptives to the Southwestern States Should be Discouraged —**

In a report published, November, 1909, by the United States National Association for the study and prevention of tuberculosis, it is stated that 7,180 persons hopelessly diseased with tuberculosis annually go to die in the States of California, Arizona, New Mexico, Texas and Colorado, most of them by order of their physicians. Half of these cases are so far advanced in this disease that cure cannot be hoped for in any climate or under any circumstances. Besides, at least 60 per cent. of them are so poor that they have not sufficient means to provide for the proper necessities of life, which means that 4,315 consumptives are either starved to death or forced to accept charitable relief every year. Attempts are therefore being made in Southern California and in Texas to exclude indigent consumptives or to send them back to the Eastern States. A good many consumptives, how many we cannot say, go from Canada to the Southwestern States. Now, consumption when diagnosed at an early stage can be arrested in Canada, and consumptives, rich and poor, should be encouraged by physicians to devote themselves to the hygienic treatment of their disease at home, before it is too late. To further this project, the erection and maintenance of consumptive hospitals in cities, towns and counties ought to be encouraged by medical societies. Looked at from an economic standpoint, it is quite clear that the conservation of

the financial resources of Canadian consumptives, particularly the poorer ones, would be more effectively secured if these patients were treated in Canadian hospitals. The money spent by them in travelling to and from the United States, with the doleful certainty that in many cases the expenditure of money will be in vain, and the fact that the percentage of curable cases of consumption is about the same in both countries, should induce physicians and philanthropists to agitate for the establishment of hospitals for consumptives in Canada, instead of encouraging the migration of these patients to the United States.

#### **Ontario Clinic for Nervous and Mental Diseases—**

In a communication signed by Dr. C. K. Clarke, Medical Superintendent of the Toronto Hospital for Insane and Dr. Ernest Jones, of the medical staff of the same hospital, we are informed that the Ontario Asylum Service has opened an out-patient department under the title of the Ontario Clinic for Nervous and Mental Diseases. Thanks to the Toronto General Hospital, the patients will be seen on Wednesday and Saturday mornings at nine o'clock in the building on Chestnut Street, occupied by the Gynecological Service of the Hospital. The aim of the undertaking is to supply advice and help to the patients, in the application of various psycho-therapeutic measures of treatment. Besides early cases of the psychoses, such as dementia præcox, manic depressive insanity, etc., cases of such mental maladies as obsessions, *folie de scrupule*, *folie de doute*, hysteria, phobias and anxiety neuroses will also be accepted. No cases of organic disease of the nervous system will be treated.

#### **Canadian Cream—**

Bulletin No. 189, (Cream) issued by the Laboratory of the Inland Revenue Department, Ottawa, gives the results of the analysis of 65 samples of cream purchased by the inspectors of the department in 13 out of 15 inspectorial districts of Canada.

This is the first time that a systematic inspection of cream has been made under the Adulteration Act. The work reported shows that the Canadian public is offered and accepts as cream an article varying in butter fat from about 42 to 11.10 per cent. The highest specimen registering 42.66 per cent. butter fat was sold in the District of Quebec, P.Q., the one registering 11.10 per cent. butter fat was sold in London, Ont., the next poorest sample, viz., 11.4½ per cent. butter fat was sold here in Toronto.

The chief analyst recommends that the following definition of cream be made legal in Canada.

(1) Cream is that portion of milk, rich in milk fat, which rises to the surface of milk on standing or is separated from it by centrifugal force, is fresh and clean and contains not less than eighteen per cent. (18) of milk fat.

(2) When guaranteed to contain a higher percentage of milk fat than eighteen (18) per cent., it must conform to such guarantee.

(3) Cream must be entirely free from gelatine, succrate of lime, gums or other substances, added with a view to give density, consistency or apparent thickness to the article.

(4) Cream must contain no preservatives of any kind; nor any coloring matter, other than is natural to milk.

(5) Evaporated cream, clotted cream, condensed cream, or any other preparation purporting to be a cream (except ice-cream) must conform to the definition of cream, as given above and must contain at least twenty-five per cent. of milk fat.

The report closes with the statement that a number of cream thickeners are on the market. Gelatine is a constituent of most of them; but calcium succrate, gum tragacanth and other substances are often present. The chief analyst states that, in the next collection of cream made for analytical purposes in Canada, a systematic examination will be made for cream thickeners.

There is no legal standard for cream in Canada. The

standard mentioned by the chief analyst, is rather low. If, however, a standard for butter fat in cream is to be fixed by the Canadian Parliament, it would be well to place the standard so low that any honest specimen of cream could reach or exceed it.

#### **The Cost of Milk Production—**

In Toronto, to-day, "certified" milk sells for 15 cents a quart "uncertified" milk at the rate of 23 pints of milk for a dollar. In New York "certified" milk sells for 20 cents a quart, "uncertified" milk for nine cents a quart. In Canada and in the United States more elaborate care, more expensive work in dairies increase the cost of milk-production and raise the price of milk to the consumer.

Anything therefore, which serves to lessen the cost of milk-production, while at the same time improving the quality of milk, is of interest to the physician, the dairyman and the consumer.

At the Guelph Fair, Mr. H. H. Dean, professor of dairy husbandry, O.A.C., lectured December 8, 1909 to an audience of farmers on the subject of lessening the cost of milk production. He advised his hearers to pay attention to the health of the cows and to care for them diligently. Feeding must be watched carefully. Many farmers feed their cattle turnips in winter, he said, which accounted for the "turnipy" butter. He advised feeding sugar beets or Ferry's Leviathan Yellow Mangels. Stables should have lots of fresh air. Drinking water should be cool and fresh and in his judgment a cow relished water more when she got it outside. A cow should also be given exercise and should be taken out of the stable every fine day.



In answer to questions Prof. Dean said special cases needed hot or warm water, but as a general rule the cow preferred cold water. Experiments had proved that it was just as good to water a cow once or feed her twice a day, as to have water in



front of her all the time and feed her four or five times a day. He thought the best way to feed cows was to give them what they liked and could readily change into milk. By feeding cows meal or other food, the milk would not be made any richer. Mangels have no adverse influence on the flavor of milk. Some people judge the flavor of milk by its color, which was a common mistake. He strongly emphasized the need of great cleanliness.

Given a good type of dairy cattle, there does not seem to be anything in Prof. Dean's recommendations calling for that increase in the cost of milk production, of which one hears so much nowadays.

J. J. C.

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|  | <h2>Correspondence</h2> <p><i>The Editor cannot hold himself responsible for any views expressed in this Department.</i></p> |  |
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Midland, Ont., Dec. 10th, 1909.

*To the Managing Editor Canadian Journal of Medicine and Surgery.*

Dear Sir,—Like probably many other practitioners in the Province, I read the Annual Announcement to try and glean some idea of what is going on in the Ontario Medical Council. One is naturally interested in what becomes of the money held, or supposed to be held, in trust by the Council for the members of the profession, as well as in the legislation that is being made for us year by year. It is rather a difficult matter to see where we are at in the maze of discussion and controversy, but sometimes one will find some little unsuspecting-appearing remark, one almost smothered in a verbose mass of contradiction that makes one "take notice." Referring to pages 321 and 322 of the Announcement of 1909, Dr. Temple, in the Annual Report of the Finance Committee, says, "\$10,255 of the capital has been spent. No doubt some of this amount has been invested in property, but on referring to the Treasurer's statement at the back of the same Announcement I find that while the balance in the bank on June 30, 1908, was \$48,359.31, at the end of the year the balance has shrunk to \$44,745.17, a decrease of \$3,614.14 in cash balance. During the year the total receipts were \$27,756.77, which, added to the amount taken from the capital balance, makes a total expense for the year, as Dr. Temple puts it, in round numbers of \$31,365 (page 325).

This is a large sum of money and without any details of expenditure it may be difficult to imagine where the money is going. Let us try and find, if possible, some reason for this expenditure, and perhaps the reiterated warning as to the necessity for economy might make us suspicious that there is considerable waste somewhere. Dr. Johnson, on page 330, speaks of the capital or balance in banks as an "inducement to spend."

On pages 337-338, Dr. Moorhouse says, "Expenses have been running up very high and rather lavishly," and also on page 347 he speaks of the expenses of committees. On page 321 we have a reference to a special committee's expenses of \$45. This is surely a very small matter, unless it is that perhaps it may show the way the money is going.

On page 322 we are told, "That there were certain committees had a meeting during the time of the Session, and were paid \$15 for that meeting beside the general allowance."

To return again to the Treasurer's Report—special committees seem to get away with large sums! Examiners' fees lcom up very large also!

Now, Dr. Editor, perhaps you or some of your friends may be able to tell me why travelling expenses are put at 5c. per mile (both ways), when any railroad will sell return tickets for 5c. per mile (one way). Can you tell me, for instance, whether the Examiners attending oral examinations at Kingston, Toronto, and London, are paid mileage from the starting point to Kingston, back to the starting point, then to Toronto, back to starting point, then to London and back to the starting point, or are they paid mileage from the starting point to Kingston, to Toronto, to London, and finally to the starting point? Take some one place and figure what a difference that would make.

Some of these matters might be cleared up to the \$2 contributor if we had a detailed financial statement.

The territorial representative who lives at the Sault belongs to two committees, Education and Discipline, and these two committees are apparently the most expensive we have to support. It is a long way to Sault Ste. Marie, and 5c. per mile and \$15.00 per diem allowance must come high. It certainly would seem too bad to deprive Dr. Gibson of his right to sit on Committees because of expense, but if any other member of the Council was capable of taking his place surely a saving could be made. "Dr." Editor, could you give us the detailed expenditures of these two Committees?

What I would suggest to the members of the Ontario Council—perhaps I am presumptuous, but here it is—Let us have an altered Announcement in 1910; cut out the members' remarks; give us only the resolutions, with mover's and seconder's names,

and yeas and nays; and add a detailed statement of every expenditure; go to the Ontario Legislature and get a Medical Act that you can interpret, and one that will confer power to act, and save us legal expenses of \$746.00, as was incurred last year. (largely in advising the members of the Council whether they could or could not act under the present Medical Act.)

We want economy, but if we cannot have it let us at least have a "run for our money," give us the details.

SIMCOE PRACTITIONER.



### THE ACADEMY OF MEDICINE

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The third slated meeting of the Academy of Medicine was held in the Biological Building of the University of Toronto, on Tuesday, December 7th. President Alex. McPhedran occupied the chair, and Dr. E. J. Hamilton, as of yore, was general secretary. The guest of the evening was Dr. Maurice H. Richardson, Professor of Surgery at Harvard University, who delivered one of the finest addresses that the Academy has so far been privileged to listen to. Professor Richardson's subject was, "The Borderland of Medicine and Surgery," and we hope to publish the lecture *in extenso* for our readers in the February issue. The address was listened to by a large audience with great interest. The Academy is indeed honored by the visit to our city of such men as Professor Richardson, and their kindness in coming to Toronto on such brief visits in order to address the Fellows bespeaks a bright future for the Institution at 9 Queen's Park. Mr. Irving H. Cameron moved a vote of thanks to Dr. Richardson in the following words:

Mr. President,—It is quite unnecessary in this audience to affirm, but still I should like to assure our honored guest, so that he may not carry back a false impression of us, that the Surgical Department of the University of Toronto is not composed of surgeons occupying the questionable borderland which you have made the subject of your strictures. On the contrary, I would desire that the impression of the asperities experienced by the "fellows" at the tire should be so softened and modified in transmission to "The Hub" that he might carry away with him the "Yankee notion" that we are really better than we are. And although I could have wished that it had fallen into abler and better hands to express to Professor Maurice Richard-

son our grateful appreciation of his great courtesy and kindness in sparing time from his much occupation to come so far to read to us his admirable paper on the Borderland of Medicine and Surgery, now that I am on my feet I cannot forbear to say how great a pleasure it affords the Professor of Surgery in Toronto to associate himself with his Brother of Harvard in all the sentiments enunciated in his address. True, it is probable that if there were points of difference I should hardly have the hardihood or the presumption to give them utterance on this occasion, for those who know the great work they are doing in Boston for the advance of scientific surgery fully realize that Toronto, situated at the outer end of the radius, must be content to pursue a parallel and co-ordinate but distant orbit and never hope to approach the centre although it feels the constant tug of its attraction.

Were Professor Maurice Richardson an utter stranger to us, which, of course, a man of his eminence in the surgical world could not be, he would still command the heartiest welcome in our midst on account of three associations: First, as Professor of Surgery in Harvard, and the successor of my highly-esteemed and honored friend, John Collins Warren, of the thrice-illustrious name in Harvard University; secondly, as the Prosector, for six or seven years, of that never-to-be-forgotten ornament of medicine, Oliver Wendell Holmes, whose personal influence as a liberal education the address we have had the pleasure of listening to to-night so abundantly attests; and thirdly, as the assistant of Henry J. Bigelow, whose many contributions to surgery, and not least among them the demonstration of the Y. ligament, which now bears his name, and its influence in the mechanism of hip-joint dislocations and reduction, have laid us surgeons under such a weight of obligation to him. Of Professor Richardson's own achievements I forbear to speak in this assembly. But I would say to him in the words of one of his most distinguished fellow-townsmen, now unhappily gone over to the majority, "It is good for us, O brother, that you came so far to see us." There is a borderland, however, which he did not mention, and my attention was forcibly directed to it by the entrance a little while ago of Dr. Robson, of Liverpool, in company with Professor Rudolf. That borderland is the ground

whereon we stand, a fitting place on which Old England and New England meet. And indeed, it seems to me that, if the one could raise its tariff wall to a reasonable height and the other sink hers to a reasonable depth, this intervening borderland and the once "unplumb'd, salt, estranging sea," henceforth a bond of union and pontoon of passage, would be all transformed into a level plane of commerce, a veritable aequor, over which the Anglo-Saxon would roam at will, and Englishman to Englishman "the world o'er should brithers be, and a' that." To Professor Maurice Richardson our debt is great, our gratitude commensurable. Of him it shall be recorded in the Annals of this Academy and in the time-honored words of Homer, which I refrain from quoting in their original form, that "being well disposed towards us he has argued and spoken amongst us," and we thank him!

Dr. N. A. Powell seconded the vote of thanks in the following words:

Mr. President and Fellows of the Academy,—There has existed amongst us an impression, reaching in some cases almost to the dignity of an opinion, that, within the confines of medicine, only three really great contributions have come from Boston in the last hundred years. These were, of course, Morton's anesthesia, Holmes' demonstration of the contagious character of puerperal fever, and Fitz' paper on appendicitis.

In the school of medicine, which owes its origin to John Harvard, and its re-animation to Pierpont Morgan, there have been many teachers of eminence. Of its past history we may well say that "there were giants in those days." Recently, when wealth and science were combining to provide marvellous facilities for the giving and for the receiving of instruction it can hardly be denied that a measure of apprehension was felt lest men big enough and broad enough to utilize these facilities to their fullest extent might not be available.

In so far as the department of surgery is concerned, all such apprehension is at an end. We saw Henry J. Bigelow succeeded by Warren, a great surgeon and one of the soundest of surgical pathologists, and he in turn followed by David Cheever, to whose brilliant aphoristic teaching it was at once a delight and an inspiration to listen. To-night we have with us the latest

occupant of the chair of surgery, at Harvard, and all here will agree that no abler, no better, and no safer teaching could be given than that to which it has just been our privilege to listen. So long, at least, as he is spared, to fill his present position, the teaching of surgery will be all that the most critical or the most exacting could desire. He has come a long way to address us. He has given us an address worth going a long way to hear.

The December meeting of the Section of Medicine was held in the Academy of Medicine, Queen's Park, on Dec. 14th, 1909, at 8.30 o'clock. The papers read were as follows:

1. Dr. O. R. Maybee—The Pathology of Lobar Pneumonia.
2. Dr. Allen Baines—Some Points in the Diagnosis of Lobar Pneumonia in Children.
3. Dr. A. R. Gordon—The Treatment of Lobar Pneumonia.

#### DISCUSSION.

Dr. Machell spoke of the difficulty of early diagnosis, also the necessity for good nursing and good hygienic conditions and guarding against over-medication.

Dr. John Ferguson also emphasized the necessity for good nursing, plenty of pure air, and the best of hygienic surroundings.

Dr. W. J. Wilson said that while water was valuable, it should be given with care in cases of dilatation. The condition of the bowels should be carefully watched and gas not be allowed to increase so as to embarrass the circulation. Belladonna had proved of considerable value. Preference in treatment should be given to fresh air, careful feeding and good nursing.

Dr. Alexander McPhedran—Believes that the death-rate in pneumonia has been lowered. He condemned indiscriminate drugging, also the pneumonia jacket and poultices. The condition of the patient does not depend on the area of lung involved. When death occurs it is usually due to some circulatory condition. He condemned the use of alcohol and nitro-glycerine, but thinks stimulation by digitalis, strychnine, caffeine and strophanthus is valuable. He believed in early venesection where dilatation of right side of heart exists. Also believed in stimulation by application of alternate heat and cold.



Dr. L. S. Webster thinks opiates are of value in early stages of disease where restlessness and delirium are present.

Dr. Rudolf said that while pneumonia is occasionally epidemic yet is, as a rule, not contagious. Believes in use of alcohol in alcoholic patients. Also in use of opiates for sleeplessness in early stage of disease.

Dr. Harold Parsons believes in good effects of oxygen gas when administered regularly and early enough, especially in cases where cyanosis is present. Believes in use of opiates at times. Says that prognosis in children is fairly good.

Dr. Pepler believes in systematic use of digitalis and strychnine.

Dr. Machell thinks hot pack safer and of more value than opiates in children.

Dr. McPhedran also likes the use of the hot pack. Says that chloral hydrate is valuable for irritable conditions.

Dr. Graham Chambers believes the diet to be an important factor, using, himself, a liberal diet in the early stages and a light diet in the later stages of the disease.

Dr. Mabee, in reply, emphasized the fact that pneumonia should be treated as a general infection.



Dr. Allen Baines, in reply, believes in use of oxygen. Also of opium and venesection, both of the latter to be used with great care in children.

Dr. A. R. Gordon, in reply, stated that he also is in favor of the use of opium where indicated. Also in use of oxygen. Does not agree with Dr. Chambers that heavy feeding should be used in any stage of the disease.

Fifty-two members were present.

N. K. W.

This month the Academy will be addressed by Dr. Llewellyn F. Barker, Professor of Medicine, Johns Hopkins University, Baltimore, a Canadian who, in his work, has done honor to the country that gave him birth.

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|  | <b>News of the Month</b> |  |
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**RETIREMENT OF MISS SNIVELY AFTER TWENTY-FIVE  
YEARS OF SPLENDID SERVICE**

Miss M. A. Snively has resigned her position as Superintendent of the Training School for Nurses of the Toronto General Hospital and has been granted by the Board of that institution as a mark of appreciation of her services a retiring allowance of \$700 a year.

This announcement made at a gathering at the hospital on Dec. 2nd, held in celebration of her completion of 25 years of service in that capacity came as a surprise to the 500 guests and friends who attended.

Mr. J. W. Flavelle, chairman of the Board, occupied the chair.

Mrs. G. N. McPherson, the oldest graduate in the city, on behalf of the Board, the nurses, the visiting staff of doctors and friends, presented Miss Snively with a purse containing \$1,000.

The address was read by Lady Pellatt on behalf of the Alumnae Association. This stated that she had rendered inestimable service, raising the standard of the Canadian nurse to a place second to none in the world.

She had found it a labor and made it a profession. When she commenced her duties in 1884 method was unknown and the daily routine of a nurse was characterized by drudgery.

Miss Snively thanked them heartily for the signal mark of appreciation of her services.

Mr. J. W. Flavelle also expressed the high regard in which Miss Snively was held by the Board. She had approached the Board a year ago and asked to be relieved, but was asked to reconsider the matter and remain a few years longer. This year she again asked for relief as the burden was becoming too heavy. No time was set for her resignation going into effect but she wanted to leave next June.

A large number of people were present at the presentation, including President Falconer of Toronto University, and Mrs. Falconer, Mrs. J. W. Flavelle and Miss Flavelle, Mr. and Mrs. W. E. Rundle, Mr. and Mrs. P. C. Larkin, Dr. J. N. E. Brown, superintendent General Hospital, and Mrs. Brown, Mr. and Mrs. Reginald Pellatt, Dr. and Mrs. H. C. Scadding, Miss Brent, superintendent Hospital for Sick Children, Miss Mathe-son, Supt. Isolation Hospital, Miss Underhill, superintendent Home for Incurable Children, and a large number of other ladies and gentlemen, and nurses who have been trained under Miss Snively.

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#### WAS VOTE LEGAL BY THE DOCTORS ?

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Are all the acts of the Medical Council passed at the sittings just concluded illegal ?

That is the question A. R. Hassard on behalf of Dr. W. R. Cook, whose name has been stricken off the list of medical practitioners, is endeavoring to decide.

"I haven't had time to look into the matter fully," he said to *The Star* this morning, "but I am of the opinion that every-thing that the council did is illegal because men voted at the council who should not have been given seats under the Act.

The Act says that a member is to be chosen from the Uni-versity of Toronto, Queen's University, the University of Vic-toria College, the University of Trinity College, and several other educational bodies."

#### CHANGES SINCE THEN.

"That is the way the Act reads to-day, but it was made a number of years ago, and since then the University of Victoria and the University of Trinity College have been done away with. They used to be separate institutions, but some time ago both of them were affiliated with the Toronto University, and so have lost their identity. My contention is that as a result of the amal-gamation Toronto University alone is entitled to a representative on the council and not Victoria and Trinity.

"F. N. G. Starr represented Victoria and A. J. Johnson,

Trinity. If they should not have been present as the Act decides, then their votes were illegal and even one illegal ballot is sufficient to upset the doings of the council."

Mr. Hassard will use the argument when he applies to the Divisional Court on an appeal from the council's decision in the case of Dr. Cook.

#### STILL HAVE RIGHT.

J. W. Curry, K.C., counsel for the council, stated that he had not been asked about the matter yet, and speaking in an off-hand manner stated that he thought the representatives of Trinity and Victoria were entitled to vote at the council. The fact that they are affiliated with Toronto University, in his opinion, does not take away their right to be represented.

"Even if they should not have voted the vote was still enough to have carried the decision in the Dr. Cook case," he said.

The difficulty over the seating of the members came up at an early meeting, but as everyone seemed to be of the opinion that the representatives of the colleges in question were entitled to be present, the matter was not gone into fully.

If Mr. Hassard's contention proves to be the correct one then the council will have to go over the same ground again, as all it did would be unconstitutional.—Toronto Star.

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### CANADIAN WOMEN DOCTORS

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A glance at an early register of the Ontario Medical College reveals the fact that Jenny K. Trout was the first woman licensed to practise medicine in Ontario. Dr. Trout is the wife of Edward Trout, for forty years publisher of the *Monetary Times*. The list of early women graduates follows:

Jenny K. Trout, May, 1875.

Emily H. Stowe, August, 1880.

Augusta Stowe Gullen, April, 1883.

Alice McGilvary Corliss, Australia, April 29, 1885.

Margaret Corliss, Australia, April 29, 1885.

Helen E. Reynolds, Kingston, April 29, 1885.

Marion Livingstone, Mount Morris, N.Y., May 11, 1887.

Susie Carson, China, May 8, 1888.  
Elizabeth Embury, Belleville, May 8, 1888.  
Allie A. Lawyer, May 8, 1888.  
Mary C. B. McKay, Stellarton, N.S., May 8, 1888.  
Alice McLaughlin, May 8, 1888.  
Annie L. Pickering, May 8, 1888.  
Opia Sisley, Agincourt, Oct. 25, 1888.  
Isabel McConville, Kingston, May 22, 1889.  
Lelia Ada Davis, Toronto, Oct. 29, 1889.  
Susanna Peep Ecole, United States, May 22, 1890.  
Minnie Brown, May 22, 1890.  
Clara Demorest, Melita, Man., May 22, 1890.  
Emily J. Irvine, Woodstock, Oct. 30, 1890.  
Ida Eliza Lynd, Toronto, May 22, 1890.  
Mary H. McDonell, Hensall, May 22, 1890.  
Maggie McKellar, India, May 22, 1890.  
Emily J. Smith, Woodstock, Oct. 30, 1890.  
Hattie A. Walker, May 22, 1890.

Besides these there are about fifty more lady graduates in Ontario.

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#### ITEMS

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A Grand Prize (Highest Award) has been conferred upon Messrs. Burroughs Wellcome & Co. for their exhibit of 'Tabloid' and 'Saloid' brand products and 'Wellcome' brand Chemicals. at the recent Alaska-Yukon-Pacific Exposition, held at Seattle.

The Medical Profession of Canada will be interested to learn that one of the large English manufacturing pharmaceutical houses in the personality of Messrs. C. J. Hewlett & Sons, Ltd., of London, a firm who have been making high-class proprietary medicines for nearly 80 years, have registered at Ottawa their different preparations under the new Canadian Patent and Proprietary Medicine Act which came into force last April. The Canadian profession can therefore have increased confidence in this firm's goods and may depend upon it that they are of the best and purest materials.



The Physician's Library



If the readers of this issue will turn to page lxi, they will notice an important 2-page announcement of Messrs. P. Blakiston's Son & Co., medical publishers, Philadelphia. This firm have been publishing medical works for a great many years past and have made for themselves a most enviable reputation. The books to appear most recently from The Blakiston Press include:

Gatewood. Naval Hygiene. By James Duncan Gatewood, M.D., Instructor in Naval Hygiene, United States Naval Medical School, Washington. With eight Colored Plates and 105 other illustrations. Octavo. xiv + 779 pages. Cloth, \$6.00; half morocco, \$7.50.

Gould. Biographic Clinics. By George M. Gould, A.M., M.D. Complete in six handsome volumes. Price of each volume, cloth, \$1.00. Vol. VI.—Essays Concerning the Influence of Visual Function, Pathologic and Physiologic, upon the Health of Patients. 12mo. viii + 492 pages.

Knight and Bryant. Diseases of the Nose, Throat and Ear. By Charles H. Knight, M.D., Professor of Laryngology, Cornell University Medical School; and W. Sohler Bryant, M.D., Adjunct Professor, Department of Diseases of the Ear, New York Post-Graduate Medical School and Hospital. Second Edition Revised and Enlarged. Octavo. xix + 631 pages; 239 illustrations. Cloth, \$4.50.

Tyson. The Practice of Medicine. Fifth Edition, Revised. By James Tyson, M.D., Professor of Medicine in the University of Pennsylvania. Fifth Edition, Revised and Enlarged. 5 Plates and 245 other illustrations; 13 in colors. Octavo. xxv + 1438 pages. Cloth, \$5.50; half morocco, \$7.00.

Potter. Therapeutics, Materia Medica, and Pharmacy. Eleventh edition, enlarged. Including the Physiological Action of Drugs, Special Therapeutics of Diseases and Symptoms. By Samuel O. L. Potter, M.A., M.D., M.R.C.P. (Lond.), formerly Professor of the Principles and Practice of Medicine, Cooper

Medical College, San Francisco. Eleventh Edition, Revised and Enlarged in accordance with the latest reprint U. S. Pharmacopeia. 3vo.; xix + 937 pages. With Thumb Index in each copy. Cloth, \$5.00; half morocco, \$6.50.

Rockwood. Chemical Analysis. Introduction to Chemical Analysis for Students of Medicine, Pharmacy and Dentistry. By Elbert W. Rockwood, M.D., Ph.D., Professor of Chemistry, Toxicology and Metallurgy in the College of Medicine, University of Iowa, Iowa City. Third Revised Edition. Illustrated. 12mo.; ix + 242 pages. Cloth, \$1.50.

Webster. Diagnostic Methods, Chemical, Bacteriological and Microscopical. By Ralph W. Webster, M.D., Ph.G., Asst. Professor of Pharmacologic Therapeutics, and Instructor in Medicine, Rush Medical College (Medical Department, University of Chicago); xxxiv + 641 pages, with 37 Colored Plates and 164 other Illustrations. Cloth, \$6.00; Half Morocco, \$7.50.

Beard. Treatise on Ophthalmic Surgery. By Charles H. Beard, M.D., Surgeon to the Illinois Charitable Eye and Ear Infirmary (Eye Department), Octavo. With over 250 Illustrations. In Press for early publication.

Binnie. Operative Surgery. A Manual for Practitioners and Students. By John Fairbairn Binnie, A.M., C.M. (Aberdeen); Professor of Surgery, Kansas State University. Fourth Edition, Revised and Enlarged. The Leather-Bound Series of Manuals in two volumes. Vol. II.—Vascular System, Bones and Joints, Amputations. 550 Illustrations. Full Limp Leather, Gilt Edges, Round Corners, \$3.50.

Attention is called to the announcement of the Canada Law Book Company, of this city, appearing on page xlvi of this issue. This firm are offering a number of the latest books from the Oxford Press, at a most attractive discount. their reason for so doing being that they are giving up their medical book department. It would seem to be the chance of a lifetime. The books include: "Diseases of the Larynx," by Harold Barwell, M.B. (Lond.), F.R.C.S. (Eng.). "Treatment of Diseases in Children," by G. A. Sutherland, M.D., F.R.C.P. "Surgical Emergencies," by Percy Sargent, M.B. (Cantab.), F.R.C.S. (Eng.). "Skin Affections in Childhood," by H. G. Adamson, M.D., M.R.C.P. "Heart Disease, including Thoracic Aneurism,"

by F. J. Poynton, M.D., F.R.C.P. "Practical Anesthetics," by H. Edmund G. Boyle, M.R.C.S. "Diseases of the Male Generative Organs," by Edred M. Corner, M.C. (Cantab.), F.R.C.S. "Diseases of the Ear," by Hunter Tod, M.B., F.R.C.S. "Diseases of the Nose and Throat," by E. B. Waggett, M.B. (Cambridge). "Auscultation and Percussion, with the other methods of Physical Examination of the Chest," by Samuel Jones Gee, M.D., F.R.C.P. "Medical Lectures and Clinical Aphorisms," by Samuel Gee, M.D., F.R.C.P. "Clinical Lectures and Addresses on Surgery," by C. B. Lockwood. "A Manual of Venereal Disease," by Officers of the Royal Army Medical Corps. "Functional Nervous Disorders in Childhood," by Leonard Guthrie, M.D., F.R.C.P. "Operations of General Practice," by Edred M. Corner, M.C. (Cantab.), F.R.C.S. "Enlargement of the Prostate," by Cuthbert Wallace, M.S., F.R.C.S. "Cancer of the Womb: its Symptoms, Diagnosis, Prognosis, and Treatment," by Frederic J. McCann, M.D. (Edin.). As these books are bound to go quickly, our readers had better phone Main 346, in order to secure what they need.

*A System of Ophthalmic Therapeutics*, being a complete work on the non-operative treatment, including the prophylaxis, of diseases of the eye, edited and chiefly written by CASEY A. WOOD, M.D., C.M., D.C.L., late Professor of Ophthalmology, Northwestern University Medical School; ex-President of the American Academy of Medicine, etc. Chicago: Cleveland Press. 1909.

One wonders how a book of 926 pages is needed to deal with the subject of ophthalmic therapeutics, but a "system" is supposed to be complete or nothing, and the editor is evidently determined that it shall be complete. One scarcely expects to find in a work on ophthalmic therapeutics a chapter given up to a scheme for the systematic examination of the eyes of school children, or one on the examination of corporation employees. In Chapter VIII., the use of electricity in ophthalmic practice, a number of pages are given up to the relation of the details of illustrative cases.

There is a good deal of repetition; necessarily so, as Dr.



Wood first deals with the remedies used in eye diseases, taking them up in alphabetical order; later on he treats of eye diseases with the remedies used for each disease.

This plan has, even though prolix, the advantage that but little of value can escape consideration, for a work of this type a complete and comprehensive index is essential. Sixty-seven pages are given up to the index.

As a work of reference, and as a monument of industry and thoroughness, this book will always be held in high esteem.

M.

*Soured Milk and Pure Cultures of Lactic Acid Bacilli in the Treatment of Disease.* By GEORGE HERSHEL, M.D. Second Edition. London: Henry J. Glaiser. Chicago: Chicago Medical Book Co., 1909.

This volume of seventy-two pages, in its second edition, deals in a concise fashion with certain clinical and bacteriological aspects of the soured-milk question. It has been said recently that since the slight abatement of the psycho-therapeutic craze the soured-milk problem, or the Metchinoff treatment (as it is popularly designated) has come to the fore, especially in the minds of the laity, thanks to judicious advertising. This being taken as true, it is well to have a review of the exact status of affairs. This the author does very well. The clinical aspect gleaned from the work of Combe, Arbuthnot, Lane, Charrin, Schridt, and Strassburger, and his own experience, is well presented. The most recent bacteriological literature, including a comprehensive study by Heinemann and Hefferan is also referred to and the salient points elucidated. The conditions or symptoms likely to be benefited by treatment with soured-milk are given and one is impressed with the honest endeavor on the part of the writer to point out that the lactic acid bacillus is not a panacea but that it has a distinct field of usefulness.

In conclusion the reviewer can cheerfully recommend this little work to the medical man who is desirous of becoming au fait with the situation in this particular therapeutic field. Certain improvements in a later edition will add to the value of the book. For instance, illustration B, under figure 8 is blurred and of little value. A typographical error on page 9 in the foot-

note where Wochenschrift is spelled Soshenschrift, and a statement on page 56 to the effect that neurasthenia is sometimes the first stage of melancholia or general paralysis, might easily be questioned.

J. G. F.

*Clinical Memoranda for General Practitioners.* By ALEX. THEODORE BRAND, M.D., C.M., and JOHN ROBERT KEITH, M.D., C.M. London: Bailliere, Tindall & Cox, 8 Henrietta St., Covent Garden. 1909. (All rights reserved.)

This little work of 207 pages is intended for general practitioners and especially the younger members of the profession.

The work is divided into four parts, viz., Medicine, Surgery, Obstetrics, and Gynecology and Therapeutics.

All kinds of questions are referred to under their respective headings, and we are bound to say a perusal of them will often prove a great help to the young general practitioner. It is a good book for the office desk, where it can be often referred to. The references are so short and to the point that one can look up what he wants in a few minutes.

W. J. W.

*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.

Although there have been few changes made in this edition compared with the Fourth Edition, the work as a whole has been thoroughly revised and contains many important modifications and considerable additions and the latest drugs described.

A. J. H.