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CANADA MEDICAL RECORD

SEPTEMBER, 1901.

Original Communications.

CANADIAN MEDICAL ASSOCIATION.

The 34th Annual Meeting of the Canadian Medical Association opened at Winnipeg, Manitoba, on the morning of the 28th of August and continued for the two following days. There were in attendance over 175 members from all parts of the Dominion, the second largest gathering in the history of the Association; and the meeting itself has been pronounced the most successful of any yet held under the auspices of this Association. There were several visiting doctors from the United States.

Dr. H. H. Chown, of Winnipeg, the President, occupied the chair, while Dr. F. N. G. Starr, of Toronto, discharged the duties of Secretary.

In the absence of Chief Justice Killam, Dr. J. H. O'Donnell, one of the oldest practitioners in the West, delivered the address of welcome. He referred to the conditions present in 1869, when Winnipeg was an outpost of civilization, and gave interesting references to Drs. Cowan, Curtis, J. Bird, Beddom and Bund, who were already in the West when Dr. O'Donnell moved there in 1869. His address was very much appreciated by the members of the Association.

Dr. R. W. Powell, of Ottawa, the Past President of the Association, then introduced Dr. H. H. Chown, the President-Elect to the Association.

Dr. Chown, on rising to reply, was received with hearty cheers, testifying to the high esteem in which he is held by his fellow practitioners throughout the Dominion. He briefly thanked the Association for the honour they had conferred upon him at the meeting in Ottawa one year ago.

Dr. Starr, the Secretary, presented his Annual Report. It referred to the meeting at Ottawa last year, to the attendance of 153 members, which was an increase over former meetings in this city, to Dominion Registraton and to the formation of a Physicians' Medical Protective Association.

Dr. Edebohls, of New York, and Dr. Sutton, of Pittsburg, were welcomed to the Convention and requested to participate in the discussions.

THE QUESTION OF MEDICAL DEFENCE.

This was introduced by Dr. Russell Thomas, of Lennoxville, Que., who had been delegated by the St. Francis District Medical Association to present this subject to the Canadian Medical Association. He made a strong plea for the formation of a Medical Defence Union, and thought that all were agreed of the necessity for such. He supported his contentions by citing two or three cases already well known to medical practitioners in Canada, and, after showing that such defence unions were a success in England, he concluded by outlining the plan of medical defence already in vogue and supported by the St. Francis District Medical Association, which he was authorized and prepared to hand over entire to the Canadian Medical Association. The discussion of this important matter was deferred until later on in the session.

ADDRESS IN MEDICINE—"THE QUESTION OF MEDICAL EDUCATION."

Dr. J. R. Jones, of Winnipeg, delivered this address. In opening his remarks he referred to the unsolved problems of Medical education, the importance of which were especially manifest in view of the establishment of a Dominion Medical Board. Uniform or equivalent curricula, he thought, would

greatly facilitate paving the way for the accomplishment of this object. He thought that the great aim of the Canadian Medical Association should be to create a Dominion Medical Board upon such a sound and enduring basis that the qualifications could be registered in every province of the Dominion. They should not only be Canadian, but Imperial, capable of registration in Great and Greater Britain. There should be no special education for the profession of medicine, and the defect in the preliminary education of medical students should be corrected. The standard is not high enough. Many students come into the medical college, their minds totally unprepared, undisciplined, not competent to engage in the different studies of a profession to advantage. Dr. Jones would not eliminate Latin, but would go a step farther and advocate a more general knowledge of Greek, as Greek was *par excellence* the language of science. He quoted from two eminent authorities, who favour the retaining of classical education as training for professional studies—Dr. Alexander Hill, a member of our own profession, who is Master of Downing College, Cambridge, and Prof. Jebb of Berlin. He referred to medical matriculation examinations, and deplored the lamentable defects in the English paper, the most neglected subject in our primary schools. From an experience of many years as an examiner at the University of Manitoba, Dr. Jones has concluded that the teaching of English takes a very subordinate position in our schools. The defect was a universal one; and it was obvious, if English should become a prominent subject of medical matriculation examinations, every student ought to be able to express his thoughts coherently and intelligently. The didactic lecture came in for adverse criticism, and defects and useless waste of time, which could be more profitably employed, were pointed out. Persistent work in the dissecting room, under the guidance of an experienced demonstrator, who will describe, discuss, and constantly orally examine the student is a rational and effective method of teaching Anatomy. Medical Jurisprudence and Sanitary Science were not properly taught.

Dr. Jones supported the "case" method of teaching; and from personal experience he favours the English system of clinical clerkships and dresserships as the most feasible, practicable and thorough for the development of medical teachings. He referred to the question of Dominion Registration, and pointed out two serious objections to Dr. Roddick's Bill: First, the great number of the representatives on the Council, entailing expenses beyond at least our immediate resources; and second, the fact that one of the contracting parties to Dominion Registration may secede, and the elaborate fabric, the work of many years, tumble to the ground. The able paper of Dr. Jones was received with much gratification by the Association.

Dr. R. B. Nevitt, Dean of the Woman's Medical College, Toronto, in moving a vote of thanks to Dr. Jones for his able paper, stated that he had placed his finger on the weak point of Medical Education. Dr. S. J. Tunstall, of Vancouver, seconded the motion, for the vote of thanks and also congratulated Dr. Jones for the excellent manner in which he presented his subject.

DOMINION REGISTRATION.

Dr. T. G. Roddick, of Montreal, who has so long and so ably advocated this much-to-be-desired measure, delivered a stirring address on the subject, ably reviewing the subject of inter-provincial registration from the time of its inception to the introduction of his Bill at the last session of the House of Commons. The special committee appointed on this subject had not yet reported, so the discussion was postponed until the committee had a chance to meet and report later on in the session. Dr. Roddick now seems to hold to the opinion that the suggestion of Dr. Britton, of Toronto, that representation by population, for Ontario at least, would be advisable.

INFECTIOUS PNEUMONIA.

Dr. W. S. Muir, Truro, Nova Scotia, read this paper. He reported four cases, all of which had occurred between

the 1st and 13th of April of this year, in the same house and in the same family. The first occurred in a child of ten years, the disease terminating by crisis on the 6th day, the child making a good recovery. A sister aged fourteen contracted the disease, terminating by crisis on the 9th day, but followed two days after by left-sided pleuro-pneumonia. This proved fatal. The third occurred in a sister of fifteen years of age beginning with a pain on the left side, and terminated on the 10th day by crisis and recovery. Number four developed pneumonia, but recovery was quick, the patient being about in two weeks. There was no influenza in the town at the time. Dr. Muir spoke of the organism of pneumonia, its cultivation and its detection.

First Day—Afternoon Session.

PRESIDENT'S ADDRESS.

As this was the first time that the Canadian Medical Association had met in Manitoba, Dr. Chown referred briefly to the future of that important province. Although less than 10 per cent. of the arable land was under cultivation, Manitoba's farmers would this year have a crop estimated at 85,000,000 bushels of grain. He then referred to the work performed in Winnipeg for the purpose of making that city a healthy one, and, in spite of the level nature of the land an excellent system of sewers had been introduced through all the streets, and efficient arrangements had been made for regular flushing of the sewers by means of tilting basins at the upper end of each main sewer. As Winnipeg has two rivers at her doors, the problem of removing sewage was easily and safely solved. Dr. Chown then referred to the water supply, and said that the people of Winnipeg enjoyed as pure water as could be found in the world. An examination of the city water would show that there were in it only nine to thirty colonies of bacteria. The water is taken from an artesian well seventeen feet in diameter and forty-eight feet deep, and, although they have been pumping for months a supply of from two million to three million gallons per day,

there is not the slightest evidence of any diminution of the amount flowing in. This well is supposed to tap an underground passage which runs from Lake Manitoba, and, as this lake is 130 miles long, the supply is inexhaustible. The underlying rock formation in that section of Manitoba is magnesia limestone, and, consequently, the water contains a large amount of the carbonate of lime and of magnesia, and is too hard for satisfactory use in boilers and hot-water appliances. This is overcome by using Clark's method of softening by precipitation of these carbonates through the action of limewater, and the softening plant is unique on this side of the Atlantic. Dr. Chown then referred to the question of tuberculosis, and thought that Koch's tentative denial of the oneness of tuberculosis of man and tuberculosis of cattle still needs the proof of non-inoculability from cattle to man. He instanced cases of young farmers free from tuberculous taint, living in newly-built houses, harbouring no bacilli and separated by long distances from their neighbours, in whom tuberculosis constantly makes its appearance; and we have here an experiment on a wide scale, and, if you can eliminate heredity, house infection and contagion from other cases, to what cause can you ascribe the origin of these outbreaks? Medical education, the plan of Dominion Registration, as introduced by Dr. Roddick, malarial fever, proprietary drugs, the progress in surgery and the future of bacteriology and hæmatology were subjects ably dealt with; and in concluding Dr. Chown felt that a duty rested upon the medical profession to get at the true cause of all forms of disease, and rescue the public from both the honest fanatic and the ignorant pretender by doing not only what these claim, but doing more and doing it better.

Sir James Grant, of Ottawa, moved a vote of thanks to the President, and characterized the address as extremely interesting and instructive. Dr. J. L. Bray, of Chatham, seconded the motion.

EPIDEMIC CEREBRO-SPINAL MENINGITIS.

Dr. James McKenty, Gretna, Manitoba, presented this paper, which gave an account of an epidemic occurring in North Dakota during the winter and spring of 1893. It occurred within an area extending fifty miles from east to west and twenty miles from north to south, and was comparatively definitely limited. About seventy persons were seriously ill, and almost as many others suffered from mild manifestations of the disease. Of the seventy cases twenty-five ended fatally—a mortality of about 35 per cent. In the practice of Dr. McKenty there occurred some thirty cases, a brief record of twenty-two of these being kept. The average age was seventeen years; the youngest, fifteen months; the oldest, thirty-eight years. The duration of the disease extended from twelve hours to fifteen weeks. No *post mortem* was made in any case. Dr. McKenty then described in detail the clinical aspect of several cases.

SPLENIC ANÆMIA, WITH CASE.

Dr. A. J. Macdonnell, Winnipeg, contributed this paper with the history of the case. This was an exceedingly rare disease. In 1898 the number of cases recorded did not exceed thirty, but since that time there has been fifty additional cases reported. R. N., aged 27 years; environment good; has never had malaria; habits and mode of life good; positively never had syphilis. The present illness began in August, 1899. Felt heavy on the right side with a feeling of fullness and weight. In January, 1900, gave up work on account of muscular weakness. There was no vomiting. The patient consulted Dr. Macdonnell in March, 1900, walking into his office with considerable difficulty. There was no enlargement of lymphatic glands. Enlargement of the stomach could never be percussed or palpated. Liver dulness was practically normal. There was no jaundice or pain in the liver region. The patient succumbed to the disease, but no post-mortem was held. Another case occurring in a patient aged seventeen was reported. Dr.

Bell made a blood-count in this case, which at different times ranged 3,540,000, then 3,600,000, then 3,400,000, with 7,602 white-blood cells. In this case all the other organs were normal; and there seemed to be no pre-disposing cause in this case. Dr. Macdonnell stated that only ten autopsies had been made on people dying from the disease. He referred to the conditions found post-mortem in these cases. The treatment was stated to be rest, diet and vigorous doses of arsenic. The mortality is set down at 20 p.c. As far as operation is concerned physicians will not be satisfied until it is clear that the patient recovers from the operation as well as from the disease. If we are sure of our diagnosis, then surgical intervention is deemed advisable.

PHYSICAL DEVELOPMENT.

Dr. J. N. Hutchison, of Winnipeg, read a carefully prepared paper on Physical Development. The paper did not deal with anything new, but called attention to and emphasized certain facts of considerable importance. He considered that children were sent to school at too early an age, and, as a result, there was danger of brain over-work. He insisted upon the necessity of having healthy parents and deplored the system of education which developed the mind at the expense of the body. He was an advocate of periodical lectures by duly qualified physicians to separate classes of boys and girls on the subject of sex, but the primary responsibility in this matter he placed upon the parents. There would be real progress in the prevention of tuberculosis when people, the subject of the disease, recognized that they should not marry. The paper which was listened to with close attention closed with a reference to the problems of those unfortunates who are neither mentally nor physically qualified for the duties of life.

REPORT OF CASES TREATED WITH SUPER-HEATED DRY AIR.

Dr. W. H. Pepler, of Toronto, introduced this subject in a paper which cited his experience and observations in the treatment of certain cases by this plan or process. He briefly

described the apparatus and the method of treatment. It only takes twenty minutes to reach a heat of 300 degrees F. The average duration of the application of the heat is forty-five minutes. The physiological and therapeutical effects noticed were referred to as dilatation of blood-vessels, etc. He administers the treatment one hour after meal time with due regard that there shall be as little as possible excitement and exertion. He has not seen any ill-effects from the treatment. He first gave notes of the case of a patient, a man aged thirty-five years, who had suffered for some time from varicose ulcer of the right leg, with considerable pain. This patient had a treatment of 35 minutes' duration, and was able to walk home with very little discomfort. After three times, in ten days, the ulcer was very much reduced in size. The second case was a patient twenty-two years of age who had been troubled with rheumatism for two years past. A temperature of 320 degrees was employed with good satisfaction. Several other cases of rheumatism and eczema were reported. The treatment in each case proved highly satisfactory, patients never complaining of any discomforts and all expressing satisfaction with the treatment. Dr. Pepler subjects a considerable portion of the patient's body from a temperature of 280 to 320 degrees F. The results are often not apparent for some time after treatment.

Dr. McAdam, of Battleford, asked Dr. Pepler if he had ever tried the treatment with high temperature, where he had any doubts of the condition of the heart.

Dr. MacDonald, of Brandon, referred to a case which had come under his observation in which there was heart trouble. Perspiration occurred freely, but with no effect in a depressing way upon the circulation. Treatment in this case was continued for two weeks, but he had never determined that there had been any effect upon the heart, although there was a small heart-lesion at the time.

Dr. Pepler in reply: He could not speak personally as to any deleterious results from weak heart. Of course there were many cases reported where heart trouble was present.

He personally had never noticed any heart or head symptoms in his cases. He thought with care there would be no bad results.

ORTHOPEDIC TREATMENT OF DEFORMITIES AND DISABILITIES RESULTING FROM DISEASES OF THE NERVOUS SYSTEM.

With special reference to tendon transposition, by Dr. B. E. McKenzie, of Toronto, who spoke of disabilities and deformities resulting from paralysis, some of which were commonly regarded as hopeless; but the conditions of a great majority of them were remediable and should receive a considerable amount of attention. He was at some pains to explain the respective motion of joints, particularly the ankle joint and knee joint, especially calling attention to the normal conditions of equilibrium, and then showed how the muscles of some of the groups at times became paralyzed and the balance and equilibrium thereby destroyed. Mechanical treatment was often necessary and often efficacious as well; massage and electricity had their respective places, but he made particular reference to the method of treatment that had been in vogue for twenty years and had been introduced on this continent by Dr. Parish, of Philadelphia. He went carefully into an explanation as to how muscles can be transferred from their usual point of action and then he gave an account of several cases in which he had successfully accomplished this. In his opinion amputation of a limb, because of apparent disability, should seldom or never be resorted to.

In answer to Dr. McAdam, Dr. McKenzie disapproved of jackets in treatment of curvature of the spine.

Dr. Clarence Starr, Toronto, stated that the subject was of great interest to him, as he was interested pretty largely upon the same lines of surgery. Mr. McKenzie had indicated a large number of cases of paralysis which can be wonderfully helped by operative procedures.

Dr. Starr thought that Dr. Bowlby, of Boston, deserved

a great deal of credit for the work he has performed in this connection.

Dr. H. B. Small, of Ottawa, referred to a case Dr. McKenzie had operated on. In this case, previous to operation, the boy had great difficulty in arising from the sitting posture, and when walking he had to rest every few yards. After the operation he was very much improved, and when Dr. Small last saw him, about a week ago, he could walk very easily, and never had to support himself. The improvement during the last four or five weeks was especially very marked.

Second Day—Morning Session.

MILD SMALL-POX.

Dr. G. A. Kennedy, McLeod, Alberta, presented this paper. It dealt with the recent outbreak of the disease in the North-West Territory, an outbreak which was widespread and which had existed for some time before its true nature was recognized. Dr. Patterson, quarantine officer for the Dominion Government, was satisfied that there had been 1,500 cases. A noteworthy fact was that the greatest number of cases occurred among the French half-breeds, who had never been vaccinated, and further, Indians on reserves had not suffered to any great extent, as annual vaccination is the rule. Not one case was seen or heard of among Galicians, Doukhobors or Roumanians, which was due to the fact that compulsory vaccination was the rule in youth, and then they had been re-vaccinated on their recent passage across the Atlantic and at Halifax. Fifty per cent. of all cases were extremely mild in character, forty per cent. were cases of typical varioloid; ten per cent. were severe, almost confluent. The mortality was slight, only thirteen deaths occurring, and the disease prevailed fully as much amongst adults as amongst children.

Dr. Muir, Truro, Nova Scotia, discussed the merits of the different vaccines on the market, and the paper was further discussed by Dr. MacDonald, of Brandon; Dr. Inglis,

of Winnipeg; Dr. D. H. Wilson, of Vancouver; and D. Montizambert, of Ottawa. The latter considered it would be unfortunate if the impression went abroad that any doubt existed in the minds of the members of the Canadian Medical Association as to the true nature of the disease which had been epidemic for some years. He considered the facts presented in Dr. Kennedy's paper, relating to Doukhobors and Galicians, were perhaps the most valuable portion of it. At the close of this discussion the following resolution was moved by Dr. R. S. Thornton, seconded by Dr. J. L. Bray and unanimously adopted:—"Resolved, that in view of the general prevalence of small-pox throughout the continent, this Association desires to urge upon the profession and the public generally the necessity of vaccination and re-vaccination."

CHRONIC ULCERATION OF THE STOMACH, SIMULATING CANCEROUS DISEASE.

Relation of a case of Gastro-Enterostomy with Murphy Button, Recovery, By Dr. J. F. W. Ross, Toronto. This occurred in a woman twenty years of age, the condition of whose stomach had been bad for three years. She was a nurse in the training school of a hospital, and her gastric conditions grew gradually worse and worse. Dr. Ross was asked to see the patient by Dr. E. B. O'Reilly, Hamilton, in December, 1899. He found her emaciated, with the opium habit already formed. In January, 1900, he again saw her with Dr. Griffin, of Hamilton. At this time rectal alimentation was being persevered in with considerable benefit. In March, 1900, she was discharged from the hospital and remained well for two weeks. As soon as food passed into the stomach great rigidity of the right rectus muscle was noted. When the patient came under Dr. Ross's attention she weighed about 75 pounds. As malignant disease of the stomach is rare at this age of life, it was difficult to diagnose the tumour as such, and the symptoms pointed to the pyloric end of the stomach; it was not possible to say whether cancer-

ous or not. The symptoms pointed to the presence of ulcer, but the thickening easily made out lead to the belief that malignant disease had been grafted on to the ulceration. Some dilatation also could be made out, but the rhythmic muscle waves so characteristic of pyloric obstruction could not be found, but a large growth was found at the pyloric end. The case was looked upon as hopeless, and decision was arrived at, not to remove the growth, but to give temporary relief by gastro-enterostomy. This was done and the patient made an uninterrupted convalescence. Eleven months after the operation the patient weighed 140 pounds and looked the picture of health. On examination of the abdomen no mass could be felt, and the patient was not suffering from any gastric symptoms at all. Dr. Ross then went into the literature on the subject, quoting Fagge, Sydney Martin, Moynihan and Mayo Robson.

Dr. Laphorn Smith, Montreal, began the discussion, stating that the case was especially interesting to him, but rather from the general practitioner's point of view. He believes that no case of cancer of the stomach every begins as cancer of the stomach. First, there is some sort of irritation of the mucous membrane. This irritation finally becomes a chronic ulcer, and upon this the germ of cancer is engrafted, or whatever it is which is the essential constituent of the cancerous process.

Dr. Martin, Montreal, discussed the importance of the examination of the stomach contents in these cases.

Dr. Bruce, Toronto, stated that he had an experience with a case a year ago which corresponded closely to the one Dr. Ross has reported. His patient was thirty-eight years old.

Dr. Gilbert Gordon, of Toronto, thought that we should look at these cases from the standpoint of the physician as well as from the standpoint of the surgeon.

Dr. Howitt, Guelph, stated that the second case of ulceration of the stomach upon which he operated was one of acute perforation.

Dr. Ross thanked them for the reception they had given his paper.

SOME FORMS OF HYPERACIDITY AND THEIR TREATMENT.

Dr. C. F. Martin, of Montreal, presented notes of some interest, judging from the results of systematic examination of the gastric contents. The unfortunate general employment of the term "dyspepsia" is responsible for the disregard of this condition. In the case of organic disease producing excessive secretion, the diagnosis is often difficult. He gave the history of two cases in illustration, the second being an individual forty-five years of age, who gave the unusual history of having been ill for six months. There was no obstruction of the pylorus, but simple dilatation of the stomach. He also referred to the medical treatment following gastroenterostomy.

Dr. MacDonnell, of Winnipeg, discussed this paper.

MEDICAL DEFENCE.

The report of the committee on Medical Defence was here presented by W. S. Muir, of Truro, N. S. It reported favourably on the formation of a Medical Union, and the organization thereof was immediately perfected. It will be known as the Physicians' Medical Protective Association, will be incorporated, and will have for its object the protection of the character and interests of medical practitioners in Canada. It will further promote honourable practice, will aid in suppressing or prosecuting unauthorized practitioners and will seek to advise and defend or assist in defending members in cases where proceedings involving questions of professional principle or otherwise are brought against them and other like matters. Dr. R. W. Powell, of Ottawa, was elected President; Dr. McKinnon, of Ottawa, Secretary, and Dr. James Grant, jun., of Ottawa, Treasurer.

REPORT OF COMMITTEE ON DOMINION REGISTRATION.

It is proposed to secure an Amendment to the B. N. A. Act, or to take advantage of section 91 of that Act, and under it obtain legislation from the Dominion Parliament, by which the profession in Canada might form a Dominion

Council and which could be supplemented by legislation by the various provinces recognizing any certificate of standing issued by the Dominion Council as entitling a holder to practice in such provinces. Dr. Muir approved of Dominion Registration, and spoke for the Province of Nova Scotia. Dr. Jones voiced the sentiments of the profession for Manitoba. Drs. A. A. Macdonald and J. L. Bray endorsed the scheme for Ontario. Dr. Russell Thomas spoke for Quebec. Dr. Christie said that New Brunswick was in favour of Dominion Registration. Dr. Lafferty said the North West Territories were favourable.

Second Day—Evening Session.

CANCER OF THE UTERUS, WITH LANTERN DEMONSTRATIONS.

This was a very interesting and profitable demonstration conducted by Dr. Thos. S. Cullen. In introducing Dr. Cullen, Dr. Chown spoke of him as a young Canadian who had gone wrong in having removed to the United States and having never returned. Dr. Chown considered that the experimental work pursued by Dr. Cullen, if done in Canada, would meet with as signal success as that which attended his labours in the United States. For over an hour Dr. Cullen was engaged in showing a large number of excellent lime-light views, the results of microscopic examinations of tissues, each view being lucidly explained by the demonstrator. At the close of his excellent demonstration Dr. Cullen was accorded a hearty and unanimous vote of thanks, moved by Dr. Eccles, of London, and seconded by Dr. Gray, of Winnipeg, and carried amid great applause.

SKIN DISEASES WITH LANTERN DEMONSTRATIONS.

This was another valuable demonstration and was conducted by Dr. Francis J. Shepherd, of Montreal. He first exhibited cases of blastomycetic dermatitis, and further spoke of a few cases which he had seen of this disease. Views were also given of cases after treatment with iodide of potash. Some interesting views were those caused by drug eruptions,

of which he showed two or three due to salicylate of soda. In one of these Dr. Shepherd said that the lesions first came out with large welts like urticaria. This is rather a rare form of drug eruption. It appeared after two doses of ten grains each of the drug. One case almost died of acute laryngitis from the eruption in the throat. Amongst other views shown were papular purpurs, which is generally associated with rheumatic attacks, psoriasis of the nails, X-ray burns, as the result of one application, and most interesting were cases of small-pox, one showing postules upon the palm of the hand, particularly interesting, as in adults you never see chicken-pox upon the palm of the hand, but you invariably do in small-pox. Views of feigned eruptions were also shown. This demonstration proved so interesting to the members that Dr. Shepherd was frequently called upon to give more or go on.

THE VARIETIES AND DISTRIBUTION OF BACILLI DIPHThERIEÆ AND THEIR CLINICAL SIGNIFICANCE.

Dr. F. F. Westbrook, of the University of Minnesota, presented a paper on this subject, primarily from the laboratory point of view. He exhibited a carefully prepared chart, showing in tabulated form the results of numerous examinations in schools, and stated the conclusions which he deduced from these facts. Formerly, it was believed that the bacillus remained localized at its point of entrance, but now within recent years, however, careful observations have showed that the toxins had been distributed throughout the body and the bacillus itself found in organs far removed from the atrium. From evidences of 230 cases of diphtheria at autopsy, observers had called attention to the frequency with which the bacillus of diphtheria was found in the organs of the body. The bacillus and its toxins have been shown to be capable of producing lesions which differ greatly from each other, as in ulcerative endocarditis, meningitis, etc. In summarizing Dr. Westbrook said, where each school was reported and where great care was taken in the isolation of clinical cases with typical form, the percentage was very small.

REMOVAL OF HAIRY TUMOUR FROM THE STOMACH WEIGHING
23 OUNCES—SPECIMEN—RECOVERY. BY DR. H. A.
BRUCE, TORONTO.

The subject of the case was a woman aged 26; she had been married six years, and had two children. A lump was noticed in the abdomen two months previous to the birth of the last child. Patient had no symptoms. The lump was about five inches in width, and it could be lifted forwards. It reached to within three inches below the umbilicus. It gave the patient no special discomfort, there being absolutely no symptoms present. Dr. Bruce advised exploratory incision. This was done on July the 22nd last, at St. John's hospital, Toronto. On opening the abdomen in the middle line the spleen and kidneys were found in normal condition, but there was a large mass in the neighbourhood of the stomach. The surgeon could make out the mass lying free in the stomach, a portion extending through the pyloric end of the stomach. An incision was made into the stomach and the mass removed. After removing the mass of hair, the opening of the stomach was closed in the usual way. Hot salt solution was given every two hours and nutrient enemata every six hours. Twenty-three hours after the operation sips of hot water were given by the mouth. Forty-eight hours after operation patient was given one half an ounce of milk and lime water every hour. She left the hospital on the twentieth day. The tumour was entirely of hair exactly the same colour throughout and the same colour as the hair on her head. It was 24 inches in length, being about 2 inches in diameter at one end and gradually tapering to a point at the other. Dr. Bruce considered this case rare, but offered no solution as to how the hair got into the stomach. There were no evidences of hysteria present in the patient. There are some specimens of hairy tumours in the McGill Museum at Montreal.

Third Day—Morning Session.

A CASE OF TRANSPLANTATION OF THE URETER FOR CURE OF URETERO-VAGINAL FISTULA. BY A. LAPHORN SMITH, MONTREAL.

This occurred in a married woman thirty-four years of age, who came to Dr. Smith on the 1st of July. During parturition forceps were employed and the vagina lacerated, and ever since there has been a constant flowing of urine by the vagina. Operations for the relief had been performed in England without success. Dr. Smith had seen Sanger perform an operation of this character in Leipsic, when he was there three years ago, namely, to open the peritoneum running over the large vessels at the brim of the pelvis and to feel for the artery, see the vein and pick up the third tube, which was the ureter. The operation was done in the highest Trendelenburg posture. A very small incision was made in the peritoneum lining the pelvis in the line of the ureter, a silk ligature was passed around it, and then the ureter was severed a little above the ligature. The end of the ureter was split open to a distance of a third of an inch. A slit was then made obliquely into the right upper corner of the bladder and the ureter stitched into it—the mucous membrane of the ureter to the mucous membrane of the bladder with very fine chromicised catgut. This is the first time this operation has been done in Canada, and Dr. Smith stated that not a drop of urine had passed through the fistula since.

SYPHILIS AS SEEN BY THE OPHTHALMIC SURGEON.

This paper was read by Dr. F. Buller, Montreal. In commencing his paper Dr. Buller expressed the hope that it would elicit a little discussion. It often falls to the lot of the ophthalmic surgeon to discover the presence of active syphilitic virus where the disease had long since been considered cured or that the subject cherished the belief that there was no more to fear from it. The ophthalmic surgeon is scarcely,

if ever, called upon to treat the disease in the primary stage. The largest share of his work is in connection with the tertiary period, and in this class of case the disease has been apparently cured for a long period of time. Dr. Buller considers that the time at which the syphilitic lesion makes its appearance is always a very important element in the diagnosis. Discussing medication, Dr. Buller does not believe that the protiodide of mercury at least as ordinarily administered is a reliable anti-syphilitic. He appears to favour the inunction method first and then gray powder. The following took part in the discussion of this paper: Dr. Lafferty, of Calgary; Dr. Muir, of Truro; Dr. Laphorn Smith, of Montreal, and Dr. Shepherd, of Montreal, who also condemned the protiodide treatment.

THE PRESENT OUTBREAK OF SMALL-POX IN AMERICA.

This subject was presented by Dr. H. M. Bracken, Health Officer, Minnesota. He outlined the origin and traced the course of many outbreaks in various parts of the State of Minnesota. The case of a porter on the Great Northern Railway, who arrived in St. Paul in March, 1899, was mentioned as the source of the outbreak. He was supposed to have contracted the disease in Seattle, and, when told that he had small-pox, he said that if so there was plenty of the same disease where he came from. Other epidemics were spoken of in various parts of Minnesota, with a total of 9,429 cases, and the disease has still many centres in that State. It is impossible to locate positively the source of the present wide-spread epidemic farther than that it spread from the southern and south-western States into North Dakota, Minnesota, Nebraska, Montana and Texas. Dr. Bracken showed that returning soldiers from the Philippines were not responsible for its introduction. He suggested that it was probably imported into the United States by Cuban refugees before war broke out between that country and Spain.

An interesting discussion took place on this paper. Dr. Russell Thomas wanted to know where the best vaccine was

manufactured, a product that could be relied upon.

Dr. Inglis, formerly Medical Health Officer, Winnipeg, related his experience in the schools of Winnipeg, and spoke of some of the bad results obtaining through impure vaccine.

Dr. Bracken in reply: Vaccine was frequently spoilt by not being kept in proper temperatures, as it was frequently being shipped in cans which were too hot, and subsequently kept in warm offices. The Health Commissioner, of Minneapolis, kept all his vaccine in an ice-box, but, of course, not frozen, and had obtained good results. Replying to a question in regard to isolation, Dr. Bracken favoured eighteen days' quarantine.

THE NECESSITY OF A RECOGNITION AND ISOLATION OF TRACHOMATOUS PATIENTS IN CANADA.

In the absence of Dr. W. Gordon M. Byers, Montreal, Dr. C. F. Martin, of the same city, read this paper. The paper recited the history of a young girl from Glengarry County, Ontario, who came to the Clinic at the Royal Victoria hospital, Montreal, with a most intense condition of granular lids. She had been unable to open her eyes properly for months past, and her vision was reduced to the counting of fingers. The seriousness of her disease had not been recognized at home as she mixed freely with other members of the community. Another case was referred to in the County of Leeds, and in this case as well no precautions had ever been taken to prevent the spread of the disease. Dr. Byers believes that there are many unrecognized and untreated cases scattered here and there throughout the Dominion. The disease is said to be prevalent in districts of Manitoba and certain centres in the Eastern counties of Ontario, and others in Quebec. The Trachoma problem has had to be faced by one Government in Europe, and the matter has been brought to the attention of the Dominion Government, which has not yet taken any action in the matter. Dr. Montizambert stated that the question of exclusion of trachomatous immigrants had been under

consideration by the government for some time. He considered these people somewhat undesirable immigrants

A FEW NOTES ON THE TREATMENT OF TYPHOID FEVER.

Dr. J. L. Bray, of Chatham, discussed this subject under medicinal, dietetic and hygienic headings. The first he thought might be eliminated, except in cases where complications arise, and he thought a certain amount of medicinal treatment useful during the initial stages. He was in the habit of employing calomel. Tympanites could be avoided to a great extent by a proper diet. In feeding, now, he gives very little milk, but that little always peptonized. He believes in making the patient drink two or three quarts of pure water in the twenty-four hours. Albumen water with sugar may be given from the first; after the first two weeks he gives liquid peptonoids, or some of the numerous preparations of beef, jellies, mutton broth or a soft boiled egg.

As regards the hygienic treatment, the bedding and the night clothes should be changed daily. The room should be kept thoroughly ventilated, admitting plenty of fresh air and sunshine. The patient should be sponged frequently with tepid water, and you get just as good results from tepid water as from sponging with very cold water or the cold bath, and it is not so distasteful to most patients. In hospital practice Dr. Bray used the electric fan after using the tepid water. He has found this plan very satisfactory, especially in young and sensitive children.

Dr. Russell Thomas discussed the paper, and said that he had found the ice-cap beneficial, that it did not disturb the patient, and had a decided effect in reducing the temperature.

Third Day.—Afternoon Session.

THE ADDRESS IN SURGERY.

This was delivered by Dr. O. M. Jones, Victoria, B.C., and it proved a very able and masterful effort. He opened his address with a reference to surgical diseases in Western

Canada as compared with those in the East, and stated that he had often found Western sufferers more impatient, which often demanded severer methods. He illustrated this by reciting a humorous incident. A lodging-house keeper, on learning that one of her boarders was to have an operation performed on a Wednesday, wrote to the surgeon asking that it might be postponed until Friday, as her daughter was to be married on Thursday, and they didn't want the corpse home until after the wedding. The address dealt mainly with surgery of the stomach, and related the deductions Dr. Jones has arrived at from his own experience of twenty-six cases. His first operation upon the stomach was in 1893,—a case of pyloric obstruction in a wiry woman. Senn's plates were used. This patient died in three days, the result not being encouraging, and Dr. Jones attributed the failure to the use of catgut instead of silk sutures. The introduction of Senn's plates and the Murphy button gave a great interest to intestinal surgery, as before 1890 operations on the intestines were rare. He discussed the preparation for operation, and first spoke of gastrostomy, an operation which he had performed five times for ulcer of the œsophagus. In four of the cases the operation was performed with very excellent results. He then discussed the class of case in which pylorotomy is indicated, and said that rapidity of operation in these cases is the very important factor; prolonged operation has generally proved fatal. A suitable case should be cancer of the pylorus. The time occupied in performing the operation is not great. In one of his cases he performed posterior gastro-enterostomy; this patient still lives, and it is now nearly three years since the operation. Gastro-Enterostomy was next discussed. This, Dr. Jones considered the most important and most interesting part of the whole subject. It is the most frequent and the most useful, and the simplest of all the operations performed upon the stomach. It is performed for pyloric cancer, ulcer and stenosis and for gastric ulcer, dilatation, etc. Nothing can be simpler than this operation performed with the Murphy button. Dr. Jones has

used it in fourteen cases, and in only one case was there any trouble. In two of his cases, which died from shock, he examined one and found perfect union. He has found that the passage of the button has taken from fourteen days to four months, and in several cases he has not been able to obtain the button. A recital of several cases followed, which proved very interesting. Dr. Jones closed his paper with a few words on perforating duodenal ulcer.

Dr. F. J. Shepherd, of Montreal, proposed a vote of thanks, Dr. A. A. Macdonald, of Toronto, seconded this; Sir James Grant, of Ottawa, supported the motion, which was unanimously passed by the Association.

A SURGICAL PROCEDURE FOR THE RELIEF OF OVARIAN-TENSION PAIN.

Dr. Henry Howitt, Guelph, Ont., read this paper. Is not pain, frequently, if not usually, caused by tension on some nerve filament? In Dr. Howitt's opinion the answer should be in the affirmative. The operation Dr. Howitt employs is quite simple. The ovary is exposed, and then a number of cross-sections are quickly made through the tense capsule in such a manner as to divide it. Then the large graffian follicles are opened. They are merely touched with carbolic acid. If the capsule is thickened a portion should be removed. Hemorrhage has never been troublesome. Adhesions give rise to no complications. Dr. Howitt recited the histories of two or three cases in support of the operation.

Dr. Laphorn Smith stated that he had never heard of this operation before, and considered that it was original with Dr. Howitt.

SYMPOSIUM ON TUBERCULOSIS.

Professor Russell, of the University of Wisconsin, introduced this subject in a careful yet exhaustive paper on human and bovine tuberculosis and their inter-relation. The importance of any phase of investigation relating to tuberculosis and its relation to milk is unquestioned in these

latter days when the general public is beginning to appreciate, for the first time, the magnitude of the problem that confronts them in attempting to lessen the ravages of the "great white scourge" of the human race.

In considering this subject it may be reached from two points of view:

1. From the standpoint of animal industry.
2. From that of public health.

Bovine tuberculosis and animal industry.

The rapid extension of the disease amongst cattle within the last few decades has forced upon breeders and dairymen the necessity of considering this subject whether they desire it or not. It is customary in many quarters, even yet, to decry all consideration of this matter as unnecessary, inexpedient and harmful to the dairy interests. But, as is too frequently the case, the motive for such action rests upon a financial foundation, and many breeders are averse to a calm, judicious discussion of the matter simply because it may mean financial loss to them.

Since the introduction of the tuberculin test as an aid in the diagnosis of the disease in cattle, it has been positively determined that the malady, at least in its incipient form, is very much wider spread than was formerly supposed, but it by no means follows that all animals that react to the tuberculin tests are actually in a condition in which they or their products are dangerous to man and beast.

The slow insidious nature of the disease that characterizes it in the human is also to be found in the cattle, and not infrequently an animal may be infected with the seeds of the disease for a considerable time—even a year or so—without showing in any degree physical symptoms that are manifest to even the animal expert. Such animals are not diseased in the ordinary meaning of the term, *i.e.*, they are not capable of transmitting the disease, either directly or indirectly, through their milk or meat. The affection in such cases is latent; generally confined to various lymphatic glands, but animals so affected are, however, potentially

dangerous, for the latency of the disease may be overcome through the operation of various factors, and the chronic type may thus be awakened into the acute phase. It is in this way that the disease spreads slowly and unperceived through a herd. Before it has made such inroads as to cause actual death of any considerable number of animals, many more have acquired the trouble, at least in the earlier phases. Necessity of controlling its spread and eradicating it is evident for the sake of the herd itself, if from no other point of view. Successful animal industry, especially with cattle, requires that the herd shall be kept free from all taint of this disease. As to treating milk, Professor Russell said pasteurization and sterilization were the two best forms of applying heat to destroy the organism. He recommended the rotatory Pasteurizing machine, one of which has been used in Winnipeg for some years as the best method of removing organisms from milk.

Dr. Good, of Winnipeg, in discussing the paper said that it afforded him some relief to learn that milk is not so dangerous after all. He stated that he had been avoiding milk and all organic fluids for the past year or two, but he was glad to know that he could now go back to its use with the same freedom as in its younger days. He then moved a vote of thanks to Professor Russell, seconded by Dr. McArthur, which was unanimously adopted.

Dr. A. J. Richer, of Montreal, contributed the next paper on the Sanatorium Treatment of Tuberculosis. This treatment had been introduced by Dr. Trudeau in America under great difficulties, and at the present time this distinguished scientist was able to house and treat over one hundred individuals in his institution. According to Dr. Richer, the treatment is made up of rest, outdoor life, over-feeding and medical supervision. The latter was described as the key-note to success in phthisical treatment. Over-feeding was also emphasized.

The last paper was contributed by Dr. Gilbert Gordon, of Toronto, and it referred to the ætiology and the early

diagnosis of pulmonary tuberculosis. He spoke of the early stages of the disease, and thought that we ought to be able to diagnose it before the appearance of the bacilli in the sputum. Direct inheritance he considers very rare. The inhalation of dried sputum is the most direct cause. Dr. Gordon considered that we are woefully behind in Canada in fighting this plague, and more money should be spent by governments and philanthropic individuals in fighting this disease. He went carefully into the symptoms of the pre-tubercular stage and considered that a persistent cough was a very dangerous symptom.

Another important discussion took place upon this topic. Dr. Lafferty warned the profession in Ontario against sending advanced cases to the Northwest Territory. Dr. Barrick, of Toronto, pointed out that Ontario was leading in regard to the treatment of tuberculosis, and he hoped to see the sanatorium brought with a wide open door to all conditions of life. Dr. Brett, of Banff, suggested that the association should pass a resolution pointing out to the Parliament of Canada the necessity of providing for the establishment of sanatoria for the benefit of the community.

The report of the Nominating Committee was presented by Dr. W. S. Muir, Truro, N.S., who expressed regret at having to accept the resignation of their general secretary, Dr. F. N. G. Starr. Montreal was selected as the place of meeting in 1902, and a suggestion was left with the members of the Association that they meet in British Columbia the following year.

These officers were elected for the ensuing year :

President.—F. J. Shepherd, Montreal.

Vice-Presidents.—Prince Edward Island—S. R. Jenkins, Charlottetown ; Nova Scotia—T. F. Macdonald, Hopewell ; New Brunswick—Wm. Christie, St. John ; Quebec—J. Alex. Hutchinson, Montreal ; Ontario—Bruce L. Riordon, Toronto ; Manitoba—A. J. Macdonell, Winnipeg ; Northwest Territories—H. G. McKid, Calgary ; British Columbia—J. M. Lefebvre, Vancouver.

General Secretary—George Elliott, 129 John street, Toronto.

Prince Edward Island—H. D. Johnson, Charlottetown; Nova Scotia—J. M. McLean, North Sydney, C. B.; New Brunswick—W. E. Ellis, St. John; Quebec—C. F. Martin, Montreal; Ontario—H. A. Bruce, Toronto; Manitoba—J. T. Lamont, Treherne; Northwest Territories—G. A. Kennedy, Macleod; British Columbia—G. Morris, Vernon.

Treasurer—H. B. Small, Ottawa.

Executive Council—Jas. Stewart, T. G. Finley, J. M. Elder.

The Winnipeg meeting of the Canadian Medical Association will go down in the annals of the history of that Association as the best meeting ever held under its auspices. On the first day alone 130 members were registered, and the total number at any time reached 177, a number considerably larger than that at Ottawa last year, and second in point of numbers to the meeting at Toronto in 1899. A large number of new members was elected, particularly from Ontario, Manitoba, the Northwest Territories and British Columbia. Every province was represented at the Association meeting with the single exception of Prince Edward Island, one delegate coming as far as North Sydney, Cape Breton. The meeting was generally voted a pronounced success, and certainly the profession in Winnipeg and Manitoba and the citizens of Winnipeg more than eclipsed in point of social functions any previous meeting. The reception by the Board of Governors of the Winnipeg General Hospital, the reception by the ladies of Winnipeg at Wesley College, the special trip down to Lower Fort Garry, where Mr. and Mrs. Chipman extended their hospitality to the members and their wives and invited guests from Winnipeg, the visit to the Ogilvie Mills, the reception at Government House by Lieutenant-Governor and Mrs. McMillan and the special trip out to Brandon through the great wheat belt of Manitoba with the entertainment provided by the ladies of Brandon,—all

will stand as a series of social functions which have never been surpassed in the history of the Canadian Medical Association meetings. One of the best and most important discussions took place on the formation of a Medical Defence Union; and it is very gratifying to have to record it, that such an organisation was unanimously supported by the Association. All the leading officers of this protective Association are in Ottawa, and Dr. Russell Thomas, of Lennoxville, P.Q., along with Dr. W. S. Muir, of Truro, N.S., are deserving of much praise for the great good work they have performed in this connection. Much regret was expressed at the resignation of the General Secretary, Dr. F. N. G. Starr, of Toronto, who has so long and so faithfully, so ably and energetically, discharged the responsible and important duties of this position. At a time when the Association is so prosperous it is due to the new General Secretary and other officers that a united and earnest effort be put forth by all the members of the Association to continue that prosperity.

Selected Articles.

THE CAUSE OF DIFFUSE PERITONITIS COMPLICATING APPENDICITIS AND ITS PREVENTION.

Every surgeon who treats patients suffering from acute appendicitis must be impressed with the fact that an unfavourable outcome in any given case means that the infection, which was originally confined to the small space occupied by the vermiform appendix itself, has first invaded the tissues immediately surrounding this organ and has been distributed over the entire peritoneal cavity. In other words, in fatal cases the patient practically always dies, as the result of a diffuse peritonitis.

Other conditions may arise which may result in a fatal issue. There may be a septic thrombosis of the vessels in the vicinity of the appendix, or an empyaema, or even pyaemia, but by far the greatest number of deaths occurs from diffuse peritonitis, and if it is possible to prevent this, the mortality from appendicitis must at once fall enormously. In order to plan a means for the prevention of this condition, it is well to study the pro-

gress of the disease from its onset.

There is danger of the occurrence of diffuse peritonitis in the following classes of cases:—(1) In gangrenous appendicitis; (2) in perforative appendicitis; (3) in cases in which the caecal end of the lumen of the appendix is closed and the distal portion so thoroughly distended with septic material as to make its walls permeable to micro-organisms; (4) in the very rare cases in which there are small abscesses in the walls of the appendix not directly connected with its lumen, and (5) in cases in which there is a septic thrombosis of some of the vessels, but not sufficient to cause gangrene.

The first, second, and third conditions are so common that every surgeon who operates frequently during the acute attack has seen them many times.

Were it possible to keep the septic material in these cases within the circumscribed area in which it occurs primarily, it is plain that the condition would remain comparatively harmless.

The appendix is virtually surrounded on all sides, excepting in the direction of the median line by relatively fixed tissues. Above we find the lower end of the caecum and the caecal end of the ileum; to the right and in front is the parietal peritoneum; behind the peritoneum covering the iliacus muscle, and towards the median line it is surrounded by loops of small intestines. Moreover, the omentum extends far beyond its lower end. It is true that the appendix may be displaced downwards, but in this case it will again be surrounded by fixed tissues which seem especially adapted to dispose of septic material. Again in this case there is an enteroptosis affecting the caecum, and always with this a marked lowering of the transverse colon and stomach and with these the omentum. Thus we see that the natural anatomical arrangement for the protection of the general peritoneal cavity is extremely efficient. There is but one weak point in the anatomical provision for this protection, namely, in the direction of the median line, because the great mobility of the small intestines naturally favours the distribution of septic material to all parts of the peritoneal cavity. If we can prevent the small intestines from doing harm in this direction, we will have accomplished our end, theoretically at least.

At this point I wish to direct your attention to another important anatomical condition. The blood supply of the omentum is so enormous that it will readily dispose of a very severe infection by walling off the

surrounding structures if it is permitted to give its physiological attention to a single area. It is a well-known fact which every one who frequently operates during the acute attack of appendicitis, has had many opportunities to observe that the omentum crowds itself about any inflammatory or traumatic lesion within the peritoneal cavity the moment the latter occurs, and if left undisturbed, a few hours will suffice to cause efficient protective adhesions. These adhesions become stronger every hour and the blood supply in the omentum becomes greater, so that if no disturbance arises, one can reasonably expect efficient protection to the general peritoneal cavity from the omentum.

Another important fact must not be lost sight of in this connection. The fact that the surrounding structures are relatively fixed in position favours the condition of rest of the inflamed part and permits the omentum to act after the manner of a splint applied to an inflamed joint. The value of rest as a preventative to the extension of an infection in any part of the body cannot be over-estimated. Consequently, if it is possible for us to secure this condition of rest, we have gained another important point in the right direction.

In case the appendix is displaced upwards its position is even more favourable, because the available amount of omentum is thus increased. Again, if the appendix is retro-caecal in its position, which is very frequently the case, the infection of the general peritoneal cavity is more easily prevented than when in its normal location. If anteriorly misplaced, it is likely to be fastened to the anterior abdominal wall by the adherent omentum.

It is plain, then, that the infection of the general peritoneal cavity must occur from a disturbance on the part of the small intestines, and must be due to their peristaltic motion. It is significant that in almost all cases of severe acute appendicitis, the obstruction to the passage of gas and intestinal contents through the ileo-caecal valve is one of the early symptoms. Nature is trying to prevent this very dangerous disturbance by closure of the ileo-caecal valve. We have a condition corresponding to the contraction of the muscles surrounding an inflamed joint, to the closure of the eyelids in conjunctivitis, etc. Moreover, the muscles overlying the appendix become tense. Everything tends toward the establishment of conditions of rest in the vicinity of the inflamed organ.

It is a fact which has been demonstrated a great number of times, that peristalsis does not occur unless food or catharics are introduced into the stomach. If the attack occurs shortly after a meal and before all of the food has passed through the ileo-caecal valve, its presence may cause peristaltic motion in the small intestines. Upon reaching the ileo-caecal valve the latter may prevent its passage into the caecum, causing return peristalsis, and the intestinal contents are forced back into the stomach, whence it may be expelled by vomiting or be again forced into the small intestine, giving rise to further peristaltic motion. Moreover, it will give rise to the formation of gas, which must cause disturbance and pain in its attempt to pass the ileo-caecal valve.

This motion, it is plain, will be harmful primarily from the fact that it gives rise to pain by disturbing the sensitive inflamed tissues, and secondarily from its likelihood of carrying infectious material with which it has come in contact in the vicinity of the inflamed appendix to other parts of the peritoneal cavity.

Besides this, the physiological attention of the omentum can now no longer be directed to the single area of infection, because other parts of the peritoneal cavity require its protection, and such portions of the omentum as are not yet thoroughly adherent about the inflamed appendix are likely to be diverted from this point.

Theoretically, then, the disturbance which is to be feared to so great an extent is caused by the presence of food or cathartics in the stomach, and its logical remedy would be to absolutely prevent the introduction of any form of food or cathartics into the stomach and the removal by gastric lavage of any portion of food which may be retained in the stomach at the beginning of the attack. It may be necessary to perform gastric lavage twice, or at most three times, in order to entirely remove remnants of food which may have regurgitated into the stomach from the small intestines by reason of return peristalsis. That this is not only true theoretically, but also in practice, I have demonstrated in a large number of cases, and many other surgeons who have followed the same plan of treatment have informed me of the fact that their experience has agreed with mine.

It is true that a few surgeons have reported failures with this method, but an investigation of their treatment in each instance has shown that they disregarded one of the three cardinal points in the treatment. They either gave just a little liquid food by the mouth, or they gave

some form of catharics, or disturbed the rest of the intestines by giving large enemata, or they neglected removing the stomach contents by gastric lavage. Of course, the slightest amount of food is sufficient to start peristaltic motion of the small intestines, and the same is true of cathartics, and consequently, if either of these features in the treatment is omitted, one cannot hope for the same results. It does not matter what form of appendicitis may be present in any given case, it seems clear that this form of treatment must be useful, because in the milder cases it will result in rest of the affected part, and consequent rapid resolution; while in the severe cases it will guard against mechanical distribution of infectious material, and in all cases it reduces the tendency to meteorism, and stops the pain.

There is, however, one class of patients in which I have found this treatment of the greatest value. I refer to the class in which the appendix is gangrenous, or perforated, and in which there is already a beginning general peritonitis. These patients give the impression of being extremely ill. There is complete obstruction to the passage of gas or faeces. There is nausea or vomiting and marked meteorism; the pulse is small and quick; usually there is a high fever, but the temperature may be subnormal; respiration is rapid, and the abdominal muscles overlying the appendix are tense. The patient is in a condition in which I formerly operated at once, day or night, as a last resort, only to find that it was too late in more than one-third of the number of cases, the mortality increasing with the time that had elapsed since the beginning of the attack. In this class of cases there is still a recovery of over 90 per cent. if the principles laid down above are thoroughly applied.

If peristalsis is absolutely inhibited, as it can be, the infection will soon become circumscribed and the pus can be evacuated with safety. Moreover, the condition I have just described is in itself the result of the administration of food and cathartics. Had these patients received neither food nor cathartics from the beginning of their attack, the condition would never have advanced to this dangerous point. This refers particularly to a class of cases which Richardson has so well described as "too late for an early and too early for a late operation."

If the plan I have outlined above is carried out, the following changes are likely to occur:—The nausea and vomiting will cease after one or two, or at the most three, gastric irrigations. The meteorism and the pain will

decrease greatly during the first twelve hours, and will almost completely disappear in twenty-four hours. The pulse becomes slower and firmer and more regular, the breathing deeper, and the patient's general appearance improves to an astonishing extent. If the temperature was high, it will go below 1008 F. the first twenty-four hours, and in three days it will be practically normal. The abdominal muscles will become soft as soon as the stomach contents have been removed by gastric lavage. Usually the improvement is so rapid that one is tempted to spoil everything by giving nourishment by mouth, because the patient's condition does not seem serious enough to warrant such severe measures.

That this form of treatment, which I have employed since 1892, at first only in selected cases, and later more and more generally, is really of great value, is shown by clinical results. My mortality in cases of perforative or gangrenous appendicitis, with beginning diffuse peritonitis, is less than one-fourth as high as it was in the cases operated at once upon making the diagnosis, and even in advanced cases of diffuse peritonitis there has been a marked decrease in the mortality in my experience. It might be said that these cases were not due to perforated or gangrenous appendicitis, but that they were simply severe catarrhal cases, which are known to result favourably under any form of treatment. To this I would respond that I have later removed the appendices in many of these cases, and have almost invariably demonstrated the correctness of the diagnosis.

In my statistics I utilize only the cases which I have operated in the Augustana Hospital, because of these I have full and accurate records, while of those operated in other hospitals and in private homes my records are not accurate, because there the patients and assistants are not so completely under my control. From January 1st, 1898, to May 1st, 1901, I have operated in this hospital upon 565 appendicitis cases, which I have divided into three groups: (1), those who entered the hospital suffering from diffuse peritonitis; (2), those who entered the hospital suffering from gangrenous or perforative appendicitis, and (3), those who entered the hospital suffering from recurrent appendicitis in the interval between attacks, or at the beginning of a recurrent attack when the infectious material was still confined to the appendix. Of the first class I treated 18 cases, with 10 deaths, 55.5 per cent. mortality; of the second class I operated 179 cases, with 9 deaths, 5 per cent. mortality; of the third class I

operated 368 cases, with one death, 1-3 per cent. mortality. Total, 565 cases, with 20 deaths, 3.5 per cent. mortality: The statistics contain all patients who entered the hospital suffering from appendicitis; even those who died a few hours after admission.

Of Classes 2 and 3, all were operated, so there can be no doubt concerning their diagnosis. Of Class 1, all but 4 were operated, and these were in an absolutely hopeless condition when they entered the hospital. I will state also that during this time no patient suffering from appendicitis was refused admission into the hospital.

Judging from the authorities upon this subject, our mortality of 55.5 per cent. in diffuse peritonitis is as low as that recorded by any of the authors whose statistics contain a considerable number of these cases, while some authors with less than half this number report as low as 20 per cent. mortality. Krogius has compiled the statistics of fifty-eight authors whose combined mortality is a little over 70 per cent.

As compared with my own experience in former years, when all of these cases were treated surgically at once, my experience in this series of cases of diffuse peritonitis following appendicitis is quite encouraging.

It is in the second class, however, in which the greatest benefit from the treatment is found. In this class, according to most modern authorities, Murphy, Mynter, Porter, Lennander, Bull, and many others, there is a mortality of at least 20 per cent. This, in my cases, has been reduced to 5 per cent., and had the treatment been instituted at the beginning of the attack, I am certain that the mortality could easily have been reduced to one-half of this. In Class 3 there should have been no death. Many of these cases had been treated through their acute attack by the method I have described, before being sent to the hospital. But as not all of the cases I treated outside of the hospital came later to operation, it is not fair to utilise these in demonstrating the value of the method.

Again, I have treated a large number of cases through the acute attack of appendicitis with this method which have never been operated, and which I have not included in my statistics, because the correctness of the diagnosis could not be established by actually demonstrating the condition present in the appendix.

However, the fact that there was a mortality of less than one-third per cent. in so large a number of cases is significant. It shows the value of a method by which

cases of acute appendicitis in whom an operation is bound to give a high mortality at best can be changed to chronic appendicitis in which the mortality following operation is almost nothing. It is, of course, not possible to come to any definite conclusions from a collection of statistics, because there are so many differences which can not be balanced.

Among these cases one is especially instructive because it illustrates the danger of operating too early. The patient entered the hospital five days after the beginning of the attack. His condition was exceedingly grave, as indicated in the history. With an immediate operation I should have expected his death within thirty-six hours. The diagnosis was made of gangrenous appendicitis. He was placed on exclusive rectal feeding. Within twenty-four hours his pain had entirely disappeared, his general appearance improved greatly, the meteorism subsided, his temperature fell three degrees, his pulse came down forty beats per minute, his abdominal wall became soft, and twenty-four hours later I began to doubt my diagnosis. At the end of the fourth day his condition had improved so much that, upon his request, I concluded to operate, because he was normal in every respect with the exception of a slight induration in the region of the appendix and pain upon deep pressure. It seemed to me as though the process must have stopped just short of a perforation. Had he been left without an operation there could be no doubt but what he would recover temporarily from this attack. It seemed perfectly safe to operate. Upon opening the abdomen I found a perforated gangrenous appendix surrounded by a small abscess completely walled off by the omentum. I removed the appendix and the surrounding pus with great care, and drained the cavity, expecting the patient to recover, but a diffuse peritonitis developed, from which he died five days later. This case impresses the lesson that it is not wise to operate until the patient has fully recovered from the acute attack. Of course, he should be cautioned as regards his diet in order to prevent a recurrence, but I am confident that the mortality in my practice will be still smaller in the future, especially because I shall wait longer after the acute attack before removing the appendix.

The danger of rupture of a circumscribed abscess into the general peritoneal cavity has been the cause of great anxiety. My experience has led me to conclude that this practically never happens unless food or cathartics are

given by the mouth. In my entire experience it has happened but once, in a child, aet. 7, which was brought to the hospital on the fifth day after the beginning of an attack of gangrenous appendicitis with beginning diffuse peritonitis. It had received food and cathartics constantly since the beginning of the attack, and although its condition seemed hopeless, either with or without an operation, it improved slightly from day to day under exclusive rectal feeding, but never became well enough to make drainage of rather an extensive infection of the entire area between the umbilicus and pubis and right anterior superior spine of the ilium safe, and still, had I anticipated the likelihood of rupture into the remaining portion of the peritoneal cavity, I should certainly have made the attempt with the hope of bringing about a recovery. On the fifth day the abscess suddenly ruptured. I anaesthetised the boy within half an hour, made a free incision, washed out the peritoneal cavity, drained freely, but the child died in six hours. In this case gastric lavage had not been employed because the child was very nervous and we feared the effects of the fright. I have frequently seen cases in which food and cathartics were given in whom this accident occurred.

Aside from the benefit to the patient of increased safety, there are other advantages to be derived from this plan of treatment, which are well worth considering. Being able to operate during the quiescent state, drainage is not indicated, and consequently there is no likelihood of the concurrence of post-operative ventral hernia. With the reduction of the area of infection, the amount of peritoneal adhesions must necessarily be reduced. As a matter of experience I can say that faecal fistulae almost never occur in cases treated by this method.

Of course, all these advantages, as well as the prevention of diffuse peritonitis, can be accomplished if the appendix is removed during the very beginning of the attack, before the infectious material has passed beyond the walls of the appendix, but unfortunately it is but very seldom that a patient enters the hands of a surgeon at so early a stage.

I am positive that the mortality would have been at least four times as great had all my patients been operated at once, upon admission. There are three cases which do not properly belong in this group, because perforation had not actually taken place, but I am confident that this was only prevented by the treatment. Moreover, each one of these cases had quite advanced peritonitis at the time of admission, which would undoubtedly have pro-

gressed rapidly had not peristalsis been inhibited. In each of these cases the attack was exceedingly violent until this form of treatment was instituted, but subsided very promptly after commencement of this treatment.

Conclusions.—As a result of my clinical observations I am prepared to formulate the following conclusions:—

1. Peristaltic motion of the small intestines is the chief means of carrying the infection from the perforated or gangrenous appendix to the other portions of the peritoneum, changing a circumscribed into a general peritonitis.

2. This can be prevented by prohibiting the use of every kind of food and cathartics by mouth, and by employing gastric lavage in every case in which there are remnants of food in the stomach or in the intestines above the ileo-caecal valve, as indicated by the presence of nausea, or vomiting, or meteorism.

3. The patient can be supported by the use of concentrated predigested food administered as enemata not oftener than once in four hours, and not in larger quantities than four ounces at a time.

4. This form of treatment, when instituted early, will change the most violent and dangerous form of acute perforative or gangrenous appendicitis into a comparatively mild and harmless form.

5. Cases of perforative or gangrenous appendicitis with beginning general peritonitis can usually be carried through the acute attack safely with this method.

6. In all cases of this class gastric lavage should be practised in order to prevent the absorption of decomposing material from the alimentary canal.

7. In cases of doubtful diagnosis this form of treatment should always be employed.

8. This treatment will prevent a large proportion of the most troublesome complications and sequelae of appendicitis, such as ventral hernia, faecal fistulae, extensive adhesions, etc.

9. The patient should be permitted to recover fully from his acute attack before an operation is performed, except in cases encountered within the first thirty-six hours after the beginning of an attack or in case of the formation of a superficial circumscribed abscess.

10. It often requires but a small amount of any kind of food to change a harmless circumscribed into a dangerous diffuse peritonitis.

11. The treatment does not protect the patient against a subsequent attack.

12. It does not contra-indicate the removal of a diseased appendix before the septic material has extended beyond this organ.

13. It is indicated in all intra-abdominal conditions in which it is desirable to prevent the distribution of septic material by means of peristaltic motion.

14. The laity should be taught to stop feeding and giving cathartics to patients suffering from intra-abdominal diseases.—*A. J. Ochsner, M.D., of Chicago in Medical Press.*

Progress of Medical Science.

MEDICINE AND NEUROLOGY

IN CHARGE OF

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TREATMENT OF PNEUMONIA WITH SALINE INFUSIONS.

Recent mortality statistics show that pneumonia has displaced consumption as the leading cause of death. Some years ago a study was made of the comparative mortality under treatment at the beginning of the century, which employed bleeding, calomel and emetics, the result of the comparison being unfavourable to the modern supporting theory of treating the disease. If we are able to estimate correctly the signs of the times in the treatment of this disease, the stasis theory is rapidly yielding to the conception of a toxemia. It was but natural to think that the labouring heart, in a case of pneumonia, should have its work enormously increased by the consolidation of the lung, and the consequent difficulty of carrying on the pulmonary circulation. A consideration of the effects of pneumo-thorax effusions in pleurisy and other conditions in which a portion or even the whole lung was out of use ought early to have taught that the mere mechanical hindrance to the circulation of the lungs was comparatively insignificant. A symptom that is present in over two-thirds of the cases, and in nine-tenths of those that are severe, is albumin in the urine, the large majority having this symptom associated

with casts. This shows the profound toxemia which exists, and the labouring heart is not caused by a mechanical stoppage to the circulation, but by interference with its nutrition caused by a toxin. Elimination in typhoid and other systemic infections has long been recognized to be of value, but the stasis theory of pneumonia has greatly interfered with its application in the treatment of pneumonia. Inhalations of oxygen, which some have believed to be so efficient, were based upon the theory of a limitation of atmospheric air, though it is rare in pneumonia that more than one-fourth of the aerating surface is involved, and experience shows that from other causes not associated with toxemia more than one-half the entire surface of the air cells may be out of use, without seriously compromising respiration. The use of digitalis from the beginning of the disease is likewise based upon the theory that the heart had an extra amount of work to do, because of the difficulty in pushing the blood through the engorged lung. No one has seriously proposed to treat typhoid fever with large doses of digitalis, notwithstanding that the heart sometimes fails in that disease.

A study of a large number of cases treated on the old theories of elimination shows its efficiency in pneumonia. Of course, by the older physicians, this was carried to an extreme. Bleeding, calomel, and sometimes emetics, were employed, regardless of the condition of the patient, but solely to combat a hypothetical condition which was supposed to be productive of inflammation. Notwithstanding these drawbacks, the results as shown in the mortality table were favourable, because whatever the errors of this treatment, it in effect secured a rapid elimination of toxic products from the blood.

At present there is a tendency to return to the treatment of the fathers, and we predict that with a recognition of pneumonia as a toxic disease, and not one in which the chief difficulty is stasis, there will result such a change in treatment as will materially lower the present frightful mortality. The excellent results achieved in the use of baths and friction and elimination by the kidneys will be supplemented by the use of normal salt solution injected hypodermically, or into the rectum, or transfused directly into a vein. If the latter method is employed, it must be followed by the abstraction of an equal quantity of blood. Even in cases in which the solution is used by the bowels or under the skin, it would probably be better to supplement it by the withdrawal of a certain amount of blood; this eliminates the toxin and dilutes the blood

serum and improves the nutrition of the heart muscle. Systematically tried in pneumonia, it will be found to be far more efficient in stimulating a labouring heart than digitalis or strychnine supplemented by inhalations of oxygen.—*Medicine.*

EPIGASTRIC PAIN.

H. W. Bettman, in the *Cleveland Journal of Medicine* for July, 1901, says that epigastric pain occurs in gastritis, ulcer and cancer of the stomach, and in hyperchlorhydria. It may occur in gastric syphilis and in malaria, and the relation of this symptom to the foregoing conditions is fairly well understood.

It is frequently not recognized that gall-stones and inflammation of the gall-ducts may lead to epigastric pain, which is often mistaken for gastric disease. The author regards it as probable that the majority of cases diagnosed gastritis, accompanied by paroxysmal pains in the epigastrium, with prostration and collapse, are in reality cases of gall-stones and cholecystitis. In the epigastric pains due to gall-stones the attacks occur independently of the taking of food, and come on without apparent cause. The writer lays it down as a rule that "gall-stones should be suspected whenever patients complain of regularly recurring, or paroxysmal, severe epigastric pain, coming on several hours after eating, and when a careful examination of the digestive functions of the stomach reveals no abnormality."

Epigastric pain is sometimes dependent upon spinal disease. Hilton describes a case of a young patient, who had been treated for a long time for disease of the stomach, and was found to have a tuberculous process between the sixth and seventh dorsal vertebrae.

Epigastric pain may be produced by pelvic lesions, and more rarely by eye-strain. Such a diagnosis is usually arrived at by exclusion, namely, correct habits, regulating the diet, and increasing the amount of exercise effecting no improvement in the pain.

In chlorosis, epigastric pain of a gnawing or boring character, increased by the ingestion of food, is sometimes found. In many respects it suggests gastric ulcer. There is an absence of nausea or vomiting, and normal or diminished acidity of the gastric juice. It is found that this sort of pain yields readily to the administration of Blaud's pill and Fowler's solution.

Arterio-sclerosis is sometimes accompanied by epigas-

tric pain. Elderly patients often complain of a cramp just below the ensiform cartilage, coming on usually after meals when any exercise is indulged in. Even slow walking suffices to rouse the pain, which ceases as soon as the patients stand still or sit down. The peculiarities of this pain are that it occurs in those of advanced years, is most pronounced in the two or three hours following the ingestion of food, and is not accompanied by local tenderness.

Medicine.

PNEUMONIA.

No routine treatment for pneumonia exists, but there are many approved therapeutic measures. Among these Crook (Phil. Med. Jour.) mentions the patient's surroundings, a cheerful, well-ventilated room with temperature between 65 and 72 degrees, digestible liquid food and cold applications to the chest. Poultices are not much advocated of late, blood-letting is coming more in favour in florid cases and where the heart is seriously embarrassed by the pulmonary obstruction, or cyanosis or dyspnoea prevails. The hypodermic injection of saline solution in connection with the blood-letting is advised by Michel. Arterial sedatives are less favoured than formerly, though they still have some advocates. Routine purgation and antipyretics are generally condemned, and the profession is still at variance to some extent as regards the use of opiates. Crook thinks that on the whole they should not be resorted to until insomnia, pain or restlessness renders them necessary. Alcohol is losing favour, and the weight of opinion is against the use of digitalis. Oxygen inhalations are safe, but their usefulness is disputed. As regards specific medication to destroy the pneumococcus in the blood, there is some evidence of the value of the salicylates, creosotal and the silver salts internally. Serumtherapy of the disease is still in the experimental stage, a standardized serum is not yet available, and the progress in this direction during 1900 has been very slight.

SURGERY.

IN CHARGE OF

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CAMPHOR IN THE TREATMENT OF VARICOSE ULCERS.

Camphor is a drug which for many years was held in great esteem, especially in extra-professional circles; indeed, the late M. Raspail founded a school of therapeutics which still rejoices in great popularity in France, based on the use of camphor internally and externally as a curative agent. Its anti-spasmodic properties, though well authenticated, have of late fallen into disrepute, or at any rate into disuse, and externally it is only employed in this country in the form of a liniment of which it is but a subsidiary constituent. Two German physicians have recently called attention to the value of camphor dressings in promoting the cicatrisation of varicose ulcers of the legs which are notoriously refractory to treatment. They make use of an ointment containing 2 per cent. of camphor, with from fifteen to twenty parts of oxide of zinc, or, if this be found too irritating, they prescribe a mixture of two parts of camphor with forty parts of zinc oxide, and fifty parts of olive oil. An alternative application is a solution of the drug in spirit, but this must only be applied after the ulcerated surface has been thoroughly cleaned of scabs and crusts by poultices. It is asserted that under this treatment the most obstinate ulcer will cicatrise within three weeks, which is more than is claimed for the much lauded oxygen treatment, over which, moreover, it has the advantage of being more generally applicable at a vastly smaller cost.—*The Medical Press.*

EXAMINATION OF THE BLOOD IN SURGERY, ESPECIALLY FROM THE POINT OF VIEW OF DIAGNOSIS.

Silhol says that Hartmann, of Paris, was the first to examine his patients systematically for blood changes. Mikulicz examines every patient in his service, while certain American surgeons, as the author states, do likewise. It seems that in France, however, the matter has

been as a rule neglected. Three points should be observed: (1) The determination of the hemoglobin; (2) a count of the white and red elements, and (3) dry specimens to show the varieties of leucocytes as well as the form of the red elements present. Interesting practical results are to be attained. Mikulicz does not operate when the hemoglobin sinks below 40 per cent., as the patient is too weak to stand it. Increase of the white elements suggests a reaction in defence of the organism, and is of the utmost importance. The author appends a large number of cases to show some of the interesting details in connection with the subject of differential diagnosis as aided by a study of the blood.—*Revue de Chirurgie*.

FATAL TREATMENT OF ANEURISM BY THE GELATINE METHOD.

Two cases of considerable medical interest were investigated last week at Guy's Hospital by the City of London coroner. As most of our readers probably know, a new method of treating aneurism by the subcutaneous injection of gelatine has recently been introduced. One of the house-surgeons at Guy's, Mr. L. Stamm, had three cases of thoracic aneurism under this specific treatment. He himself sterilized the gelatine, of which several ounces were injected into the leg or other part of the body, so as to enter the general circulation, where it increases the coagulability of the blood and so leads to the consolidation of the sac. Of the three cases thus treated, one was discharged cured, while the two others developed tetanus and died. There can be no doubt that the specific organism of tetanus was introduced along with the gelatine. This accident is most unfortunate, as it will tend to cast a stigma upon what is undoubtedly a valuable scientific method of treating an incurable disease. No blame can be attached to the house surgeon, who had taken every precaution possible from a human point of view. The treatment was first introduced by Lancereaux, of Paris, who administered every six or eight days four to five grammes of gelatine in two hundred cubic centimetres of 0.7 chloride of sodium solution. If properly sterilized there should be local reaction at the point of injection. Lancereaux reported five cases of aneurism, of which three were cured. It is therefore obviously unfair for the newspapers to speak of the method as hospital experimentation upon patients.—*Ed. Med. Press*.

THE CANADA MEDICAL RECORD

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Editorial.

ST. FRANCIS MEDICAL ASSOCIATION.

A meeting of the district of St. Francis Medical Association was held in Sherbrooke on 11th of September. The reading of prepared papers was dispensed with, on account of the amount of general business which claimed attention. Several very interesting cases met with in practice were detailed. The following were elected officers for the ensuing year:—Dr. Rioux, Sherbrooke, president; Dr. D. W. Smith, Sherbrooke, 1st vice-president; Dr. McCabe, Windsor Mills, 2nd vice-president; Dr. Thomas, Lennoxville, secretary-treasurer; Dr. Gadbois, Sherbrooke, assistant secretary. Council—Drs. Worthington, Pelletier and Williams. Dr. Thomas, who had attended the meeting of the Canadian Medical Association at Winnipeg the last three days in August, reported that the Association had endorsed the principle of the Medical Defence Union, as formed by the St. Francis Medical Association, with the exception of the name, which it was decided to change to that of the Medical Protective Association. The St. Francis District Medical Association is a comparatively youthful association, but it appears to have a good deal of vitality and energy.

The New York *Medical Record* of August 17 says: "It is reported that Mr. Monson, Colorado State Dairy Commissioner, has offered to submit himself to inoculation with bovine tuberculosis in order to test the question of the communicability of this disease to man. He is said to be a believer in the non-identity of the two forms of tubercle bacilli. If there are many such with the courage of these convictions, the solution of this problem should not be long delayed."

**THE WINNIPEG MEETING OF THE CANADIAN
MEDICAL ASSOCIATION.**

Apart from the very interesting and accurate report of the papers which were read and the discussions which took place, which will be found in another part of this issue of the *Record*, a short editorial on some of the other features of the meeting may not be out of place. When it was decided to hold it this year in Winnipeg it was not without misgivings on the part of many members as to the success which might be expected to follow such an experiment. When it is remembered that many of the eastern members would have to travel over two thousand miles and the western members over a thousand, it must be admitted that there were some grounds for doubting whether the meeting would have a large attendance. But the actual facts proved that these fears were unfounded, for the registered attendance was the largest in the history of the Association, now extending over thirty-four years, and nearly fifty of those who attended travelled over a thousand miles to reach the meeting and another thousand miles to return home. It was the unanimous opinion of all present that the journey was a delightful one, in the course of which friendships and acquaintances were formed which will probably last through life, and that the meeting at Winnipeg, both from a scientific and social standpoint, could not have been surpassed. So well satisfied was everybody with this meeting, it was decided that after the one next year in

Montreal the meeting of 1893 should be held at Vancouver, three thousand miles from Halifax, where many of our members live. Our British brethren could hardly imagine how easily and pleasantly this long journey can be made in the splendid "Imperial Limited" train of the Canadian Pacific Railway, which makes the run from Montreal to Vancouver in exactly one hundred hours. One has a good night's rest in a spacious and comfortable berth, and after washing and dressing, and even shaving, for which there is every convenience, one walks a few hundred yards along the corridor and vestibules, under cover all the time, to the dining car, where an hour is spent in pleasant company over a breakfast which could not be surpassed at the best hotels. Then you return to your own or to some other car where groups of eight or ten gather together in the smoking compartment, and spend the time till lunch in relating experiences and making or renewing acquaintances. Another hour is spent in the dining car, where, perhaps, as in our own case, one finds himself seated beside some distinguished army or navy officer, who entertained us with an account at first hand of the war in China, and the relation of much information concerning the manners and customs of the various natives he had met. During the afternoon a stop is made sometimes for an hour, and a street car ride is taken through some interesting town. After dinner the evening is spent in telling stories or playing cards.

We would strongly advise those who intend to take this trip in 1903 to go and return by what is known as the Lake and Rail Route, by which two delightful days are spent on the magnificent inland ocean steamers traversing two of the great lakes from Owen Sound to Fort William. This was a never-to-be-forgotten pleasure to the fifteen or twenty doctors and their wives and daughters who formed the party, and was alone worth the whole cost of the trip. Montreal was represented by nine members, every one of whom contributed a paper, among them being Drs. Roddick, Shepherd, Buller, Laphorn Smith, Hutchison, Martin, Finlay, Richer and Drummond, while three others,

Sir Wm. Hingston, Dr. Blackader and Dr. Gordon Byers, sent papers. Dr. Roddick made one of the best addresses of his life on Interprovincial Registration, and Dr. Shepherd gave an interesting demonstration of skin diseases with lantern views. Among the foreign visitors were Dr. Edebohls, of New York ; Dr. Stanbury Sutton, of Pittsburg ; Dr. Cullen, of Baltimore ; Dr. Bracken, of Minnesota ; Dr. Warner, of New York ; Dr. Wesbrook, of Minnesota, and Dr. Russell, of Wisconsin. The paper of Dr. Owen Jones, of Vancouver, on cases of intestinal surgery, was a remarkable one, and could hardly have been excelled by the most eminent men of New York or London.

The city of Winnipeg was a surprise to everyone ; its magnificent streets and street car service ; its substantial buildings ; its beautiful parks, and the immense amount of business and prosperity everywhere evident. We all agreed that it would soon outrival its older sisters in the East. The hospitality of the profession and the laity of Winnipeg it will be hard to equal ; the public reception at Winnipeg in the Wesleyan College ; the afternoon tea at Lower Fort Garry, given by Mr. and Mrs. Chipman, the Hudson's Bay Commissioner ; the reception given by the Lieut.-Governor and Mrs. McMillan, and the trip to Brandon to view the wheat fields, a never-to-be-forgotten sight, followed by a luncheon tendered by three physicians of that town, and cooked and served by the ladies of that place ; and the visit to the Ogilvie Mill in Winnipeg, the largest in the world, where the delicacies of London were washed down with the finest wines of France ; these were all events which will long remain fresh in the memory of those who were so fortunate as to participate in them.

The water supply of Winnipeg was an object lesson which many an older city might well learn from. The city being built at the confluence of two rapid but very dirty rivers, the Assiniboine and the Red River, was well situated for drainage ; but the water supply was very bad ; so an immense well was dug a mile from the city, forty feet deep, where an inexhaustible supply was found ; but it

contained so much carbonate of lime and magnesia that it would have ruined the furnaces and boilers; so by stirring in five tons of lime with three million gallons of water, the substances which make the water hard are precipitated, after which the water is filtered through hundreds of frames of cotton, until it comes out as clear as crystal, and free from microbes and foreign matters. As population pours into the North-West, as it is bound to do, there will arise a demand for hundreds of doctors from the overcrowded profession in the East; and when the call comes, happy will be the men who hear it and settle down to practice in what will soon be known as the granary of the world.

A. L. S.

PUBLISHERS DEPARTMENT.

CANADIAN HOME JOURNAL BOUGHT BY MR. HUGH
C. MACLEAN.

That the tendency to amalgamation nowadays has been extended to journalistic circles as well as commercial is shown by the recent purchase of *The Canadian Home Journal* by Mr. Hugh C. MacLean, publisher of *The Ladies' Magazine*, Toronto. The journal, which was established many years ago, will be discontinued as a distinct publication, and will be merged into *The Ladies' Magazine*, which has already won a place for itself as the popular home paper for Canadian women.

It is with confidence of the merit of their product, also in view of the eminent satisfaction *Pil Orientalis* (Thompson) has given among physicians using it in their practice that the Immune Tablet Company, Washington, D.C., have adopted the unusual course at great expense of sending out complimentary boxes so physicians may prove the exceptional merit, aphrodisiac effects and general tonic value before prescribing it to their patients, and they can rely upon obtaining only the best of possible results.

Pil Orientalis (Thompson) is put up in three strengths, No. 1, No. 2 and No. 3 extra strong, and it is always advisable in obstinate or "depraved" cases to put the patient on a full course of No. 1 rather than attempt to bring the sexual organs into sudden activity.

After a fair exhibition of *Pil Orientalis* (Thompson) the Immune Tablet Company would be pleased to receive any comments, particularly if unfavourable, as they may be able to give some suggestions to meet some of the many complications in this distressing class of disease.