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THE
CANADIAN JOURNAL
OF
MEDICINE AND SURGERY

A JOURNAL PUBLISHED MONTHLY IN THE INTEREST OF
MEDICINE AND SURGERY

J. J. CASSIDY, M.D., EDITOR.

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TORONTO, JANUARY, 1897.

NO. 1.

Original Contributions.

Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than anything else. — RUSKIN.

THE OPERATIVE TREATMENT OF MAMMARY CARCINOMA.*

BY GEORGE T. M'KEOUGH, M.D., M.R.C.S.ENG., L.R.C.P.EDIN.,
CHATHAM, ONTARIO.

WITH the exception of the marvellous advance in abdominal surgery, there has been no greater progress in the whole field of surgical science during the past decade than in the operative treatment of mammary carcinoma. I believe that the surgical treatment of breast cancer, as formerly carried out, did more to produce a want of confidence in surgical skill and to foster charlatans than any other surgical procedure.

During my student days, some twenty years ago, the operation for cancer of the mammary gland was a very simple one—an elliptical incision; the breast, or rather a portion of it, removed: the axilla rarely entered, or, if attacked, very imperfectly so, and the pectoral fascia never touched. The consequence was that whilst the operation might have relieved pain and quieted the patient's anxiety with false hopes for a few short weeks, or possibly, if the tumor was ulcerating, got rid of a disagreeable mass, a cure was scarcely ever hoped for by the surgeon, as a recurrence was almost

* Read at meeting of Ontario Medical Association, Windsor, Ont., June, 1893.

inevitable, and if such a fortunate result ensued, it was looked upon as a piece of good luck rather than good surgery. When Billroth's results—eight cures only in 143 cases—were published in 1878, they were the best that had been given to the profession up to that date.

How different are the results that have been published within the past year by leading operators. Surgeons in giving their statistics have universally adopted Volkman's three-year limit—that is, they record as cures those cases which after the expiration of three years show perfect health, and no sign of any local recurrence. Dr. W. T. Bull, of New York, gives details of 118 cases, with 26.6 per cent. of recoveries. In 40 per cent. of his cured cases the axilla was involved, and in the cases in which the axilla was not infected he had 54 per cent. of recoveries. Dennis reports thirty-eight excisions of the breast for malignant disease, with 45 per cent. having passed successfully the three-year limit. Halstead has had about 50 per cent. of cures; and Watson Cheyne, in his Smithsonian lectures this year, gives the records of sixty-one unselected cases, many of them far advanced, all of them with disease in the axillary glands, with the remarkable result of 57 per cent. of cures.

These favorable results are due, first, to a more perfect surgical technique. Antiseptic and aseptic surgery have done almost as much for operations of the breast as for celiotomies. They are also due to a better knowledge of the pathology of carcinoma and of the precise manner in which it spreads and infects surrounding tissues and organs.

Carcinomata are apparently on the increase, and the mammary gland is one of its most favorite seats. There can be no doubt that the earlier an operation is undertaken for cancer of the breast the more favorable will be the outcome. No medical man is justified in making light of a lump in the breast, and in elderly women he takes a great responsibility upon himself who is willing to watch the case for a diagnosis. As 90 per cent. of all tumors in the breast in women over forty are malignant, the sooner the growth is subjected to the radical or complete operation after it comes under observation the more favorable are the chances for a cure. When women are educated to know the importance of the early removal of these lumps, and with improved surgery they will learn, the surgeon will be consulted in an earlier stage of the development of the disease, and consequently the results will be

infinitely better. It is rare now for a medical man to see a case before the axillary or other glands are more or less invaded, and the chances of cure are very much greater if the operation can be performed before the infection of the adjacent lymphatic glands. It has been estimated that over nine thousand women die annually in the United States from cancer, and about one-fourth of these cases have their origin in the breast. One can therefore readily understand the importance of the subject for discussion, and the benefits that may accrue from proper operative treatment.

But it is not only necessary that the operation should be accomplished early, it is equally necessary that it should be thoroughly performed, no matter how soon the case comes under observation, as the cancer cells invade the lymphatic vessels and nearest glands in a very early stage of its history, and the object of the treatment should be the cure and not merely the temporary relief of symptoms. Dr. Nicholas Senn in his recent address before the surgical section of the American Medical Association, puts the situation in a nutshell when he states that "the essential features in the modern treatment of malignant tumors may be summed up very briefly as follows: Operate early and thoroughly." With some surgeons the pendulum, however, seems to have swung too far. Amputation of the arm at the shoulder joint has been advocated in order to thoroughly remove all axillary complications. Mr. Arbuthnot Lane divides the clavicle in order to clear out the supra-clavicular glands. Halstead, of Johns Hopkins, removes in all cases the pectoralis major. Wilby Meyer, of New York, goes still farther and removes both the greater and lesser pectoral muscles. Such radical procedures, however, are apparently unnecessary, and in operable cases equal or better results are obtained with less aggressive surgery. When the disease is so diffuse that it is necessary to remove so much of the surrounding structures, the chances are that the disease is past cure by any operation. Watson Cheyne, whose results are as good if not superior to any that have been published, states that the "minimum operation for cancer of the breast that will offer any probability of cure must include the primary disease, the whole breast, the tissue in which the lymphatics run, including the pectoral fascia from the breast to the axilla and the whole of the axillary glands."

I believe this operation meets with the approval of most leading surgeons of experience, and any operation within these limits must be considered incomplete.

The same antiseptic and aseptic precautions should be taken in this operation as in an abdominal section. A general bath, shaving the arm pit, a thorough disinfection of the operative field the day previous to the operation, the parts protected with antiseptic gauze, with a farther cleansing and disinfection just before the operation. The first incision will depend partly upon the situation of the tumor, usually an elliptical or circular incision from the sternum to near the axilla answers. The amount of skin sacrificed should correspond to the prominent part of the organ: this is necessary even when the tissues are not attached to the adjacent skin or the nipple retracted, as the suspensory ligaments which extend from the breast tissue to the integument contain lymphatics, which early become infected with cancer cells. Every vestige of the mammary gland must be removed. The skin should be undermined and elevated, and all lobules of the breast, which sometimes extend in the fatty tissue nearly as high as the clavicle, onwards as far as the sternum downwards to the abdominal muscles, and outwards and backwards to the latissimus dorsi, should be carefully detached and removed. The incision should extend down to the great pectoral muscle, and in order to completely remove the pectoral fascia in which the lymphatics proceed outwards, Cheyne recommends shaving off a layer of the pectoral muscle. This, I believe, should be done in all cases, and is sufficient usually without removing, as Halstead does, the entire muscle, unless nodules of cancer can be felt in the muscular substance, when the whole muscle should be removed with the breast. The functions of the arm and shoulder are much more impaired when the pectoral muscle is entirely removed; but when it becomes a question of cure or recurrence the impairment of function should not be a point for debate. Hemorrhage is controlled by the hands of an assistant or by pressure forceps, and is usually not very profuse.

The axilla is attacked by an incision from the angle of the breast wound along the lower border of the pectoral muscle. After cutting through the skin and superficial fascia, the knife is discarded for the fingers or some blunt dissector, and the entire axilla, including the space between the two pectoral muscles, the space of Morbenheim, at the very apex of the axilla, up under the clavicle and even into the subclavian triangle of the neck, must be completely denuded of all fat, glands and lymphatics, until the important vessels and nerves stand out as in an anatomical dissection. It is almost the unanimous opinion of surgeons of experience that

the axilla should be opened up and cleaned out in every operation for malignant disease of the breast. Keen, who has operated over two hundred times, says that he cannot detect enlarged glands in the axilla once in ten times until it is opened. It is highly important that the breast and adjacent fat, including the glands and fat from the axilla, be removed *en masse* and not in piecemeal, as it is important that no diseased structure should be cut into, so as to obliterate cells which might infect healthy tissue. It is also an advantage in separating the glands and diseased tissue in the axilla to have them dragged down by the weight of the previously excised breast. An advantage in widely separating the skin for the removal of all possibly infected tissue is the greater facility with which the edges of the flaps will coaptate when brought together. If the skin will not readily come together, it is better to bring the flaps as close as possible without undue tension, and adopt skin grafting at the time or subsequently, in order to close the wound.

The dressing of the wound is important. If all oozing can be stopped and the parts left perfectly dry, drainage may be dispensed with, otherwise it is better to leave in a piece of sterile iodoform gauze for twenty-four hours. The wound should be united with interrupted silk-worm gut sutures. It is very necessary in applying the sterilized gauze dressings and bandage to have firm, equable pressure everywhere to completely close all dead spaces so as to prevent any accumulation of serum. The arm should be kept confined to the side for a few days. If drainage is not used the dressings will not require changing for a week or ten days, when the wound should be found perfectly healed.

The mortality from the complete operation is very small, considering the important structures exposed and the shock consequent upon a more or less prolonged operation. The results of a number of leading American surgeons who have published their results recently show a mortality of less than one per cent.

TWO CASES OF SLOW PULSE.*

BY P. A. DEWAR, M.D., C.M., ESSEX, ONT.

WITH no idea of bringing anything new, or even anything particularly instructive, to the majority of the members of the Association, but rather with the hope of receiving some information in the treatment of cases which have been to me very interesting and unusual, have I decided to call your attention to certain forms of slow pulse. Text books lay down fairly definite rules as to pulse rate and quality, yet none of us have been in practice very long before we begin to regard those cases of typical pulse the exception rather than the rule. The two cases which I wish to bring before you to-day are not, I think, ordinary when considered in this light even. The causes of slow and irregular heart's action are so numerous that the difficulty in any one case is not in assigning a cause for the trouble (to the patient, at least), but rather in determining which one of the many causes is to be credited, and removed, if possible, thereby treating the ailment in the only logical way by taking away the disturbing element and allowing nature to once more assert herself. Slowness of the pulse is seen by every busy practitioner almost daily: but the slowest of which I have seen any record is a case mentioned by Pepper of twenty-two to the minute. Flint mentions cases running as low as twenty-six to the minute—nearly always of a functional and temporary nature, and very rarely of intracranial origin. As my time is limited, and as I wish to bring the patients before the Association, I will give a brief synopsis of each one's history and be done:

Mr. Naylor, sixty-three years of age; habits active, physically and mentally: family history good, past history excellent; previous sickness, malaria five years ago, and acute rheumatism fourteen years, from both of which he made apparently good recoveries: habits, temperate. Was called to see him for his present disorder over two years ago. Condition, pale and haggard-looking: respiration, sighing: digestion, faulty; all the other organs, with the exception of heart, normal; heart beats, strong and regular; pulse, twenty-two to the minute, not accelerated by change of position nor on exercise, not easily compressed. Advised quiet and regulated diet, and gave digestives, thinking the condition of pulse

* Read at meeting of Ontario Medical Association, Windsor, Ont., June, 1896.

functional, and probably due to flatulent dyspepsia. Next day, pulse twenty: other conditions the same. The following day, the pulse having fallen to eighteen, had in consultation Dr. Inglis, who regarded the trouble as probably due to some central lesion. Next day the pulse fell to sixteen, and remained that way for one hour. and although we used every form of heart stimulant that two other medical men and myself could think of, we could not cause the pulse to go one beat faster. For two months the condition remained much the same, the pulse sometimes going as fast as thirty-six and frequently falling to twenty. At the end of that time he had distinct attacks of petit mal and twice convulsive seizures, in which he bit the tongue. During the last year the pulse had become rapid, weak and irregular, the heart dilated, and the patient presents many of the symptoms belonging to epilepsy, notably enfeebled memory.

The second case first came to me some months ago, stating that he felt well in every way, but consulted me because his friends were alarmed at attacks of loss of consciousness that he had suffered from at intervals. When I examined him I found a fairly healthy, strong and active man, with no other disorder apparent except that the pulse beats were irregular and running about twenty-five to the minute. Since then there has been little change in his condition, except that under the use of bromides the attacks (probably epileptic) have become rare.

Query, What is the connection, if any, between these cases of slow pulse and epilepsy?

Local Anæsthesia in Labor.

Dr T. H. Weagly (*Times and Register*, October 5, 1895) has obtained excellent results in cases of rigidity of the cervix by local anæsthetics applied to the parts by a spray apparatus. He claims that the following solution will expedite and soothe the first stage of labor, and even when the occiput has entered deeply into the pelvis the pain accompanying the expulsion of the head may be reduced to a minimum by spraying the vaginal surface of the perineum and outlet.

- B. Phenolized cocaine solution (3 per cent.) ℥i.
- Trinitrin solution (2 per cent.) ℥x.
- Sulphate of strychnine gr. ʒ.
- Listerine ℥i.

Gynæcology and Obstetrics.

A CASE IN PRACTICE.

On the 20th December last the writer saw, in consultation with Dr. T. McKenzie, a woman aged forty-two, in labor with her first child. She had then been ill about thirty-six hours, the membranes having ruptured with the onset of labor. The pains recurred every two or three minutes, were fairly severe, but without the bearing-down element which one would expect after that length of time. On making a digital examination the os was high up, dilated about the size of half a dollar, and while not being rigid, was not very dilatible. A vertex presentation at the brim was readily felt, but the position could not possibly be made out with any degree of certainty. The history of the case suggested an occipito-posterior position, and external palpation of the abdomen strengthened that supposition, but it was not until the patient was anaesthetized, the os dilated by the method suggested by Harris, of Paterson, N.J., and the whole hand introduced into the uterus, that we were able to decide positively that it was an occipito-posterior position, and the long diameter of the head in the right oblique diameter of the pelvis.

Three methods of delivery were now open to us and discussed briefly, the hand being kept in utero. One was to rotate the head manually, crowding over the body with the external hand. Another method was version, and the third was to temporize, allowing the case to go on in the hope that as the occiput reached the pelvic floor it would rotate into the second vertex position, when nature or the forceps would complete the delivery. This method seemed contra-indicated on account of the probable length of the labor, the possibility of a "persistent occipito-posterior" position and consequential certain death of the fetus, and general bruising of the soft parts.

The first method was considered impracticable on account of the loss of liquor amnii so long before, and consequent moulding of the soft parts at the entrance to the brim, tending to produce a reversion to the original position, even if rotation were possible. We elected to try the second method, and though the uterine wall grasped the baby thoroughly, by steady pressure upward on the head for about a minute, then crowding the

buttocks over to the left and forward, one foot was easily reached, then the other, and version accomplished in a few minutes. The delivery of the head caused some considerable delay, but by adopting the Moriceau (or Veit-Smellie) method we succeeded in getting away a living baby weighing seven and a half pounds.

From the ragged appearance of the membranes, it was thought that a portion must have been retained. Digital palpation of the whole endometrium failed to find any portion of it. As the uterus was twice invaded by the hand, it was deemed prudent to flush it out with a hot 1-100 carbolic solution. Recovery normal. The practical deductions are :

1. That a long tedious first stage, with non-entrance into the brim, is presumptive of some abnormality.
2. That it is sometimes impossible to make out the position without an anæsthetic, and that even then one is occasionally unable to do so without the introduction of the hand within the os.
3. That version, though contrary to the ordinary text-book teaching, can be accomplished many hours after the liquor amnii has drained away.
4. That it is advisable to make an intrauterine search at the time, if there be a fair suspicion that a piece of membrane or placenta has been left behind.
5. That where the hand, or a hand of each of us, as in this case, has been within the uterus, an intrauterine douche is advisable.
6. That the technique was all that could be desired, as shown by the perfectly smooth recovery.

THE TREATMENT OF ECLAMPSIA.

(From the International Gynecological Congress in Geneva.)

Charles: Eclampsia is the result of different causes, and accordingly more or less dangerous. Usually the result of poisoning of the blood by an accumulation of waste products normally removed by the liver and kidneys; rarely of reflex nature. Intoxication of renal origin is most common, and generally accompanied by albuminuria and œdema of various parts of the body. Albuminuria, however, is not the cause of eclampsia, but only a disease symptom originating from the like cause. The disease is most frequent in primiparæ, but the death rate is higher in multiparæ. *Charpentier*:

The urine of every pregnant woman must be examined with great care at frequent intervals; when the presence of albumin in the urine shows that the woman is threatened with eclampsia, danger can be avoided by a strict milk diet. At the beginning of eclampsia venesection is indicated in women of robust constitution and with a cyanotic countenance; 300 to 500 grammes of blood should be abstracted. Afterwards chloral is administered. Eclauptic attacks are combated by chloroform inhalation, while diuresis is favored through subcutaneous infusions of physiological saline solution. Whenever possible, the natural termination of labor is advised, and use of instruments is cautioned against. If, in spite of pains, delivery does not progress, version or forceps is indicated in the living child, otherwise craniotomy. The soft parts, however, must be dilated or easily dilatable before instrumental delivery should be attempted. The induction of premature labor should be reserved for exceptional cases. Casarean section and accouchement forc  are only permissible as *dernier ressorts* in desperate cases. *Veit*: Many cases will recover under any treatment. The proof that a forcible delivery in deep narcosis gives the best prognosis has as yet not been substantiated. The results obtained from the systematic administration of large doses of morphine have not been equalled by other methods. The favorable reports of success from venesection are not sufficient in number to permit the passing of final judgment. A rational therapy of eclampsia is not possible until the etiology is absolutely clear. Hastening of labor by rupturing the membranes, delivery after completion of dilatation, administration of large doses of morphine to diminish the frequency of attacks, no nourishment per os, and the production of diuresis through external means, is to-day the best and safest method of treatment. In exceptional cases more grave operations may be permissible. *Byers*: Elimination of toxins is hastened by an administration of hot baths and pack, cathartics and diaphoretics. If eclampsia occurs before the onset of labor, the latter should not be artificially stimulated. In intrapartum eclampsia the administration of chloroform and rapid termination of labor are advised. Rest, milk diet, laxations and hot baths are the best prophylactic therapy. *Tarnier*: Milk diet is the best prophylactic. Since 1897 he has treated cases of eclampsia with chloroform, chloral, venesection, and milk—the latter, if necessary, administered with the stomach tube. The mortality at his clinic has sunk to 9 per cent and there has so far (September) not been a single death during

1896. *Lindfors* demonstrated specimens showing a dissemination of liver cells in the blood of eclamptic women. He drew particular attention to the fact that the emptying of the uterus is not always followed by a cessation of the eclamptic seizures. *Pancord* advises milk diet as the best known prophylactic. *Queirel* observed during the years 1890-96, in 1,200 labor cases, twenty-seven cases of eclampsia: not one case originated in the hospital. He ascribes the absence of eclampsia among hospital cases to the rigid milk diet enforced in every case of albuminuria. *Morisani* draws attention to the cessation of albuminuria and eclamptic seizures after death of the fœtus. There must, therefore, be a certain connection between fœtus and eclampsia. In the treatment of eclampsia the following rules are laid down: Medical treatment only during the fourth and fifth months of pregnancy. In the beginning of labor, after sufficient dilatation, immediate delivery is indicated. If the os is rigid and contracted, artificial dilatation, preferably with the finger. *Dührssen's* method of deep incisions is not favored; instead of these, he advises in desperate cases Cæsarean section. *Pasquali* agrees with *Morisani*, and *Fochier* believes that the cause of eclampsia is the resorption of digestive products by the stomach: he therefore recommends washing of the stomach and the instillation of milk and chloral.—*American Journal of Obstetrics*.

Pelvic Diseases and their Principal Causes. What Should the Laity be Taught Concerning them?

John M. Duff says, in the *American Journal of Obstetrics*, November, 1896: One of the principal causes, and one which, I am sorry to say, is becoming more common every day, is criminal abortion. This increase is not due alone to an increase in illicit intercourse. There is a sadder side to the subject. This practice, soul-destroying, productive of moral depravity and of physical disease and pain, has invaded the sanctity of the marital chamber, where, in some communities at least, it is increasing to an alarming extent. The young married woman who desires a long honeymoon resorts to it because her pleasures must not be interrupted by the honest fruit of her womb; the woman of society, whose time is too precious to give to the care of children; the woman who believes she has already a family as large as she can support and care for—all unblushingly resort to it and thus lay the foundation for diseases

which will eventually make life a burden. My observation shows me that while much of this is done with a careless indifference to results, much of it is done through ignorance of its sinfulness and of its physical danger. The impression that it is sinless during the first three months of gestation, and that during this same period it is devoid of danger, has considerable to do with its frequency. He claims that the same life is destroyed at one month as is destroyed at four to six months, and to say it is sinless would be as unreasonable as to say it would be sinless to take the life of a boy of ten, but wicked, villainous murder to take the life of a man of fifty years of age. In regard to the various methods used to prevent conception, he thinks all of more or less harm, but he cannot abstain from criticizing the use of the intrauterine protector, the use of which is, he is told, encouraged by reputable practitioners to that extent that for a stated sum monthly they introduce it just after menstruation and remove it again prior to the next period. Such a practice cannot, it appears to him, eventually do otherwise than produce an endometritis which will entail a retinue of evils, the gravity of which it is terrible to contemplate. The invasion of disease may be so insidious as not for a long time to cause alarm; but these women will live to curse the man or woman through whose influence they were led to use them.

Intrauterine Medication.

W. S. Playfair, after discussing various methods of intrauterine treatment for diseases of the endometrium (excluding fibromata) in which he speaks favorably of applications of phenol and glycerine and the curette, says: "My own decided preference as a means of intrauterine medication is for the application of the negative current after the plan introduced by Apostoli. The precise method of action is doubtful, but it appears to modify the nutrition of the endometrium and its deep-seated glands in a very remarkable manner. I have rarely used more than five or six applications—generally three after one period and two after another—these consisting of from eighty to one hundred milliamperes of the regular current. This is practically painless, nor have I seen a single case in which subsequent mischief resulted. The efficiency of this method of intrauterine medication is best proved by the frequency with which it is followed by pregnancy in old-standing cases of

acquired sterility." He then goes on to speak of its drawbacks, the costly and elaborate plant required and the time and skill necessary during treatment. These difficulties make it quite intelligible to him why it has not been more generally used.—*Am. Jour. Obs.*

Increased Frequency of Cancer.

Roger Williams, in discussing this subject, says: "Probably no single factor is more potent in determining the outbreak of cancer, in the predisposed, than high feeding. There can be no doubt that the greed for food manifested by modern communities is altogether out of proportion to their present requirements. Many indications point to the gluttonous consumption of meat, which is such a characteristic feature of the age, as likely to be especially harmful in this respect. Statistics show that the consumption of meat has for many years been increasing by leaps and bounds, and it has now reached the amazing total of one hundred and twenty-six pounds per head per year, which is more than double what it was half a century ago, when the conditions of life were more consonant with high feeding.

"When excessive quantities of such highly stimulating forms of nutriment are ingested by persons whose cellular metabolism is defective, it seems probable that there may thus be excited, in those parts of the body where vital processes are still active, such excessive and disorderly cellular proliferation as may eventuate in cancer.

"No doubt other factors co-operate, and among these I should be especially inclined to name deficient exercise in the open air."—*Am. Jour. Obs.*, from *Med Chron.*

Menstruation.

H. M. Jones describes in the *Lancet* a case of intense vasomotor coloration of the face associated with dysmenorrhœa and oophoralgia. The ecchymoses of the cheek resembled at times that due to a severe contusion. The discoloration was chiefly below the eyes and in the malar region, but occasionally involved the forehead.—*Lancet*, Aug. 1st.

H. T. M.

Medicine.

OBSERVATIONS ON THE SERUM REACTION IN TYPHOID FEVER AND EXPERIMENTAL CHOLERA BY THE DRIED BLOOD METHOD.

BY WYATT JOHNSTON, M.D., AND D. D. M'TAGGART, M.D., OF MONTREAL.

Abstract.

A GRATUITOUS public service of serum diagnosis was introduced last September by the Board of Health in the Province of Quebec. Suitable outfits for taking samples, consisting of pieces of sterilized paper enclosed in envelopes with printed directions and blank spaces for information to be filled in, have been placed in chemists' shops, where outfits for diphtheria diagnosis are already kept.

In case of a negative result and the suspicions of typhoid continue, a glass tube is furnished in which a duplicate sample of fresh blood is also required to be sent. A large drop of blood is allowed to dry on the sterilized paper. The drying of the blood is only for the purposes of easy transmission. At the laboratory the blood is moistened by a drop of sterilized water and then mixed with a drop of fresh and actively motile pure broth culture of typhoid bacillus and examined by the microscope. The motion rapidly stops and the bacilli run together in loose coils or clumps. This takes place usually in a few minutes, but sometimes may require three or four hours, and sometimes twenty-four hours. On the other hand the stoppage of motion may be instantaneous, and as this will delay rather than aid the formation of clumps, it is better to make a second sample, in which the serum is less concentrated. As a rule a slow reaction gives larger clumps than a quick one.

In a small proportion of cases in which the clumping proceeds in an atypical manner, a certain number of motile forms can be seen even after several hours. This partial or incomplete reaction we have met with chiefly (1) in the very early stages, (2) or late in convalescence, (3) in relapsing cases, and (4) in very mild cases.

The gradual and progressive loss of the motion, and the slow but steady growth of the clumps, together with the fact that the motion never becomes considerable, enables this incomplete reaction

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to be distinguished without much difficulty from the brusque stoppage followed by the prompt reappearance and increased activity of motion occasionally seen when normal serum in concentrated form is mixed with a typhoid culture. Although aseptic precautions are not required when the action is complete within a few minutes, the occasional occurrence of this slowly developing reaction makes it necessary to guard as far as possible against the development of extraneous motile forms in the blood. As these might be present upon any odd piece of paper employed, special slips are provided with envelopes which have been sterilized. Positive results were obtained in 123, or 95 per cent., of the 129 cases which there was serious reason to believe were true typhoid.

If we exclude convalescent cases and cases in which no re-examination was obtained, there remains only one case of severe fever strongly resembling typhoid which did not react to the test made repeatedly under favorable conditions. In this case both the fresh serum and the dried blood were tested, and both gave negative, or at least indecisive, results.

Ninety-nine and four-tenths per cent. of cases examined under satisfactory conditions gave decisive results. Ninety per cent., however, is thought to be as high an average as can be expected in public health work. The reaction was found in sixteen out of seventeen cases, after intervals of from three weeks to three months after their discharge from the hospital.—*British Medical Journal*.

Retention of a Dead Ovum in the Uterus.

Graefe (*Festschrift Ruge's, Munch. Med. Woch.*) has not been able to arrive at any certain information as to the etiology of these cases from microscopical examination, though to eleven personal observations he has added fifty-nine published ones. After prolonged retention, retrograde metamorphosis is evident in the ovum. The mucous tissue becomes converted into more or less rigid connective tissue, but may even after months of retention be preserved in places, or even show patches of growth. The more developed the fruit, at the time of its death, the greater the danger for the mother. As soon as the diagnosis can be established, the uterus should be emptied—if in the first five months, by dilatation and clearing out the cavity with the finger, under an anæsthetic; if later by the induction of premature labor.

W. J. W.

Therapeutics and Pharmacology.

CHRONIC RHEUMATISM TREATED BY INJECTIONS OF CHERON'S SERUM.

PATIENT was a man aged forty-nine who had been suffering from chronic rheumatism since he was thirty-seven, all the joints being successively affected, and where no result was obtained by any therapeutic method—arsenic, salicin, etc., proving useless. Cheron's serum was then tried, 5 to 10 c.cm. being injected daily, either into the deep muscles of the back or the tissues around the affected joint according to the part affected. The result was surprising, the patient being able to resume the movements of the joints. It would seem that the rheumatic condition continued, but its effects were kept in abeyance by the regular use of the injection.—*Journal de Méd.*, August 10th, 1896.

TREATMENT OF BURNS.

LINT soaked with warm carbolized carron oil, with a thick envelope of cotton wool, is perhaps the best application for the first week; but the nauseous smell of the linseed oil combined with the fetor of purulent discharge, is horribly offensive, and helps to keep up the tendency to diarrhoea common at this period, which is frequently attributed to duodenal ulcer. Let me recommend the following alternative treatment: Dress the vast beef-red profusely suppurating wounds with gall ointment thickly spread on strips of lint, or with ointment of galls and opium or boric ointment, having about a drachm of finely powdered galls to the ounce; wrap thickly in cotton wool and bandage firmly, not loosely. Improvement is rapid, the smell diminishes, and the sufferer finds the treatment comforting. The admirable effect of the gall ointment in coagulating albumen and restraining exuberant granulations would seem to suggest it as a usual dressing in these cases: but none of our authorities mention it, nor have I seen it used excepting by myself. Indeed the only mention of galls for treatment of burns that can be found in the "ever faithful ever sure"

Neale's "Digest" is an article written in 1852, claiming that ointment of galls prevents contraction of cicatrix. It is generally recommended that the bandages in these cases should be lightly put on. But the fungous granulations are certainly more effectually restrained by firm pressure over elastic cotton wool, and there can be no question that this treatment is more merciful than the application of nitrate of silver whilst equally useful.—S. GROSE, M.D., F.R.C.S.Eng. in *Lancet*, March 23rd, 1895.

This is certainly an excellent method of treating burns, as I have treated several cases on a similar plan with gall ointment, and have been most thoroughly pleased with it. I use acetanilid, one drachm to the ounce of gall ointment.

A. J. H.

Pediatrics.

A CASE OF ECTOCARDIA.

ON a recent evening I was called by a midwife to assist her in an unusual presentation, which I gathered from her description to be transverse; but in the few minutes it took me to reach the house the child was "shot out."

After doing what was requisite for the mother I proceeded, with my friend Dr. George Barnardo, to examine the child, which we found to be about the eighth month with the heart external to the chest wall and beating vigorously; in other respects the infant seemed robust and promising.

The child was placed in an incubator, the heart being wrapped in lint kept moist with a saline solution. Prior to this the following observations were made:

1. There was no pericardium.
2. The heart occupied the same relative position outside as it would if normally situated.
3. The ventricles contracted so as to shorten the long axis of the heart, with a rotatory movement to the right, and bringing the right ventricle almost to the front.
4. Palpation and auscultation produced no change in the rhythm nor suggested sensation.
5. The sounds at the base were clear and distinct, no murmur being audible; auscultation at the apex was impracticable owing to the exaggerated movements.

6. The child cried; swallowed milk from a spoon; passed meconium, and seemed in every respect healthy.

Contrary to our expectation, it died at 5 a.m., having lived nearly six hours. It has been suggested that oil would have proved a better local application in the absence of pericardium, since death resulted from myocarditis.

The case is at present being fully investigated by Drs. Barnardo and Keith from an embryological standpoint.—CHAS. GRAHAM GRANT, in *British Medical Record*, December, 1896.

Erysipelas in Infants.

Dr. J. Lewis Smith advises for a child from one to two years old the internal use of four drops of the tincture of the chloride of iron every three hours, either alone or with one of the preparations of cinchona. He applies externally an ointment of ichthyol, a drachm to the ounce of cold cream. High temperature should be reduced by sponging, the wet pack, or the bath. Antipyretic drugs should be employed with caution, only in minimum doses and guarded by a heart stimulant. For delirium the temperature should be reduced. If the delirium does not abate, bromide of potash, chloral, or as a last resort opium, are to be given. In using carbolic acid care must be taken to guard against poisoning. The first evidence of poisoning is shown by the urine leaving a pink stain on the napkin after exposure to the air for half an hour.—*Pediatrics*, May 1st, 1896.

Muscular Macroglossia.

Dr. H. v. Ranke (*Jahrb. f. Kinderheilkunde*, xli., No. 3, 1896) names three varieties of the above affection occurring in children: 1. That in which the enlargement of the tongue is caused chiefly by increase of interstitial tissues. There may or may not be atrophy of the ordinary tissue of the tongue. The number of blood-vessels or lymphatics may be much increased, forming tissue resembling an angioma or lymphangioma. 2. There may be an increase of the tongue due to hyperplasia of all the different tissues of the tongue. 3. There may be an increase of the special tissues of the tongue due to hyperplasia of the muscles which make up its structure. The condition generally occurs in conjunction with

other congenital deformities, such as abnormality of the intestine, of the arms or of other parts of the body. It may be related to a general muscular hypertrophy or pseudo-hypertrophy. Cretinism or rachitis may be closely connected with the condition.

Infectious Vulvo-Vaginitis in Children.

Dr. Sheffield, in the *American Medical Bulletin*, May 30th 1896, summarizes his views upon this subject as follows: 1. Infectious vulvo-vaginitis in children is of gonorrhœal nature: the diplococcus present in the purulent discharge is invariably identical with that of Neisser, decolorizing by Gram's method. 2. The infection can be conveyed through common privies, baths, beds, clothing, etc. 3. The symptoms accompanying the disease are far less severe than those described in most text-books. 4. Most of the complications are preventable. 5. The value of boric acid or mild silver-nitrate solutions as prophylactics of purulent ophthalmia is very doubtful. 6. Silver-nitrate in strong solution is a reliable abortive of purulent ophthalmia, if used in the very earliest stage. 7. The mere presence of gonorrhœal discharge in a small girl, without injury to the genitalia, does not prove that rape has been attempted. 8. Physicians in charge of asylums or similar institutions should be on their guard not to admit girls with vaginal discharge, unless they can convince themselves that this is not of gonorrhœal origin. 9. The subject in question deserves a more careful study by the gynæcologist and pediatric physician, as well as by the general practitioner and medical jurist: and by their united observation we should in the near future be enabled to dispel any and all doubt as to the real nature of infectious vulvo-vaginitis in children.

A. S. G.

The Operative Itch.

This is a peculiar form of pruritus which is apt to attack members of the medical profession only. The bacillus of this disease viewed under the microscope resembles a human hand; each finger, however, being a scalpel and the thumb a pair of scissors. I speak of it only as it occurs in the realm of nose, throat and ear diseases, although my confreres in other lines of practice will readily distinguish it as it occurs in their domain. Like all other forms of itch, it requires vigorous measures to thoroughly rid each special line of practice of this troublesome parasite.—*Clinical Chronicle*.

Public Health and Hygiene.

NEW LEGISLATION.

THE editors of this Department acknowledge with pleasure the courtesy of Dr. Bryce in furnishing them with an early copy of the regulations of the Provincial Board of Health respecting abattoirs and the inspection of milk supplies, which have just been approved of by the Government of Ontario:

Regulations adopted by the Provincial Board of Health, June 9th, 1896, under Chap. 53, 59 Vict., 1896, to provide for the inspection of meat and milk supplies of cities and towns.

1. Every municipal slaughter-house or abattoir, and cattle-yards and pens, shall consist of a building and yards similar in character and equipment to those set forth in Pamphlet No. 1, 1896, issued by the Provincial Board of Health; or, if otherwise, then such as shall be satisfactory to the said Board as being equally convenient, complete and spacious. Such shall consist of:

(a) Proper and adequate yards and pens with shelter for cattle and appliances and conveniences for feeding and watering the same.

(b) Killing floor.

(c) Refrigerator or store-room with separate hanging-room and ice chamber.

(d) Proper and adequate appliances for killing, cleaning and hanging of animals, for heating of water, for removal of blood and offal and for receiving the organs and fat.

(e) A supply of water of approved purity to be supplied from town or city supply, or from tanks attached to windmill or other mechanical appliance, assuring an adequate supply for flushing and general cleansing purposes.

(f) Sufficient and proper appliances for heating and ventilation.

(g) Properly constructed and adequate sewerage and means for disposal of sewage.

(h) Adequate arrangements for disposing of refuse and offal, so as not to create a nuisance.

2. The special inspection carried on by local Boards of Health as provided for by Section 4, Chap. 63, 59 Vict., shall consist of:

(a) A personal inspection by a veterinarian of every milch cow, kept for supplying public milk, for evidence of disease.

(b) An injection of tuberculin, supplied through the local Board of Health or Medical Health Officer, and obtained from a source approved of by the Provincial Board of Health, and supplied in a proper manner.*

(c) Each animal tested and found healthy shall be described and numbered by the veterinary inspector in a book supplied and prepared by the local Board of Health, which book shall be its property. A metal tag shall be affixed to the ear of the cow, with a number corresponding to that entered in the book describing said cow.

(d) Should an animal in any dairy herd be found to give the tuberculin re-action or be found otherwise seriously diseased, she shall at once be removed therefrom, and shall be dealt with by the veterinarian of the local Board after the methods hereinafter set forth.

(e) Until the healthy animals of any such herd shall have been proved to continue free from tuberculosis as proved by a subsequent test, examinations of such herds shall continue to be made within every three months. Thereafter a test of the herd shall be made not less often than once a year.

(f) No new animal shall be admitted to any dairy herd until it shall have been tested with tuberculin by the veterinary inspector of the local Board, and if found healthy shall be described and numbered in the manner already mentioned.

3. The cows found tuberculized or to re-act with tuberculin, are to be dealt with in some one or more of the several following ways:

(a) If wasting, and the clinical symptoms of lung disease are present, the cow shall be destroyed and the carcass dealt with so as to make it unfit for use as human food.

(b) If showing the re-action of tuberculin, while in fair condition, such cows shall be placed in stables or pens separated by an

* Having had the forenoon and afternoon temperature taken to obtain an idea of the existing condition of the animal, a ten per cent. solution of normal tuberculin is injected to the amount of from one to four cubic centimetres according to the age of the animal, preferably in the evening. The temperature should thereafter be taken regularly, every three hours for a period of from twelve to fifteen hours, and carefully recorded.

Any notable rise of temperature after injection indicates the existence of tuberculosis in some one or more organs.

open air space from the healthy herd; and must not have access to the same yard, or the same food or water as the healthy animals.

(c) The preferable method will be to allow the milk supply in such cows to stop or dry up, and to fatten them as speedily as possible for slaughter; or the cow may be milked, and the milk thereafter be boiled for half an hour, and then fed to pigs or calves.

(d) A cow in calf may be kept, but the calf at birth must at once be removed from the cow and fed with the sterilized milk, if it be from a tuberculized cow. Such cows should, however, be fattened and killed while the disease is still slight and localized.

J. J. C.

CONSUMPTIVES IN HOSPITALS.

A LIVELY discussion was aroused in Boston, recently, by the proposal to establish in the suburbs of that city an institution for the shelter of poor consumptives. Among the people of the neighborhood there was almost as much excitement and opposition as if it were a question of putting a pest house in their midst for the reception of small-pox patients. Public apprehension was further aroused by the injudicious remarks of certain medical men, who were given the credit for such statements as that consumption is "as contagious as small-pox" and that "hospitals for consumptives are a source of danger to the whole community." With medical authority for such extravagant views it is no wonder that the people in general were needlessly alarmed and cast serious obstacles in the way of an enterprise that was really a perfectly proper and worthy charity.

When quarantine against consumptives was first agitated, it was pointed out by those who took conservative views that there was great danger of unnecessarily alarming the public, and causing the unfortunate victim of pulmonary tuberculosis to be shunned as if he carried the bell of the leper. Here is an instance that justifies the warning, and there will be many like it unless pains be taken to correct the extravagant view of the contagiousness of consumption which the public is fast acquiring, as the result of the teachings of the medical profession.

That consumption is a communicable disease is well nigh universally admitted by medical men, and should be generally

understood by the public, but with this knowledge should go the further understanding that the danger of contagion is but slight, and may be absolutely controlled with ease, that is, by caring for the sputum in pulmonary cases and for the alvine discharges in the intestinal form of the disease. But experience proves that it is much easier to arouse public apprehension of danger than it is to control it when once aroused. Like a prairie fire, it is easily kindled, and under ordinary circumstances may be kept within bounds, but let it once get beyond a certain limit and there is no restraining it.

It is not, then, surprising that not only should people fear the neighborhood of sanitarium devoted to the treatment of consumption, but that hotel keepers, whose pockets quickly feel any suspicion about their houses, should sometimes decline to receive guests whose appearance and actions suggested that they were suffering from consumption. The aggravating feature of the people's attitude, however, is that while it is active enough in directions where the danger is less, it does nothing to suppress the sources of greatest danger. The properly instructed consumptive in a sanitarium or hotel who is careful about the disposal of his sputum is no menace to the public safety, but against him outcry is made, while the army of spitters in public places is allowed to practise its disgusting and dangerous habit unchecked. Much is said of the danger of infection from tuberculosis by travelling in sleeping cars on lines frequented by consumptives. The risk is a perfectly manageable one by the passage of laws against spitting in public places except into proper receptacles. These laws would do good, not so much by their direct restraining power through the penalties proposed as through their educating influence upon the public, arousing them to an understanding that spitting is objectionable, not only because it is a filthy habit, but because it is likely to be the means of disseminating tuberculosis.

Experience as well as theory teaches the importance of controlling the expectoration of the consumptive. The two largest sanitarium for consumptives in the world are at Görbersdorf in Silesia and at Falkenstein in Prussia. Statistics show clearly that since the establishment of these sanitarium the number of cases of consumption among the neighboring inhabitants has decidedly diminished. The rules for the disinfection of sputum are particularly strict in these institutions and are so carefully enforced as to reduce the danger from this source to a minimum. On the other

land pulmonary consumption is on the increase on the southern coast of France in the neighborhood of Nice and Mentone, whither the climate has attracted an ever increasing number of patients with lung disease who live in hotels and boarding houses, with no instructions as to their hygienic rules except such as may be imposed by physicians in attendance who cannot be expected to see to it that advice as to the disinfection of sputum is followed out.

Admitting the communicability of consumption should lead to every precaution against the spread of the disease, the knowledge of the source of contagion is so certain, and that source is one so easily kept under control, that it cannot be necessary to institute harsh restrictive measures against this class of patients, or to withhold from them the advantages of admission under proper restrictions to hotels, hospitals or other places that are open to the public.—Editorial. *Northwestern Lancet*.

Sand Filtration of the Water Supply of Philadelphia.

At a meeting of Councils' Finance Committee, October 8th, the special sub-committee appointed to consider the bill providing for the creation of a loan of \$3,000,000 for the purpose of erecting a plant or plants for the filtration of the city's water supply, presented a favorable report. After a short discussion, a resolution was adopted requesting the chairman to introduce in Councils an ordinance authorizing the Mayor to negotiate a loan of \$3,000,000 for the erection of one or more filtration plants.

Craig Colony for Epileptics.

Since the opening of the Craig Colony for Epileptics, in New York, in February last, one hundred and forty-nine patients have been received; and observations to the present time tend to the conclusion that the enterprise will be a success as to both the patients' improvement and its patronage. The production of the colony's farm during the first nine months was about one-half of their total cost of maintenance. All the mechanical work of the colony is now done by artisans among the epileptics. Substantial modern buildings have been constructed by the corporation, and the managers will this year ask the Legislature of New York for an appropriation to construct a dormitory for three hundred more patients.

E. H. A.

Pathology.

OBSERVATIONS UPON THE RELATION BETWEEN LEUKÆMIA AND PSEUDO-LEUKÆMIA.

BY C. F. MARTIN, B.A., M.D.,

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AND

G. H. MATHEWSON, B.A., M.D.

THERE are few chapters in the domain of clinical medicine which have excited the interest of modern observers more than the diagnostic value of a blood examination. That it is an undoubted aid in the diagnosis of many diseases cannot but be acknowledged by all who have had any experience with these methods. But although they have been so extensively employed within recent years, there can be no question that hitherto the results have not fulfilled our expectations. In the light of the most recent observations it may be said with more than probability that there is no disease known other than those due to parasites, which, *per se*, can be diagnosed by an examination of the blood. Although a certain general law may apply to the conditions of the blood found in the various forms of anæmia, for example, such a law nevertheless is far from being absolute. Many of the secondary anæmias not infrequently show a blood condition which is indistinguishable from that of the progressive pernicious anæmia; and, apart from other clinical observations, it is absolutely impossible to make a satisfactory diagnosis. We have time and again observed in patients who were apparently suffering from grave chlorosis, an enumeration of blood cells corresponding to that usually found in pernicious anæmia; and the same may be said of not a few instances where tuberculosis and malignant disease have afforded similar observations. During the past year, also, in a patient suffering from anorexia nervosa, the blood examination revealed 900,000 red cells, about twenty per cent. of hæmoglobin, nucleated red cells of various sizes, and otherwise a condition which, from the stained specimen, showed all the characteristic features of the blood of pernicious anæmia.

From the work, too, that has been published in the last few years the diagnosis of such a disease even as leukæmia cannot be

established from a mere examination of the blood constituents. As has been shown by a number of recent observers, sarcomatous growths may undoubtedly induce a cellular ratio in the blood which is indistinguishable from that present in a typical true leukaemia. And hence, from our present knowledge, it would seem practically impossible to diagnose definitely a leukaemic condition, apart from the numerous concomitant symptoms, objective and subjective.

Having ourselves met in the past few years with not a few cases where an absolute diagnosis of leukaemia or of pseudo-leukaemia was rendered extremely difficult, it has seemed to us worth while to note this fact, and to mention briefly some instances which show how closely related these two conditions really are. That the relation between the two is in itself nothing new we are quite aware, but inasmuch as the matter has only been referred to in connection with isolated cases, and inasmuch, too, as the subject has apparently received far less attention than it deserves, we have taken upon ourselves to emphasize it the more.

Previous to careful and systematic examination of the blood the French writers, under the term "adénie," or "diathèse lymphogène," grouped together all those diseases which appeared to involve mainly multiple lymphatic glandular structures: hence they included leukaemia and pseudo-leukaemia under the same head. And it was not until some years later that an examination of the blood revealed occasional differences which permitted of a subdivision into various forms of lymphogenous diathesis, and of a separation of the two diseases above mentioned. Since that time it has been the practice of physicians to describe under different headings these two closely allied diseases, and yet within the past few years case after case has been recorded to show that such a separation is scarcely justifiable.

If we compare, for example, the morbid anatomy of the two affections, we observe to all intents and purposes identical conditions: we may get in both the same lymphoid overgrowths in the organs and in the tissues, not only where lymphoid elements previously existed, but elsewhere as well, and, above all, in the bone marrow. Within the last year, however, Askanazy,¹ writing in *Virchow's Archiv*, and following the views of Neumann,² who regarded leukaemia as a disease primarily of the bone marrow, has asserted that the morbid anatomy of the two diseases has one great distinctive feature: that in leukaemia the marrow throughout is diffusely affected, while in pseudo-leukaemia the changes are

always localized, manifesting perhaps multiple lymphomata, but never a diffuse lymphoid or pyoid condition. From the number of cases on record, however, proving the contrary the distinction would scarcely seem justifiable: while Askanazy's explanation of the absence of bone-marrow changes in some cases of true leukæmia are scarcely forcible enough to render the theory unimpegnable or to convince other authorities on this subject.

Nor can one distinguish between the forms of multiple glandular enlargements or the varieties of splenic tumors, the macroscopic and microscopic lesions are throughout interchangeable; in both one may have a like tendency to infiltration of cells: and in both the true and the so-called false disease metastases may occur in almost any part of the body. Recent observations have in this respect borne out the older theories of those who recognized between the two conditions no distinctive morbid anatomy.

There is no more satisfactory proof necessary to bear out the theory of this close relationship than is obtained in a casual perusal of the literature of the past decade, dealing with some cases of leukæmia, for it sufficiently illustrates the many difficulties one meets with in endeavoring to differentiate between cases of true leukæmia and of Hodgkin's disease. Almost every year within that period one or more cases are recorded, showing with what hesitation the observer is inclined to make any absolute distinction. If distinction there be, it is universally recognized to be a clinical consideration only, for from the morbid anatomy alone we can obtain no satisfactory differentiation other than the presence of increased leucocytes within the blood vessels. Even this, from the point of view of pathological diagnosis, is not free from objection, inasmuch as we may be at a loss to decide whether or not such a condition has been a terminal process, as so commonly occurs. The leucocytosis itself is a purely clinical observation, and it is mainly upon this feature that any question of differential diagnosis rests.

Concerning the clinical picture of the two maladies, we find in each an identical classification into types: in both a chronic form is described and in both a more acute, characterized often by the presence of irregular fever, early enlargement of glands, and onset of hæmorrhages and a rapidly progressive lethal termination. Such is Ebstein's case of acute Hodgkin's disease, in which, except for the condition of the blood, all the essential features of the case were identical with those of an acute leukæmia. Such, too, appears to be the reason why authors occasionally speak of a lymphatic

Hodgkin's disease where a lymphocytic leucocytosis occurs of too moderate a degree to warrant the application of the term leukæmia.

In the more chronic forms of these two diseases there is often a different mode of onset of the lymphoid enlargements, inasmuch as in Hodgkin's disease it is the glands, while in leukæmia it is the spleen that is first affected. Yet such a distinction is far from being absolute. Cases of Hodgkin's disease have been observed in which the spleen alone has been affected, while other lymphoid structures remained quite normal, and we have seen one such case at the hospital here in which, from general physical conditions, as well as from examination of the blood, it was impossible to make any other diagnosis than that of a splenic form of Hodgkin's disease.

Whether or not we are justified in considering the two diseases as distinct from any other clinical conditions apart from the blood examination we are unable to say. Eichhorst⁴ suggests that an essential difference between the two diseases may be observed in the urine: that in leukæmia there is an excess of uric acid, while in Hodgkin's disease he has never been able to observe any such condition. Considering, however, the frequency with which diseased blood conditions are attended with superabundance of uric acid in the urine, it would seem that an altered metabolism which induces the leucocytosis might likewise explain the presence of excessive uric acid in the urine, and that the condition may be associated in some way with the altered blood condition. That such a process does indeed occur has been proved experimentally by Kühnau,⁵ who has shown that an excessive leucocytosis is invariably associated with an increased production of uric acid. In this case, then, such a differentiation as suggested by Eichhorst would have quite as little satisfactory foundation as has the basis of differentiation by means of an examination of the blood.

It may very reasonably be questioned whether such a variable symptom as the incidence of leucocytosis should, *per se*, form a basis for the classification, or whether from our present knowledge we are not laying too much stress upon this one condition.—*British Medical Journal*, from the Medical Clinic of the Royal Victoria Hospital, Montreal.

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W. H. P.

(To be continued.)

Proceedings of Societies.

TORONTO MEDICAL SOCIETY.

THE regular meeting was held December 10th, in the Council buildings. President W. J. Wilson in the chair.

The paper of the evening was read by Chas. G. Stockton, Buffalo, on "Some Aspects of Enteroptosis."

The paper opened with a study of the body cavities in respect to the motility or non-motility of their contents. It was pointed out that the abdominal contents were markedly motile. Visceral displacements were much more common than generally supposed. In 1,310 cases examined there were 148 cases of enteroptosis. Most cases occurred in women, and were caused by improper dress. It was most often seen in those with poor musculature and imperfect development of the trunk. The essayist spoke first of enteroptosis of the colon, and of how this led to unusual faecal accumulations and intestinal stasis, with auto-intoxication. He pointed out farther how this condition was often accompanied by movable kidney. Some observers held that this latter condition was brought about by a loss of balance between the liver above and the intestines below, and that the perinephritic fat had little to do with the matter. Enteroptosis was also associated with flaccidity of the abdominal walls. Some of his cases had presented symptoms of transient hydronephrosis; others obstruction of the bowel; and others of gastric crisis—pain, vomiting, etc. One case had died in one of these crises. The patient often described the sensation as that of a dumb-bell in the side. The cause had been described as due to a kink in the ureter; by others to a temporary congestion of the kidney, which would explain the transient albuminuria. In one class of cases neurasthenia was a marked feature. In one case referred to there was constipation, food stagnation, abdominal neuralgia, chlorosis, headache, insomnia, great irritability, and inability to engage in mental or physical activity. For the patient's relief one ovary was removed, the rectum underwent surgical treatment, lavage and internal faradization were tried, careful attention was given to drugging, the eyes were attended to—all without any real improvement. Finally, after eight years, nephrorraphy was done and the woman was restored to health.

Professor Stockton then discussed the effect of enteroptosis on (1) the digestion, and (2) on the blood.

In the vast majority dyspepsia was present to a greater or less extent. This class did not include the so-called nervous dyspeptics. In a certain class of dyspeptics the cause of the condition could not be explained in any other way than by enteroptosis. Such patients were slender, possessed long, narrow chests: the upper part of the abdomen was hollowed, while the lower part bulged. Abdominal pulsation is to be seen, sometimes leading to the diagnosis of abdominal aneurism. There is lateral expansion of the abdomen when the patient lies flat on the back. (Diagrams were shown by the essayist illustrating this condition) Gastric splashing is easily produced. The transverse colon may be felt over the aorta, in the region of the umbilicus, 6-10 cm. on either side of the median line. Boaz holds that this is the pancreas instead of the colon. It was a point of uncertainty with the speaker. Tenderness over the solar plexus and along the spine was another symptom noted. Constipation, flatulency, epigastric weight and distension (worse after eating), nausea and attacks of pain and vomiting, enlarged liver, disagreeable taste in the mouth, offensive breath often—what the old text-books described as symptoms of indigestion were present. The complexion is muddy and sometimes pigmented. Added to these were symptoms of auto-intoxication—headache and cerebral discomfort. Examination of stomach contents showed free hydrochloric acid present, combined chlorides abundant, and fatty acids. The aspiration tube must be passed in twenty-four, sometimes twenty-eight inches. The stomach may not be large. A diagnosis of dilatation is often made. The essayist confessed treating a good many cases for dilatation before it dawned upon him he was on the wrong track. Patients did badly on farinaceous and leguminous foods. Albuminoids and a large quantity of water did most satisfactorily. A morning saline draft acted well as an aperient. This was sometimes inefficient, and required to be supplemented by flushing the colon. Most of the cases were improved by lavage, electricity, and good diet.

Dr. Stockton next discussed the relation of enteroptosis to chlorosis. In many cases of chlorosis displacements of the viscera could be made out. The anemia had been accounted for by the descent of the stomach and pressure on the solar plexus. The essayist quoted reports made by various authorities in regard to this relationship. Some patients with enteroptosis complained of

no special discomfort, yet they were below the normal standard of health. Examination of the blood showed a decrease in haemoglobin. The question which condition is precedent was a debatable one. He (the speaker) was inclined to think the visceral sagging occurred first and that the auto-intoxication gave rise to the anaemia. Sir Andrew Clark had drawn attention to the effects of stercoraceous poisoning before a study of enteroptosis had been emphasized. In addition to the usual modes of treatment of chlorosis with displacement of one or more of the abdominal viscera, what more could be done? What measures were at our command for restoration of the organs to their proper position? The abdomen should be supported with pads and bandages, corsets being removed. This would provide comfort in a great majority of cases. Several patients of the Professor's had worn supports which exerted pressure over the lower part of the abdomen, held in place by perineal bands. He had never known a patient to lay aside one of these bands voluntarily. Incidentally the speaker said that if he were returning to obstetric practice again he would return to the use of the binder, which he had discarded. Salines in the morning, with injections, were of value to overcome the constipation. In addition to these measures there should be the practice of suitable gymnastics and Swedish movements. They were of great use. These manipulations served to restore the organs in place, and tended to fix them there—by improved innervation and nutrition of the viscera. Trunk rotations and flexions served to strengthen the abdominal muscles and improve abdominal blood supply. The medical man should see that the masseur employed understands his work and possesses a proper knowledge of anatomy and physiology. Unless he did he would do more harm than good. One observer claimed to be able to replace and fix floating kidney. The essayist discussed the various operative proceedings used to retain displaced viscera. He then described a severe case in which nephrorraphy effected a cure. In all aggravated cases he would advise this operation. It would be followed by some benefit, if not by complete relief.

Dr. Olbright was glad Dr. Stockton had emphasized the importance of hygienic measures as a preventive of enteroptosis. He referred to cases in which severe dyspeptic conditions were present with a secondary chlorotic condition where he had suspected movable kidney had a great deal to do with it. He did not think all cases depended upon enteroptosis. The paper had encouraged him and

would strengthen his hands in the recommendation of fixation of the kidneys, a recommendation he had formerly made in a half-hearted manner.

Dr. Oakley asked that the reader of the paper should say a little more in regard to the diagnosis of floating kidney.

Dr. J. F. W. Ross said that the condition of enteroptosis was often due to rupture of the abdominal walls. In many cases of abdominal section he had noted the stomach below the umbilicus. As to the operation of nephrorraphy, he had given it up. Another cause for this condition was abdominal adhesions. The speaker then referred to various visceral displacements and the surgical means which had been used to correct them.

Dr. A. McPhedran said he was in accord with the essayist as to the frequency of this condition. While enteroptosis was a potent factor in the production of digestive disturbances and general neurasthenic conditions, yet it was also more frequently a result than a cause. In common with other parts of the body, the supports of the stomach and intestines would suffer relaxation. The chlorotic condition was generally unassociated with marked enteroptosis in his experience. He had searched for displacements but had found none. Besides, recovery was complete and permanent. The speaker laid stress on the importance of training the trunk and abdominal muscles, as well as those of the limbs, in girls especially. Those cases in which he had recommended the fixation of the kidney had not done well, and he was not able to recommend it with the utmost confidence.

Dr. W. J. Wilson asked what effect bandaging after pregnancy and early corsetting of girls had in producing the condition. He had observed in the latter class of cases flattening of the abdomen above and bulging below.

Dr. John Hunter facetiously remarked that the suburban doctor, into whose hands patients fell on removal to the suburbs fresh from the leading down-town men who had given them various prescriptions for dyspepsia, would now be able to diagnose their case by telling them that their "in'ards" were displaced.

Dr. T. F. McMahon detailed the history of cases illustrating the occurrence of gastric crises where floating kidney was present. Some cases of renal colic were very puzzling. If enteroptosis were the cause of chlorosis, why should it be found generally between the ages of fifteen and twenty-five and not later in life?

Dr. G. H. Carveth suggested that one cause of enteroptosis was

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referable to the bed which allowed the mid-body to sag, and tended to congestion of the abdominal and pelvic viscera.

Dr. H. T. Machell said it was hard to see how stitching up the kidney would relieve the various nervous disturbances caused by sinking of the stomach and colon.

Dr. Oldright thought there were many cases of floating kidney which did no harm, while others were connected with disturbances of the nervous system.

Dr. Stockton replied. He referred to the work of dress reform he had been interested in among the children of his city. Correct posture among school children should be insisted upon. As to why chlorosis did not occur in later life he did not know. Neither was he able to explain, he said, how fixation of the kidney relieved the neurotic and stomachic disturbances.

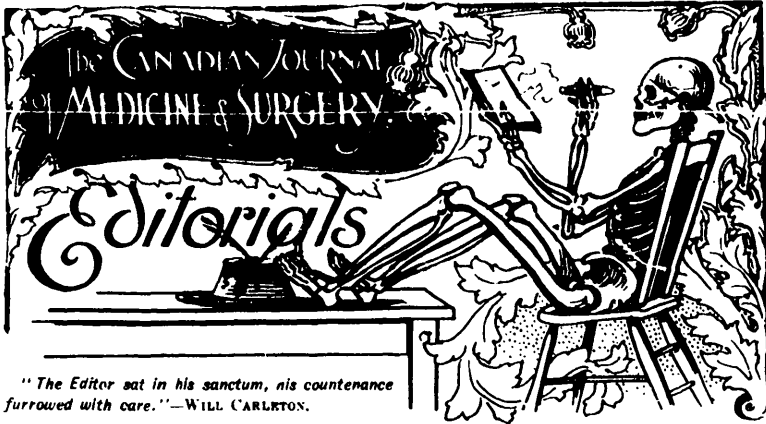
A cordial vote of thanks was tendered to the doctor.

The Society then adjourned.

JOHN N. E. BROWN, *Sec'y.*

Sanitation in Calcutta,

According to a recent Indian daily paper, is in a very bad way. Among the items of the indictment, we are told that the defective condition of the sewers has reduced the subsoil to a condition little better than a trenching ground: that the scavenging of the streets is a public scandal: that refuse, which ought to be removed before dawn, is frequently left lying about, fermenting and poisoning the air throughout the heat of the day: that the water supply is defective, and that the death rate is abnormal during the hot weather. The cause to which this disquieting state of affairs is ascribed is an old and familiar one, namely, the preponderance of native members on the municipality. The remedy propounded is drastic. "The feeling is growing stronger that the sanitation of Calcutta cannot be left indefinitely to be the plaything of gentlemen like Babus Norindro, Nath Sen and Surendranath Banerjee, and whether the reform be made from within by the expedient of nominating more Europeans, or from the outside by the more drastic measure of abolishing an elective municipality altogether and substituting some other administrative authority, a change must not be much longer delayed." Evidently some people would like to make things lively for Babus Norindro, Nath Sen and Surendranath Banerjee.—*Sanitarian.*



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VOL. I.

TORONTO, JANUARY, 1897.

NO. 1

OUR ANNOUNCEMENT.

THE CANADIAN JOURNAL OF MEDICINE AND SURGERY, of which the present is the first number, will in future appear about the first of every month, and the annual subscription is to be one dollar, single numbers ten cents.

The editors intend to devote their energies to the task of

bringing out a helpful and, withal, bright and readable monthly—a digest of some of the best articles in foreign medical journals, and an open field for the original articles of Canadian physicians.

A special effort will be made to report the work done in the clinics of the Toronto hospitals and also such other clinics as may be available. Items of interest and articles bearing on the work of the biological laboratory of the Provincial University will also be an occasional feature. The medical societies of Toronto and many others throughout the Province will be regularly reported. The quarterly reports of the Provincial Board of Health, and papers of interest to the profession written by members of that Board, will also appear.

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The Canadian profession are also cordially invited to use our pages for discussing matters of interest to physicians, and to consider the JOURNAL as their property to that extent.

We propose to carry on the JOURNAL in accordance with the ethical principles which characterize the proceedings of reputable physicians. We hope to live in harmony with our confreres of the Canadian medical press, and shall work to gain their esteem and the good opinion of our foreign exchanges. As deeds and not words count in the battle of life, we shall be willing to be judged by our record, hoping, however, that any shortcomings which may appear in this number may be credited to a first appearance.

J. J. C

MODERN CLINICAL MEDICINE.

BISHOP BUTLER has well said that "Next to knowing the truth itself, is to know the direction in which it lies." In clinical medicine, in addition to that skill, which can only be obtained by observation and practice, valuable instrumental aids to diagnosis have been multiplied of late years: but these generally come into employment when the observer has defined the seat at which he will probably find disease. Assuming that the necessary preliminary observation has been made, it must be admitted, however, that in certain well-defined plagues of modern life, such as diphtheria, phthisis and enteric fever, the bacteriologist has given to the clinician more than aids to diagnosis, in fact positive data, which illumine the obscure and give precision to the vague, thereby enabling him to apply the resources of his art at an earlier stage than was formerly possible. In this connection, it may not be unprofitable to hear what a pupil of the great Trousseau has to say on the present status of modern clinical medicine. Professor G. Dieulafoy, who succeeds Germain Sée in the chair of Clinical Medicine at the Hotel Dieu, Paris, in his opening address, which was delivered last November, shows that clinical medicine is no longer the same as it was a few years ago, that it is modified, and has been very considerably enriched, more particularly by bacteriological discoveries. He does not admit that modern experimental medicine is going to sup the foundations of her older rival, observant medicine. He does not believe that experiments on animals should replace the study of the patient, or that the medical student should pass his days of pupillage in a laboratory, instead of frequenting an hospital. He does show, however, that bacteriology is of signal service to clinical medicine.

Witness the demonstration of pulmonary consumption in a case in which, from a study of the signs and symptoms, a clinician would have felt justified in diagnosing simple bronchitis and therefore expressing a favorable prognosis. Or the still more glaring example of a physician diagnosing a case as one of follicular tonsillitis, when a bacteriological examination of the secretion, taken from the tonsil, shows that it is really one of diphtheria. Professor Dieulafoy justly says, "Clinical observation alone is unable to say if a sore throat is diphtheria or not; a bacteriological examination

can make us sure of the diagnosis.' Again, take the recent triumphant success of Widal's clump-reaction of serum on the blood of a patient, enabling the physician at an early stage of the disease to diagnose typhoid fever from la grippe or tubercular meningitis.

These examples, however, do not, in Professor Dieulafoy's opinion, diminish in any way the importance and prestige of clinical medicine; on the contrary, they should induce us to indulge the hope that, owing to continual improvements, clinical medicine will, little by little, attain the precision of an exact science. Laennec, in his day, helped to bring about this hoped-for consummation and vastly improved clinical medicine by the invention of auscultation. Every physician practises clinical medicine whenever he examines blood, urine or humors or employs the thermometer, the microscope, the ophthalmoscope, the laryngoscope and other means of verification and analysis. And when to make sure of a diagnosis he has recourse to bacteriology and experimental work, he is still practising clinical medicine.

Clinical medicine draws its sustenance, through many roots, in numberless fields: all methods of investigation increase its patrimony: its domain enlarges every day. It would not, therefore, be correct to say that there is an ancient as well as a modern medicine. Medicine is just like other sciences: it follows its own evolution and marches along with progress.

But diagnosis is only one of the aspects of clinical medicine. In treating a case of severe disease, the question of prognosis is constantly before the physician's mind, and the family and friends of the patient keep continually questioning him on the gravity of the disease, its duration and probable issue. To quote the professor, "You have a man's life in your hands: on what will you base your therapeutics: in what direction will your plan of action tend? If you lack the experience, which can only be acquired by the frequentation and assiduous and incessant observation of patients; if you are not quick to notice the changes, which may arise at any moment: if you are not clever at making out the oftentimes delicate gradations of color, which announce an approaching disease or foretell a storm: if you are not ready at the proper signal to act energetically; if you do not know how to economize the energies of your patient: if, with the hope of doing good, you overshoot the mark: if you exhaust the kidney you intended to strengthen: if you weaken the heart when you meant

just to enliven its function. in a word, if your medical education does not permit you to feel in yourself 'that interior feeling' which is like the self-felt testimony of a properly done medical duty, it is to no purpose that you are a chemist, a physiologist, a bacteriologist—you are not a physician."

Eloquent words, indeed, and true as well! Fortunate is the physician who, early in his professional career, familiarizes himself with the work of the laboratory and accustoms himself to the use of instruments of precision, ever striving to give to his diagnosis the certainty of true science. More fortunate still, if his years and clinical experience grow in harmony. Always obedient to the advances of the laboratory, always clever, painstaking and observant of his patient, striving to steer him into the safe harbor of a happy prognosis, or, at the last scene of all, ease his passage and bring him euthanasia.

J. J. C.

THE SERUM DIAGNOSIS OF TYPHOID FEVER.

ANY means which will enable a practitioner to arrive at a diagnosis in suspected typhoid fever will be heartily welcomed, and by none more than the older members of the profession. According to the theories of Pfeiffer and Widal, who made the discovery of the influence of the typhoid bacillus upon the blood of the patient, a tolerably accurate diagnosis of typhoid fever is possible within two days from the invasion of the symptoms. Dr. Wyatt Johnston, bacteriologist of the Quebec Board of Health, has given his experience with this diagnostic test in a recent number of the *British Medical Journal*. He says: "When a drop of sterilized water is added to a drop of dried typhoid blood a solution is obtained in a minute or two, which is mixed with a drop of actively motile typhoid culture, preferably not over twenty-four hours old. Examined microscopically the motion rapidly stops, and bacilli run together into loose coils or clumps. This takes place usually in a few minutes, but sometimes may require three or four hours, or even twenty-four hours."

It appears that a gratuitous public service of serum diagnosis was introduced, last September, by the Board of Health of the Province of Quebec. Suitable outfits for taking samples, consisting of pieces of sterilized paper, enclosed in envelopes, with printed directions and blank spaces for information to be filled in, have been placed at the chemists' shops, which already keep and supply

outfits for diphtheria diagnosis. In case a negative result is obtained and the suspicious continue, a small sterilized bottle containing a sterilized curette, is sent, in a mailing case. This curette can be used to obtain a small quantity of faeces, or the bottle to hold fluid blood.

Heating the paper, by holding it over a lamp, will sterilize it in a few minutes. In case malaria is suspected, the sending of a thin film of blood dried on glass, as an additional sample, would permit of this being examined for the plasmodium.

Dr. Johnston reports a percentage of 99.4 per cent. of satisfactory or decisive results from his experiments. He shows that this method of diagnosis is also applicable to cholera, in which disease Achard and Bensaude have recently shown that the reaction may be present even as early as the first day. Dr. Johnston's conclusions are as follows :

1. The use of dry blood serum diagnosis has given us what appeared to be satisfactory results for diagnostic work.
2. An incomplete reaction was occasionally obtained as early as the end of the second day.
3. The complete reaction was rarely delayed beyond the fifth day.
4. Typhoid blood, allowed to dry for sixty days, still gave the typical reaction. This might permit its application to medico-legal work.
5. In experimental cholera immunity, a typical reaction was obtained with dried blood.
6. The reaction may appear after a single dose of typhoid or cholera culture.
7. There is a possibility that the clumping of the typhoid bacilli may be utilized as a means of isolating them from cultures made from water, faeces, etc.

J. J. Mackenzie, B.A., bacteriologist of the Ontario Board of Health, who has also had a large experience with this test, is prepared to assist the profession in arriving at a correct diagnosis in suspected cases of typhoid fever. He recommends that a large drop of the patient's blood, taken from the ear or finger, be allowed to dry on a piece of sterilized non-absorbent paper and forwarded to him at the Biological Department, Toronto University. A report can be obtained in twenty-four hours by telegram, showing whether the experiment confirms or disproves the suspicion of typhoid fever.

THE INSPECTION OF MEAT AND MILK.

UNDER the department of Public Health and Hygiene, we publish the Regulations of the Provincial Board of Health relating to the construction, equipment and control of municipal abattoirs and the methods to be established for the inspection of dairy cattle supplying public milk to cities and towns. These regulations are founded on the terms of an Act passed at the last session of the Legislature for the inspection of meat and milk supplies. The public and their representatives, the Boards of Health and their medical officers are becoming very sensitive as to the quality of the meat and milk they are to consume, and have learned that not only are dangers of disease from such sources possible, but that the persons who supply these articles of food are neither well versed in the distinctions between what is wholesome and the reverse, nor anxious to investigate too closely their own supplies, though perhaps critical regarding those of others.

The Act of 1896 provides that a municipal council in a city or town may establish an abattoir, but when so established it shall be constructed, equipped and regulated in conformity with the regulations of the Provincial Board of Health. There are both sanitary and commercial reasons for this. A town might, for instance, be careful to inspect meat intended for local consumption very carefully, but might be content to allow slaughterers to ship indifferent meat products to outside markets. Farther, interested butchers might get control of such abattoirs and conduct them in such a way as to suit themselves, rather than the convenience of the public.

But the great and special benefits to be looked for are that the regulations establish a systematic means of protecting the public while informing both them and the producer, whether butcher or farmer, that it is quite possible, and likewise profitable, to study the prevention of animal diseases, and again, that if Canada is to keep pace with other countries in the competition for the food markets of the world, she must apply to the study and suppression of animal diseases the same systematic methods which have proved so successful during the past fifteen years in other countries.

The testing of dairy cows and the licensing of dairymen whose herds are free from tuberculosis, have now passed the point of discussion and have become, in several American cities, routine procedures. For instance, a by-law of Minneapolis contains the

following words: "It shall be the duty of the Commissioner of Health to cause to be made by the veterinarian of the Department of Health, or under his direction and supervision, an examination of each and every animal producing milk for sale or consumption in the said city and belonging to or controlled by said applicant or the person from whom said applicant obtains his milk, for the purpose of detecting the presence or absence of tuberculosis or any other contagious or infectious disease: and the said veterinarian of the Department of Health, in making such inspection and examination, is hereby authorized to use what is commonly known as the 'tuberculin' test, as a diagnostic agent for the detection of tuberculosis in such an animal:" and upon freedom from such disease the license is granted. When it is considered that the milk supplies of Toronto are obtained from probably not less than 7,000 cows, it is plain that the work of inspection, to be systematized and effective, will at first require some labor and expense. The Act provides, however, that the Board of Health may fix the price for inspection and charge so much per animal inspected. This method will serve the desired end of encouraging honest and business-like dairymen in their efforts to keep good cows, since a license from the Health Office becomes a guarantee of the soundness of his products. We hope that a decided advance will be made by our city and town medical officers in establishing such inspections, as are provided for under the Act, during the coming year.

THE JENNER MEMORIAL.

THE form of a memorial to Dr. Jenner, the world-renowned physician who discovered the effects of vaccination, is being discussed in the correspondence columns of the *British Medical Journal*. One physician makes the following suggestion: "Let the Jubilee year of Her Majesty be commemorated in this country by the passing of an Act of Parliament enforcing vaccination (primary and secondary), and supplying every opportunity for the obtaining of efficient, reliable vaccine. No greater, nobler or more lasting memorial could be raised." We heartily endorse what Dr. Murray Bradwood (Amersham, Bucks, Eng.) has said in this connection, and have no doubt that the matter will be promptly taken up and pushed through to a successful issue, thereby placing England in this respect as far forward as any other advanced nation.

SIXTY-FIFTH ANNUAL MEETING OF THE BRITISH MEDICAL ASSOCIATION, MONTREAL, AUGUST, 1897.

THE *British Medical Journal* of December 5th gives quite a long article on the approaching meeting of the British Medical Association in Montreal next August. The article is well illustrated with views of McGill Medical College, Royal Victoria Hospital, Laval University, and the buildings of the Medical Faculty of McGill College, all of which will have a most fruitful tendency and instil into the minds of the medical profession all over Great Britain that they are not meeting in a small and insignificant town partially inhabited by Indians and covered nine months of the year with several feet of snow, with a temperature away below zero; but, on the contrary, will prove to them that the Association is going to meet in one of the most cultured cities on the continent of America. The article goes into every detail, giving the history of the original formation, by Mr. Ernest Hart, in 1892, of branches of the British Medical Association throughout the colonies, when that gentleman, who left behind him many friends, took a tour to India and then across the Pacific to Canada, on his way addressing meetings at Vancouver, Winnipeg, Toronto and Montreal. Sir William Hingston (then Dr. Hingston) at that time bore "the burden and heat of the day" in bringing to a successful issue the formation of the Association in Montreal, and he well deserves the honor bestowed upon him in being made president of the Reception Committee, which entails less active work than would have devolved upon him in being made President-elect, a position he had to resign at the time of his appointment as Senator in the Dominion Parliament.

The article goes on to give a detailed description of the city of Montreal, McGill University Medical School and the Montreal hospitals, and also describes the buildings in which the various meetings will be held.

We sincerely hope that the meeting of this, the largest and most influential medical association in the world, will be a huge success, and we think that we may safely say that if the same depends upon the support which will be given to it by the profession all over Canada, its success is already assured.

W. A. Y.

APENTA.

PHYSICIANS are occasionally consulted as to the advisability of using natural aperient waters, and people with or without the advice of their medical advisors are often ready to use them to relieve chronic constipation, etc.

The main objection to these waters is that the dose is not constant, the effect in one instance being as great from the use of a wineglassful as would be in another instance from a tumblerful of the same water, and analysis also shows that in the process of bottling these waters, injurious organic substances are occasionally added.

Apenta, a new natural aperient water from the springs at Ofen, in Hungary, is put up under the control of the Royal Hungarian Chemical State Institute, which should be a guarantee of its freedom from injurious extraneous matters as well as its constancy. The analysis published by Professor Liebermann shows that the proportion of sulphate of soda to sulphate of magnesia is gram 15.432—24.4968 in the litre, so that this aperient water may be classed as one of the strongest in the market.

THE MEDICAL PROFESSION IN FRANCE.

WE are all more or less dissatisfied with the state of things in the medical commonwealth in these realms: it is interesting, therefore, if not particularly comforting, to note that our brethren in some foreign countries are even as we are in this respect. There is France, for instance, where it is sometimes said the profession occupies a more fortunate position. If we are to believe a distinguished journalist—M. Hugues Le Roux—we have no reason to envy our French confreres. M. Le Roux has recently discussed in the *Figaro* the question, Shall our sons be doctors? He answers it, implicitly, with an emphatic negative. In the first place it is not easy to become a doctor. M. Le Roux estimates that, reckoning in the expenses of preliminary education, it costs something like £1,600 to get the diploma. Then comes a weary period of waiting for patients, entailing further expense. If a practitioner starts in a country district he has to face the competition of the local "vet.," the cure, the bonesetter, and the blacksmith; and he is called in

only in hopeless cases, so that, with a confusion between cause and effect natural to the untutored mind, he comes to be looked upon with suspicion as a kind of Angel of Death. In towns there are the hospitals, which not only give indiscriminate relief to the working class, but take paying patients at charges varying from 2 to 12 francs a day: in these receipts the medical staff has no share. Then there are the clubs, which can always get doctors to serve them at 2½d. a visit. There is also the competition of unqualified practitioners. In spite of the law—on paper—against the unlicensed practice of medicine, Paris swarms with herbalists and “curers” of all kinds, and the vilest quacks advertise their wares in the newspapers without let or hindrance. M. Le Roux states that there is in a certain town a priest who professes to have a secret remedy for incurable diseases. His door is thronged with patients from 5 a.m. to 8 p.m., and appointments have to be made two or three weeks beforehand. This clerical healer is said to hand over £4,000 each year to his archbishop for the purposes of the Church; what he keeps for himself is not stated. The pharmaceutical chemists, with their various “specialities” and plausibly written pamphlets vaunting their efficacy, are also formidable rivals to the legitimate practitioner. The attempts which have been made by medical associations of different kinds to remedy these evils have so far failed: and, indeed, it is not easy to see how there can be any real betterment in the state of the profession so long as it is overcrowded. If M. Le Roux’s article deters any considerable number of parents from making doctors of their sons, it will have served a useful purpose. It might not be amiss if some popular journalist were to enlighten the mind of the British paterfamilias on the same subject.—*B. M. J.*

DR. H. C. PARSONS, Trinity '92, late of Johns Hopkins, is studying in London.

SIR WILLIAM MAC CORMAC, the well-known surgeon of London, Eng., is rapidly recovering from his recent serious illness and is now able to sit up daily.

SIR DOUGLAS MACLAGAN, of Edinburgh, Scotland, has intimated his intention of resigning the chair of Forensic Medicine, which he has held since 1862, in the University of Edinburgh, at a salary of £800 a year. He is to be succeeded by Sir Henry Littlejohn, of the same city.

A NEW APERIENT WATER.

BY PRIVY COUNCILLOR PROF. OSCAR LEIBREICH.

(Regius Professor of Pharmacology, University of Berlin.)

It has oftentimes been pointed out, and that, too, with reference to mineral waters, that the first condition of therapeutic efficacy is the constancy of the remedy employed. In the case of natural mineral waters this point is of the greatest importance.

The aperient waters offer the one sole exception in regard to this constancy among our natural mineral springs. These are formed by impregnation of the natural basins which supply the mineral constituents. From this, as observation teaches us, there arises an extraordinary inconstancy of the chemical constituents. The aperient waters, therefore, form an exception to the mineral springs proper. For medical purposes it is absolutely necessary, in prescribing this water, to know the dose. It has happened not infrequently that a wineglassful of aperient water has been shown to contain the same amount of mineral constituents as the practitioner would, from the analysis, expect to be present in a tumblerful. It is obvious, therefore, that neither the practitioner nor the patient can form a correct opinion in this manner; and under these circumstances it may even happen that an unexpectedly great degree of concentration may do harm by useless irritation of the intestines. There is a further disadvantage arising from changes in mineral constituents, so that, instead of the sulphates which the water should contain, chlorides are present in an injurious amount. The opinion has very often been expressed that the bottling of such waters should be under scientific control, so that their proper constitution should be ensured exactly in the same way as that of other medicines is regulated by the Pharmacopœia.

It is, therefore, a matter for high satisfaction that the aperient water, "Aperita," from the Uj Hunyadi Springs in Ofen, has been placed under State control. The Royal Hungarian Chemical State Institute (Ministry of Agriculture) has undertaken this charge, and, therefore, it is now possible to obtain a water which is free from injurious extraneous waters infected with organic substances. The analysis has been published by Professor Liebermann, Director of the said Institute. The proportion of sulphate of soda to

sulphate of magnesia is 15.432 to 24.4968 in the litre, so that this water is to be classed with the best aperient waters, and may be pronounced one of the strongest. Owing to the constancy of the Apenta water ensured by the State guarantee, that confidence in aperient waters which had been lost will be revived in favor of this important therapeutic agent. The constancy of the Apenta water makes the use of it indicated not only as an occasional purgative, but in systematic courses of treatment. It is particularly recommended for the regulation of tissue change in the most diverse diseases, in obesity, chronic constipation, portal obstruction, hæmorrhoids. Whether the lithia contained in this water is of any therapeutic importance is at present doubtful, but its presence is a distinctive feature in the analysis.

Personals, Etc.

DR. PHILLIPS has moved to 11 King Street West.

DR. JOHN HUBBARD, of Brock Avenue, has left the city.

DR. McKEOWN has removed from 92 to 82 McCaul Street.

DR. H. J. HAMILTON has removed to No. 329 Church Street.

DR. H. A. BRUCE, Tor. '92, has obtained the degree of F.R.C.S.

DR. J. NOBLE is again running for School Trustee. We wish the doctor every success.

DR. J. S. KING has opened a branch office at the drug store of D. C. Ferguson, 529 King Street West.

DR. A. E. AWDE, of Dovercourt Road, has resigned his seat on the School Board, as he has moved to Philadelphia, where he will occupy a position in one of the large hospitals.

THE Chatham Medical and Surgical Society has been reorganized and will meet on the first Wednesday of each month. *DR. J. H. DUNCAN* has been elected president, and *DR. R. V. BRAY*, secretary.

THE report of the eleventh annual meeting of the Association of Executive Health Officers of Ontario, held at Niagara-on-the-Lake, September 14th, 1896, has been received.

DR. A. BOULTBEE, of Bloor Street East, has been appointed Medical Superintendent of the Keeley Institute (Dwight, Ill.) at the corner of Sherbourne and Lynden Streets, Toronto. The doctor was married on December 28th, to Miss Hannaford, of Toronto.

DRS. ADAM WRIGHT and E. E. King have, we understand, purchased from The Bryant Press the *Canadian Practitioner*, which they propose to make brighter and more attractive than ever. Perhaps the editors will permit us to extend to them our congratulations. We have no doubt that the profession will in the future as in the past give them their heartiest support.

IN these days, when there is such a tendency amongst a certain class of druggists to substitution, the practitioner cannot be too careful when ordering the preparations of certain reliable and well-known firms, not only to state on their prescription just what they wished dispensed, but also to make a point of examining the bottle of medicine after being put up in order to see just what has been used in its composition. Fairchild Bros. & Foster, of New York, who have been placing on the market for years their time-tried pepsin and peptone preparations, recently, by legal procedures, gave a quietus to this disgraceful state of matters which we hope will last for some time to come.

MARRIAGES.

DR. T. H. HALSTED was married on October 7th to Miss C. C. Palmer.

DR. NORMAN ANDERSON, of Toronto, was united in marriage on December 8th to Miss Berta Macdonell.

DEATHS.

DR. R. J. HASTINGS, who for a year or so has practised on King Street East, died of septic pneumonia on December 1st. The doctor was a popular young man and was rapidly gathering round him a large clientele. He was a cousin of Drs. A. and C. J. C. O. Hastings, of Toronto.

THE death of Dr. Déclat is announced. He was the author of several treatises on antiseptic methods of treatment. The most remarkable of these is on the treatment of infectious diseases by carbolic acid. He was well known in Paris, and after a long medical career retired to Nice, where his death took place.

WE regret to announce the death of Dr. R. H. Gowland, Tor. '92, which took place at Johns Hopkins hospital last month, where he had undergone an operation for some kidney trouble. Deceased had commenced practice in Hamilton, his home city, and was highly esteemed by all who knew him. He leaves a wife and one child.