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OPERATIVE RHINOLOGY: ITS REGULATIVE PRINCIPLES.*

By J. P. MORTON, M.D., L.R.C.P.(Edin.) HAMILTON.

When our President honored me by asking for a paper, I said to him that I thought very few of our members would be interested in the special lines from which I could take my subjects. I will endeavor, however, to interest the general practitioner as well as the specialist for a short time.

I have chosen this subject for discussion to-night, first, because within the last twenty years this former insignificant sprig of the operative tree has become a flourishing branch; second, because many general practitioners have entered this field of work, and are fairly proficient in it; third, because of the very interesting papers lately read on post-operative treatment of the nasal mucous membrane; fourth, and chiefly, because there are some who maintain that operative rhinology has run riot, and that the majority of the numerous operations now performed on the nose by means of the saw, and especially by the cantery, are not only unnecessary but harmful.

"Too many operations are done in the nose." This is a common expression among the laity and also in the profession. It is said we have no standard, and that we operate indiscriminately and unscrupulously. We are told that very serious results often follow our operative work. To a conscientious rhinologist these are very damaging aspersions, and I will endeavor to meet them fairly and honestly, try to find out what truth they possess, show that we have a standard and make clear what that standard is.

*Read before the Wentworth Medical Society, April, 1901.

Let me first remind you of the more important symptoms which bring patients to us for nose examination:

1. Rhinitis.—A patient may have an occasional rhinitic attack through carelessness: but frequent attacks of rhinitis, either mild or acute, indicate some abnormal nasal condition. This cause should be definitely ascertained and removed.

2. Mouth Breathing, or, as the patient generally has it, "breathing with difficulty through the nostrils." Few in the community now are unacquainted with this condition and its evil consequences. Some call it a habit, but there is always a cause in the nose or throat.

3. Rhinitis Hyperæsthetica, or Hay Fever.—You are undoubtedly acquainted with the experiments of Dr. Dunbar and know of his success in counteracting the toxin with the antitoxin, both obtained from the pollen grains. Nevertheless I mention hay fever as a symptom of an abnormal nose, because Dr. Dunbar and Felix Semon who corroborated the experiments, admit that the nose must be put into a normal condition.

4. Hypersecretion and its opposite.—"My nose runs too much," and "My nose is too dry," are common expressions used by patients. A normal nose secretes about twenty fluid ounces of muco-serum per diem.

5. Epistaxis.

6. Derangements of smelling.

7. Foul Breath.—This frightens the patient with great haste to the specialist. The cause of the smell is found to be an atrophic mucous membrane, or the lodgment of secretion in nasal crevices or peritonsillar crypts, which spots are often very difficult to locate.

Then we have what might be termed distant symptoms—(1) Eustachian tube catarrh; (2) Middle ear inflammations; (3) Mastoid affections; (4) Pharyngitis; (5) Laryngitis; (6) Tonsillitis; (7) Bronchitis; (8) Asthma; (9) Accessory sinus troubles. Before leaving the symptoms permit me to mention four others not so common. They are not mentioned in this connection in text-books, and yet I have been forced to put them down to nasal conditions in certain cases.

1. *Neuralgia*.—After doing an Asche operation for straightening the septum, a patient remarked that she had been since free from her previous severe attacks of neuralgia. Undoubtedly the pressure had been removed from the first or second divisions of trigeminus, which are represented in the nose. I have since read of twelve cases where neurectomies and neurotomies, and even removal of gasserian ganglion had been performed, yet relief had not been secured for excruciating facial neuralgia until the septum had been straightened.

2. *Nervousness*.—A mouth breather never sleeps soundly.

He may think and say he does. He may be unconscious, but the nervous system is just half relaxed as indicated by dreams, vagaries of imagination and movements. A nervous system or tension all day, and only half resting all night, must soon get below tone, then the patient becomes irritable, restless and nervous. Free breathing must be secured for these cases.

3. *Coughs*.—Tonsillitic, pharyngeal, bronchitic, laryngeal and pneumonic coughs are well recognized, but we do not speak of nose coughs, and yet I believe they are common. Careful examination should be made for sensitive cough spots. A patient was sent not long ago with a most persistent cough, which bothered him all day and all night: he coughed about fifteen times a minute. He had a granular pharynx and enlarged tonsils, which I treated for nearly a month, but this gave no relief. Upon minute examination of the nose I found the cough would immediately stop when I put cocaine on a certain spot, and subsequent cauterization of this area secured relief.

4. I have often felt that the indefinite sclerotic conditions in the middle ear, and especially around the stapes' base, are caused by slight but persistent inflammation from the posterior nasal conditions, such as posterior septal projections or deviations, which are so easily overlooked.

Now, returning to the operation itself, my plan is to have as my standard the normal nose, and when any of the symptoms above referred to are present I feel myself justified in making the nose conform to this standard. If we follow this rule we cannot be accused of "sawing too many noses" or of "having a mania for operating."

The assumption of this position necessitates an answer to the important question, "What is a normal or a standard nose?" With your permission I would like to give you the principles which a study of authorities and my personal experience have led me to adopt.

Septum.—The septum should be vertical and plane. The septum generally deviates slightly, and there are often developmental ridges where septal cartilage and vomer unite, and where vomer and maxillary crest join. These may produce no symptoms. But if they do, these, which we might term natural abnormalities, should be dealt with the same as thickenings, ridges, spurs, deviations, or redundant erectile tissue of the tubercle. The resultant septum should be as nearly as possible vertical and plane. The good results of Asche operations are often lessened by forgetting to remove projections, and these are better done before proceeding to straighten the septum.

Septum should be carefully examined where it passes into the attic, for the air is drawn in through the middle and upper

meatuses and expelled through the lower. Look for redundant tissue at the tubercle of septum opposite the anterior end of the middle turbinal. In the attic branches of the fifth nerve may be pressed upon causing severe facial neuralgia. The septal division of the nasal nerve comes from the ophthalmic division of fifth, and the naso-palatine nerve (nerve of Cotunnus) comes from the sphero-palatine ganglion.

Vomer and vomerine cartilage should be examined far back. Deviations here are most frequently overlooked and are common causes of the ordinary nose symptoms as well as atrophic rhinitis and eustachian and middle ear trouble.

Finally, do not forget that small septal irregularities may be the cause of the symptoms, although at the time of examination they appear to have no bearing on the case.

Opposing surfaces should not touch. The septum and turbinate bodies should not even occasionally come in contact. Four to eight millimetres should exist between the inferior turbinate and septum, and one and a half to three millimetres between the middle turbinate and septum.

Touching may be due either to enlarged or misplaced turbinate bones or redundant erectile tissue over them. If symptoms are present, the nostrils should be repeatedly examined, even if the first examination reveals apparent normality.

Breathing space should allow of ample breathing at all times. They may be dissimilar but should be as nearly equal as possible. The amount of available mucous membrane should stand in such proportion to the breathing space that when the air reaches the naso-pharynx it will be saturated, filtered and at blood heat. This fine balance between the available mucous membrane and breathing space is absolutely necessary to the perfect performance of these important physiological functions. When the breathing space is too large, as in atrophic rhinitis, too much air passes over an atrophied mucous membrane and reaches the naso-pharynx unheated, uncleansed and unsaturated. When space is too small, as in hypertrophic rhinitis, etc., the same evil results follow for the air is gulped in through the mouth.

Erectile tissue should not be redundant or hypertrophied. Contraction under cocaine precludes hypertrophy but not redundancy. Erectile tissue is found over the turbinate bones, on the floor of the nose and on septum opposite anterior end of middle turbinal, which area is named the septal tubercle:

Besides the ordinary results of hypertrophy or redundancy of the erectile tissue, the accessory sinus openings are closed. Inflammatory secretions may then collect in the sinuses, *e.g.*, the frontal. When turgidity and intumescence pass off, and the openings become again patent, this infective collection flows out under the middle turbinal at the region of the hiatus

semilunaris into the cup-shaped infundibulum, and, therefore, into the maxillary antrum, and this is how frontal sinus and maxillary antrum trouble should not surprise us by co-existing.

My endeavor then is to have the nose fulfil, as far as possible, these conditions. We might now consider the objections raised to nose operating:

(a) Destruction of mucous membrane. The mucous membrane is the functioning structure in the nose; by it the air is cleansed, heated and saturated. It is said we cut this off and rip it up with the cautery until it becomes atrophic, and the nose is unable to perform its physiological functions. But we are not to destroy mucous membrane unless it is redundant or hypertrophied, when it is not only unnecessary to the functions of the nose, but really hinders the rest of the nose from functioning.

Snare, scissors and saw are the best instruments for removing it. If the cautery point or knife is used it should be put right into the bone and no ripping done. Only a very small scar is thus necessary, and the effect is to be gained chiefly by forming cicatricial bands between surface and periosteum and not by destroying large areas. Superficial cauterization I believe to be useless and harmful.

(b) Crusty conditions are said to result. These undoubtedly happen sometimes, but are nearly always from leaving the wound rough. Smoothness is secured by massage of the healing septal areas.

(c) Septal perforations. These occur in the septal cartilage and always mean bad surgery. They do little harm, but bother the patient by bleeding and collecting crusts. If the perforation is not large, and a thickening exists near the opening, I sometimes perform the following minor operation with success: Cut the necessary cartilaginous flap from the thickened septum, which of course has two layers, and allow it to hang by a piece of mucous membrane at the anterior end. Twist it forwards, and apply it to the perforation, after scarifying the edges of the opening.

(d) Severe hemorrhage. All experienced rhinologists can give histories of severe bleedings, primary and secondary. I use adrenalin to keep the field clean during simple operations or the first part of an Asche. I believe it increases the tendency to secondary hemorrhage. Plugging is not helpful except in rare cases, unless the wound is pressed upon. Plugging the posterior nares retards the flow of blood from nasal veins and increases congestion, and I have seen two bad cases stop on having the plugs removed. The Simpson-Bernay's tampon is very useful, and presses on the bleeding area. The patient should sit up and hold head slightly forward, this prevents

vomiting. Doctor should insist upon quietness, no speech, no food or drink; plug the other nostril, and so direct the cold air through the bleeding nostril. I do not trust to local applications or medicine given internally. When making the applications the area is greatly disturbed. No patient should be allowed to die by bleeding from nose as operation can be resorted to in the last extremity.

(*c*) Adhesions. Pyncheon calls post-operative synechia the *bite noire* of the rhinologist. Two raw surfaces should never be left opposite each other—this by way of prevention. In sawing away large projections, the mucous membrane should first be dissected upwards and then allowed to fall over the wound, this prevents synechia. When present, wait until inflammation subsides, then operate radically. Sever the band at both ends, removing sufficient tissue to insure wide separation. Sometimes one can do better by allowing about a week to elapse between severing of the ends. Tampons may be used afterwards.

What part of the nose should be operated upon? Of course the offending part. If one may choose either the scrolls or the septum the latter should be chosen, for three reasons: (*a*) The septal trouble may cause turbinal hypertrophy, whereas turbinal trouble very unlikely causes septal abnormality except in young children; (*b*) The better to prevent the functioning mucous membrane; and (*c*) Operations on the septum are more easy to perform.

Finally, I wish to give my experience regarding aseptic precautions:

After each operation there is, of course, inflammatory reaction, more or less, but one is greatly surprised at the apparent immunity of the nose to serious infections. This is a pleasing reflection, especially when one is busy and finds it difficult to live up to one's theories of asepsis. All rhinological experiences contain unfortunate cases, and I believe it is impossible to escape these. I would illustrate this by a case from my own series. I operated on a lady with ozena, to help nasal drainage: she developed erysipelas of the face. I found afterwards that she had suffered from it two months before in one of her legs. Following this, in about a month, another lady upon whom I operated developed severe facial erysipelas, and I have never satisfied myself that she was not infected by the first case through myself. I know of two other cases during five years. Precautions are necessary before, during and after operation.

Before operation: The nose normally contains germs, and these after operation may become pathogenic. These are the germs which increase during a "cold." Other more dangerous forms, as bacillus diphtheriæ, streptococcus erysipelatosus, also

those of scarlet fever, etc., may be lodged there. Therefore we should order a cleansing spray to be used freely. I would like to freely douche the nostrils, but fear middle ear trouble as a result. My plan has always been to have a sterilizing apparatus, heated by a spirit lamp behind a screen. By this means the instruments can be boiled several times daily. I would like to repeat the boiling after each case, but have found this impracticable. Then I often use a sixty per cent. carbolic lotion for my smaller instruments. These methods are simple and save time.

After operation: The patient is generally asked to stay indoors, but not in bed. A small plug of cotton in anterior nares will prevent cold air, damp air and dust from striking the wound. A one per cent. carbolic spray will be found useful; it will not kill germs, but will retard growth, and thus lessen their virulence.

Rhinologists, then, are justified in making the nose structurally normal and, in expecting, according to the principles of cause and effect, that the breathing will be bettered; that the mucous membrane will recover itself, and all the well-known evil consequences be avoided. Some cases get discouraged; they have to keep at their every-day employment, and perhaps suffer from troublesome post-operative rhinitis. But my experience teaches that all these troublesome cases can be cleared up if they will persevere. One must remember that good results are not gained until all tenderness and inflammation have left the mucous membrane. Of this one may be certain, but in closing let me say that as along all scientific lines great advances are yet before us; and this, while it keeps us humble, at the same time creates a zest for continuous inquiry.

SANATORIUM TREATMENT AND EARLY DIAGNOSIS OF PULMONARY TUBERCULOSIS.*

By ERNEST WILLS, M.D.LOND., M.R.C.P.ENG.,
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Tuberculosis is the most important disease in medical science to-day. It is needless to quote in detail the statistics showing its universal prevalence, and I will only remind you that at least 20 per cent. of the total deaths of the world are caused by the tubercle bacillus; 1,000 die annually of the disease in Montreal and 8,000 in Canada, while the number in the Dominion of those still living and suffering from pulmonary tuberculosis, although given as 40,000, is probably nearer 100,000. Thousands are suffering from tuberculosis in whom it is never recognized, as well as a large number in whom it is not diagnosed until a late stage, and therefore not recognized to-day. Since these figures are universally applicable, with a great percentage of disease and deaths always obtaining in direct ratio to the size and overcrowding of cities, it is not over-estimating the importance of tuberculosis to say it is the most important question in medicine. Fortunately, since Koch isolated the bacillus and proved its relation to the disease in 1882, great progress has been made, not only in its pathology, but also in its treatment. The possibility of the arrest of the disease and a practical cure is no longer a matter of doubt, and the best means of securing this and making it permanent is sanatorium treatment. Sanatorium treatment is the best therapeutic method for all stages of the disease, but that it may be of greatest service and may show quick and permanent results an early diagnosis of the disease is urgently called for. After referring to some points of sanatorium treatment, your attention will be drawn to some of the more general and constitutional, as opposed to the purely pulmonary, symptoms of assistance in arriving at a diagnosis while the disease is yet in an incipient stage.

Sanatorium treatment may be carried out anywhere, provided you have your sanatorium and a physician who has studied the varied principles of the treatment which should be given. It is a mistake to suppose that any case, if the essentials of treatment are observed, will do well in any climate, for there are a number of cases, most of them of slow, insidious onset, chronic yet progressive, which nothing but the invigorating dry air of a higher altitude will permanently benefit;

*Read before a meeting of the Ottawa Medical Society, April 22, 1904.

however, the discussion of this point must be reserved for a future paper. It remains, then, that the majority of early cases will improve anywhere under efficient sanatorium treatment, and it is to be hoped that in the near future there may be in each province, if not in each county, a sanatorium for the people in its vicinity; not only for their treatment, but as a centre from which will emanate a more accurate knowledge of the simple precautions for the prevention of the disease.

What, then, are the factors in sanatorium treatment, and wherein lies their importance? The factors are open air, suitable food and rest; given the proper exhibition of each of these three, the greatest of them is rest. Only under efficient supervision can they be used in their right quantity and proportion, and it is to the supervision and direction possible only in a sanatorium that the splendid results so commonly obtained to-day have been made possible. Just as genius has been defined as an infinite capacity for taking pains, success in sanatorium treatment can only be obtained by a persevering attention to detail.

Virchow long ago pointed out that in tuberculosis the vulnerability of the tissue is the important factor in the disease. To remove this vulnerability is our aim; so building up the system by fresh air, feeding and rest, that the blood and tissue cells may destroy the enemy, and resist the entrance of new ones. This resistance to, and destruction of, bacilli is of continual occurrence in normal health. Experiment by exposure of culture media wherever there are numbers of people, but especially in crowded cities, railway cars, dark offices, tenement buildings, etc., shows the presence of numbers of living, active bacilli, in the dust, and in the air. These bacilli we are continually inhaling or swallowing with our food. Why do we not all contract tuberculosis and die? The majority of us are invulnerable, because our tissues, vigorous and healthy, resist the bacillary attack, and afford them no suitable nidus.

To ensure the desired results sanatorium residence is necessary, as despite the apparent simplicity of the treatment, this is indeed a frequent stumbling block. It is apparently so simple the patient thinks he can treat himself, at any rate he can follow the directions for treatment of his physician—he cannot, and does not. It is too well known how difficult it is to get directions followed at any time; it is harder with the phthisic than any other-patient owing to his neurotic condition combined with his extraordinary optimism. He always feels better than he is, he tries to do too much, he over-exerts himself, he brings on a relapse. This brings us to a consideration of the important factor, rest. It is unnecessary to go into detail as to open air and food, except to say that the more the patient

is in the open air the better, the majority can be day and night in it, live in it, sleep in it. Given properly constructed buildings, porches or tents, food of good quality, easy of digestion, of considerable variety and great quantity, with a preponderance of cream, butter, milk and eggs, is all that is required; but rest is a more complicated factor, needing some further consideration and emphasis—rest must be mental, physical, organic.

Mental Rest: Mental rest, free from irritation, worry and interruption.

Physical Rest: Physical rest to conserve all the energy, and strength for organic needs.

Organic Rest: Organic rest that as little call as possible may be made on nervous system for administrative functional energy or for repair.

Removal from his home to a sanatorium ensures rest by freeing the patient from the numerous domestic and social worries inseparable from home life. The noise, the daily home events, which are nothing in busy health are most trying to a debilitated invalid—business news, constant visits from sympathetic friends, all these detract from the necessary rest. Not that the isolation of a patient on his back in dull, depressing solitude is advocated. Far from it; a purely vegetative existence varied only by overfeeding and sleep is the other extreme, which must be just as carefully avoided in all, but very exhausted cases. No! The patient removed from home life must have some mental amusement and occupation to prevent stagnation or discontent. The provision of these is one of the chief studies of the sanatorium physician; he must cater for the mind as well as the body, and has to study the idiosyncrasies of each patient. No tonic medicines can affect the body so powerfully and so beneficially as a cheerful, contented and occupied mind. "Laugh and grow fat" applies as much to the sanatorium patient as his healthy brother.

Suggestion is a therapeutic agent of the greatest potency. Why should its exploitation be left to faith healers, Christian Scientists, quacks and fakers? By inducing a hopeful philosophic attitude, fortunately an easy task, in the usually optimistic patient, by discouraging discussion of symptoms and feelings with fellow sufferers, providing instead other topics of thought and conversation, the patient is distracted and rested. Patients usually take readily to the necessary discipline and habits of the Sanatorium when they are tactfully enforced, and these habits remain with them, and when finally recovered they return to their homes and become there foci for the dissemination of hygienic lore and of incalculable assistance in the prevention of disease. Meanwhile the nervous system, relieved of mental drain from worry, anxiety and apprehension, can be

drawn on for the needs of the mechanism. From lessened mental tension and diminished cerebral congestion better sleep is obtained, and the most favorable time for repair and renovation of tissue is increased.

Patient's Rest: By cutting off the injurious exercise which the patient so often takes, under the mistaken impression that exercise and strength are almost synonymous, a continual drain of strength is stopped, and an injurious combustion shut off. The overtaxing of various organs ceases, the heart is relieved, the venous congestion is removed, the hitherto embarrassed stomach, liver, kidneys, etc., perform their functions more naturally, having only the daily housekeeping of the body to attend to without work induced by external labor; there is some chance of keeping pace with the waste from fever, and since undue exercise and excitement are among the causes increasing fever, the fever itself diminishes and lessens combustion. After a time, with this rest, open air and food, the patient regains tone, puts on flesh, gains strength and begins to resemble his former self, now is the time for great caution, so much rest is no longer necessary, but most relapses are due to an over-estimation of improvement already obtained and a too good indulgence in exertion—the thermometer is a never failing guide. When diurnal temperatures are taken, it is surprising how seemingly trivial a thing will cause an elevation of temperature—a friend's visit, an animated or too prolonged conversation, a game of whist, an overtaxed walk or ride, are among frequent causes; they must be guarded against, the patient must be gradually got into training, be weaned from his rest, which has been of such assistance to him, by graduated exercise, his muscle must be toned, his heart enabled to bear extra work, his lung expanded and opened up, until he is no longer soft, but fit and hard, in good training condition.

By the methods of which I have given you a sketch, 50 to 75 per cent. of cures have resulted in early cases, 25 to 35 per cent. in less favorable cases, and most advanced cases have been improved.

Early Diagnosis: An early diagnosis is the pressing need that more good be done with less expenditure of time and money. It is in the power of the profession by this means alone to do more than can be done in any other direction for the prevention of tuberculosis, since by early treatment of cases they need never advance to excavation with profuse suppuration and expectoration, and the practically sole cause of the spread of the disease, the discharge of bacilli will be enormously diminished. At present most cases when diagnosed are indeed in consumption, and yet this is not so much to be wondered at, for the detection of primary consolidation of a

few scattered lobules, surrounded by larger area of normal spongy lung, is no easy matter by physical examination, since the respiratory symptoms in the incipient stage are few and ill-defined. When these symptoms become well marked and easy of recognition, the so-called *first stage* has already passed into the second and third.

USE OF THE TERMS FIRST, SECOND AND THIRD STAGES.

Indeed it is time the stages consolidation, caseation and cavitation, as marking those periods in the disease, be given up, as a matter of experience, both in living and dead subjects; although, of course, consolidation is the first stage, all three are frequently concurrent since fresh foci are constantly appearing. Thus there is a mixture of all stages, just as successive crops of eruption will appear in chicken-pox, and the patient may show at the same time papules, vesicles, pustules and scabs. It would be better, therefore, if they were classified as incipient, advanced, very advanced, and the area of the disease were taken as a measure of its gravity rather than the condition of disease discoverable at one or more places, *e.g.*, locate the disease as apical, or present in upper lobe, lower lobe, unilateral, bilateral, etc. To return, since the diagnosis by physical signs is so difficult, the importance of the due recognition of premonitory and constitutional symptoms is proportionately valuable. It is to these that I would direct your attention, since their recognition in connection with other aids to be mentioned will render an early diagnosis comparatively easy and certain; and if this be followed by appropriate treatment the percentage of arrest, and in all but very acute cases, will be nearer 100 per cent. than 50 per cent.

A want of consideration of these premonitory and constitutional symptoms, a failure in taking a sufficiently broad view of the disease has been at the root of the matter in the late diagnosis of the disease. In our general hospitals, in the clinical demonstrations, whereby we are taught the physical signs, we see only the advanced cases; the incipient cases do not come to hospitals, except occasionally to the out-patient department: hence we come to regard the disease as a type characterized by the classical terms, cough, hectic night sweats, and hemoptyses—whereas if we look upon pulmonary tuberculosis, as it really is, as an acute specific of slow onset, whose premonitory symptoms precede by a considerable period the typical signs of its later lesions, we shall better appreciate what we so often meet in general practice. Do we not often wait for the classical trio cough, night sweats and hemoptyses, then exhibit for a time cod liver oil, hypophosphates, guaiacol,

etc., etc., etc., and finally, finding we are losing ground, send the patient away for change of air, or recommend him a sanatorium, and a sanatorium instead of a patient with some wasting fever and incipient apical disease, receives one with apical and basilar, perhaps bilateral, mischief, an overworked heart with weakened muscles, a deranged digestion system, and worn-out organs generally. It takes years of anxious supervision ere such a patient is finally restored to comparative health with permanently damaged, though no longer tubercular, respiratory system, and thus for want of early diagnosis much time and money has been expended. Early diagnosis, followed by early treatment, would have procured early arrest and permanent cure at comparatively small cost, and an immense saving of reputation to ourselves.

When patients have cough, night sweats and blood spitting, except for their natural reluctance to believe that they can be victims of the great white plague, nine cases out of ten have a shrewd suspicion of the nature of their ailment, although they shrink from admitting it, and readily accept any other explanation of their trouble. But the majority of cases of pulmonary tuberculosis of insidious onset can, and should be, diagnosed by the physician before the appearance of the fatal cough, night sweat and hemoptyses, often without two of them, sometimes without one of them.

Latent Cases : Latent cases are largely the cause of the difficulty of early diagnosis, and the more so because since many of them never become anything but latent we are misled. Symptoms appear, and without any specific treatment disappear without raising any suspicion of their true portent. The fact is, the natural tendency of tuberculosis is to get better, or in other words naturally the chances are that the patient will overcome the disease. What proof have we of this? The strongest proof of this is the constant presence in autopsies in cases known to have died from other diseases of healed tubercular lesions, cicatrices, calcified nodules, contracted cavities, etc., and not known to have had any recognizable phthisical signs. The percentage of cases in which such lesions occur is certainly 33 per cent., and has been placed as high as 50 per cent. We may infer that in numbers of people who live through the ordinary span of life, or to a good old age, consolidation of the lung extending even to caseation and cavitation occurs, but arrest and cicatrization follow, owing to their acquiring additional resistance after the incidence of the disease and they are credited only with a passing cold, or grippe, or fever, or neurasthenia, and their tardy convalescence is never attributed to its real cause. Let the same trouble attack a patient having less vigor, less resistance, and tubercle bacilli

gets the upper hand, the supposed cold or grippe, or neurasthenia passes slowly into an unmistakable consumption. These are the cases easy to overlook, and which need not be allowed to pass if one is always on the watch for insidious onset, if one does not wait for a hectic, emaciated patient before suspecting the presence of tuberculosis, or have to see an attack of hemoptyses before examining the lung. Many a strong, powerfully built man, with large chest measurement may, through some want of resistance, temporary, perhaps, be a victim of the disease, many a stout, florid woman or vigorous-looking, energetic girl, through overwork, and a series of colds, or an attack of catarrh, may have so lowered their vitality as to give the bacillus the necessary opening for its commencing attack. An ever-ready suspicion and thorough examination are the aids to early diagnosis and safeguards against that list we all have to acknowledge, privately or publicly, as cases we might have recognized.

For the convenient consideration of the early diagnosis it is well first to enumerate the general symptoms calculated to arouse our suspicion; secondly, to consider the methods of examination by which we would confirm or dispel these suspicions.

General Symptoms and History: General symptoms fall, roughly speaking, into a group of five divisions—constitutional, digestive, circulatory, nervous and respiratory, although they naturally are a good deal mixed up and overlap each other. Referring to the symptoms as a whole one may see that the chronicity or insidious onset of phthisis is one of the most striking features of the disease, and other causes of disease having been excluded long continual symptoms should ever awaken the physician's suspicions.

Constitutional symptoms comparable to the premonitory symptoms of an acute specific disease are wasting, anemia, loss of energy, absence of appetite, occasional fever, long continued debility following grippe or any of the acute specifics, especially measles, typhoid, scarlet fever—of these, chronic wasting is an early symptom, frequently preceding by a considerable space of time cough or noticeable fever, and is more often due to phthisis than any other chronic disease. It is frequently associated with anemia. Marcus Beck found tuberculosis in fifty per cent. of chlorotic girls; these, as you know, are not usually wasted, but the association of anemia and wasting in the absence of Bright's disease is doubly suspicious.

Fever: High fever often not apparent is an early and valuable sign, and if constant only for a part of every day is strongly indicative of incipient tuberculosis: the form of fever I shall refer to later.

Long continued debility, loss of energy, always feeling tired, etc., is another symptom almost as early as wasting, and sooner or later associated with it. How often the patient complains that he has no energy, has not felt himself for a long time, always feels tired, and not up to his work, etc. Loss of appetite is frequently bracketed by the patient with his feeling of weakness, and is therefore placed among constitutional symptoms and is mentioned here for that reason as well as in digestion division. Long continued debility after gripe or acute specifics, or a long drawn convalescence from such troubles, accompanied as they are by material lessening of powers of resistance should always cause incipient tuberculosis to cross one's mind. In the condition of lowered vitality present in a post-febrile period, all organs are under par and the seat of more or less fatty degeneration, they afford excellent soil for tubercle bacillus and the inactive lung, the seat of election for the organism, is its natural resting place.

There is no special phthisical appearance to be recognized, seventy-five per cent. of those suffering from the incipient stage appear in the best of health, as may be seen in any sanatorium as well as in practice.

Digestive: Functional dyspepsia, more often taking the form of hyperacidity but very varied in its character, is more frequent than any other general symptom except gradual wasting and debility. So much so that numbers of cases of incipient tubercule are located for a long time as digestive, the stomach is supposed to be the peccant organ, and the dry cough only a dyspeptic symptom. The digestive symptoms may, however, take varied forms, *e.g.*, loss of appetite, pains before or after food, constipation, or diarrhœa where there is intestinal infection and vomiting.

Vomiting is a not infrequent symptom brought on in some instances by a dry cough owing to gastric irritability or congestion and weakening of nervous control. Functional derangements by their interference with digestion and assimilation are in their turn potent causes of wasting and causing a sense of weakness and debility at an early date.

Circulation: An unduly rapid pulse, especially a pulse going to 100 or over in the evening, most frequently obtains. A small heart is common in phthisis and a cardiac erethism with undue irritability, together with especially well conducted heart sounds, owing to consolidation of lung not otherwise easily distinguishable, are frequently signs which may be the most prominent incipient symptoms, and should lead us to think of phthisis and make a searching examination. With this cardiac irritability goes an undue sensibility to cold and draughts with slight chills or shivering quite apart from fever.

Nervous System: The mental attitude of most phthisical patients is one of inexpressible hope, but if there is definite mental derangement the form is usually that of melancholia. Of the more every-day nervous symptoms neurasthenia connected with debility is met with, and looked upon as the disease, when it is only a symptom of a more serious one, viz., tuberculosis. Migraine occurs in phthisical patients as well as in other members of the family not themselves tuberculous.

Respiratory System: Symptoms of respiratory system are spoken of last, not as of least importance, but because since they more readily draw attention to the disorder under consideration it is well to emphasize the others first.

A chronic cough, or frequently recurring colds from slight causes, are indeed present in one form or other in the majority of cases. The cough is usually dry and hacking, it may occur only on rising in the morning, or any exertion causing an extra deep breath, and it is often looked upon as insignificant by the sufferer and unworthy of mention, but in connection with chronic wasting debility, functional dyspepsia, a rapid pulse, etc., is a very strong confirmatory sign. Various catarrhs—nasal, pharyngeal, laryngeal, bronchial—may precede phthisis or be a premonitory symptom. Certain it is that degenerated mucous membrane, the seat of catarrh, is in a condition unable to cope with the tubercle bacillus, and impotent to prevent its passage. A patient subject to catarrh must have lowered powers of resistance.

Pleurodynia and pains in the chest, vaguely spoken of as rheumatic, are of frequent occurrence, but of the gravest significance is the presence of pleurisy, especially so-called simple or idiopathic pleurisy: it is most probable that all such cases are of tuberculous nature. Pleurisy may be primary lesion or a recrudescence of phthisis in a quiescent case, but certain it is that eliminating rheumatism, cardiac disease, Bright's disease, and new growth for double pleurisies, a large percentage of pleurisies afterwards develop tuberculous lung trouble, and it has frequently been shown *post-mortem* that those dying from other diseases, or from accident, have been found to have unsuspected tuberculous lesions of the pleura or lung, when only supposed to have idiopathic pleurisy. Subsequent history of cases of acute pleurisy, while forcing us to conclude that in two-thirds it is a curable disease, is not antagonistic to this view since it is only in accord with our experience of local tuberculosis, while Bowditch, of Boston, has shown that in ninety cases of acute pleurisy thirty-two died of or had phthisis, a percentage large enough to show what an important role tuberculosis plays in this affection.

Examination: Having enumerated the symptoms, what can

be done to ensure a thorough examination? A history of the case, family and general, is the first step, not with a view to establishing heredity but a presence of phthisis, from which infection may have taken place, or the occurrence of neurotic troubles, such as epilepsy, migraine, asthma, etc., go to show the existence of a low vitality and small power of resistance. The personal history must be investigated for previous illness in the train of which phthisis may have followed, or for pleurisy, colds, or lapses from health, which may have been antecedent, or previous attacks of phthisis. Having thoroughly investigated the history, the examination should include thermometric, chest and sputum examination, and be followed, if necessary, by the use of tuberculin and animal inoculation for diagnostic verification.

The careful use of the thermometer is the sheet-anchor for the discovery of tuberculosis, and more than any other method leads to success when the vagaries of its temperature are borne in mind. The typical temperature is an evening rise of one half to two degrees. While a temperature of 99.6 is sometimes met with in health, it is well to regard with suspicion anything above 98.6, and a persevering use of the thermometer at two hourly intervals for two days often reveals a transient rise which would otherwise have been overlooked. It should not be forgotten that occasionally cases are met with showing an inverted temperature, that is a daily morning rise and evening fall, a reversal of the ordinary type. A subnormal temperature, especially in the morning, is very often present, and is of almost as great value as a diagnostic sign, if of constant occurrence, as a rise of temperature.

Chest Examination: It is unnecessary, and would be out of place, to enter into an extended discussion of physical signs and examination of the respiratory organs, but some valuable early signs may be mentioned together with location of early disease most commonly found.

A truer estimation of the lung expansion can be obtained by palpation than by the eye if the hands are placed first singly then simultaneously over the apices. During auscultation the earliest signs are a jerky, divided breath sound, well prolonged expiration, harsher than that of the other side, or sometimes in chronics puerile breathing, compensatory in origin, may be found in the opposite healthy lung. Short dry clicking rales are of early occurrence, and during inspiration after a cough crepitation may be obtained, due probably to opening up of collapsed air cells, which at other times is not present. Signs of past and present pleurisy should be sought for and the abnormal condition of heart sounds should receive due significance. While the apex is the commonest spot for the first lesion, primary

trouble is sometimes found in the lower lobes and a consolidation at the inner end of the second or third intercostal spaces is frequently overlooked. Perhaps the most valuable auscultation is made by listening over the lung at the part uncovered by the scapula when the patient places his hand over the opposite shoulder; very early roughening of breathing, jerky breathing, or early rales will be first detected here.

Sputum Examination for Tubercle Bacilli: If there is any sputum to be obtained its examination is of the greatest value and the presence of bacilli removes all doubt. The examination must not only be careful, but may have to be repeated and extended. Bacilli are not always present in advanced cases, much less in early cases, and their absence is no proof of the absence of the disease, but their absence is often only apparent, and repeated examination or examination of concentrated or centrifugated sputum may reveal their presence. The method of examination I will not go into since it is probably familiar to most, and the little that I could say in this paper would be of very little use to others.

Tuberculin: If still in doubt after a thermometric, a chest and sputum examination, there remains a method of the greatest value, and its safety, despite a vague idea that it may be dangerous, is on a par with its certainty, viz: the injection of tuberculin. Its value depends on the febrile reaction with pains in the chest, feeling of malaise, etc., which follows its use in tuberculous cases. The method used should be as follows: The temperature should be taken for two days at two hourly intervals to see if there is any rise of temperature, finding none on the second day, because a reaction, if any, usually comes on in twelve hours or so. One half milligram of tuberculin is injected hypodermically with aseptic precautions. If there is no result after two days, the dose should be increased to two mill. and so on up to five mill., which last dose should be repeated once. If there should still be no reaction there is little probability of tuberculosis, but if there should be a reaction the diagnosis admits of no doubt, and appropriate treatment, preferably sanatorium, should be commenced.

Trudeau has used this method in, I believe, one thousand cases and never known any untoward result. Any idea of injecting tubercle bacilli into the system is owing to a misconception of the nature of tuberculin, which, owing to the method of preparation with glycerine, heating in the auto clave to 100 degrees Cent., and subsequent filtering through Pasteur filter, and finally boiling cannot possibly contain any organism. It is perfectly safe, and in proper doses and with cautious use cannot do harm.

If still there be any doubt, in certain cases there is a last.

resort, viz., animal inoculation, inoculation of guinea pig with sputum, and after six weeks an examination of the guinea pig to see if any tuberculous lesion has developed.

Finally, I would repeat that the chronicity of phthisis renders it in most cases a probable one by principles of exclusion, when no other reason is found for an associated train of symptoms, such as cough, wasting, debility, dyspepsia, etc., that a thorough examination of temperature, chest, sputum and reaction to tuberculin will usually enable us to come to a confident diagnosis, that by appropriate treatment by open air, food and rest, at home or in a sanatorium, the disease may be arrested and cured, and that finally we may thus in time hope to enormously lessen, if not stamp out, the disease.

Selected Articles.

ABDOMINAL OPERATIONS DURING PREGNANCY.

Every medical man, whether engaged in general practice or in doing abdominal surgery, has probably met with instances of serious disease of one or other of the abdominal organs, complicating pregnancy. If, however, I may judge from my own experience, first of some years of general practice, and subsequently of ten years of abdominal surgery, such cases as urgently require operative interference are less common than one might *a priori* have expected. Probably the most frequent complication of the kind occurring during pregnancy (or perhaps it would be more correct to say that the pregnancy complicates the previously existing condition) is either an ovarian cyst, or fibro-myoma of the uterus. Most surgeons who do much abdominal work have been at some time or another called upon to remove such a tumor or tumors, which would otherwise obstruct labor. In this country (Australia) one occasionally meets with instances of hydatid cysts occupying the pelvis, which call for treatment in the same way. I have seen cases of renal calculus which, by causing symptoms, were discovered during pregnancy, and the question had to be decided as to whether immediate removal should be practised or delayed until after confinement.

In one instance I have been called upon to deal with a carcinomatous growth of the gut, causing obstructive symptoms. We may roughly classify all the instances above referred to as *mechanical* conditions, and each case must be judged upon its merits. There is, however, an entirely different class of cases, which, fortunately, is not commonly met with during pregnancy—I mean those instances in which an acute infective process attacks certain organs, such as the gall-bladder and bile ducts, the vermiform appendix, and, more rarely still, the Fallopian tubes.

Under such conditions, *i.e.*, an acute infective cholecystitis, an acute appendicitis, or an acute infective salpingitis, are we to wait, temporise, and trust that the acute symptoms will subside and permit the pregnancy to terminate normally? or should we deal at once with the pathological condition, removing the cause by operation, and leaving the physiological condition to go on to its natural ending?

Not so very many years ago it was generally held that surgical interference with pregnant women was to be avoided

under almost all circumstances. Even now, one meets instances in which pregnant women, who are suffering agonies from neuralgia, induced by carious teeth, are solemnly warned that the operation of extraction or "stopping" will probably induce premature labor, and they are left to go on with a prolonged pain and discomfort, which might easily be removed without any untoward result. It is only of late years that the safety and generally good results of major abdominal operations in pregnant women have been demonstrated. I do not mean that we should choose to operate during pregnancy if it can with safety be avoided. But in such instances as the acute infective conditions above referred to, which in themselves threaten life, there can, I think, be no doubt as to the advisability of operative interference. This fact was particularly brought home to me by the case of a gangrenous appendicitis recorded below. This patient had been seen by a surgeon and a physician, both of large experience, and for whose opinion I have the greatest respect; but because the second and third attacks of appendicitis occurred after the commencement of pregnancy, these gentlemen negatived operative interference, and advised waiting. This was, I believe, a decided error in judgment. The verdict should have been reversed. Had this been so, the patient would have been saved great risk to life, for, although she did recover perfectly, and the pregnancy was in no way interfered with, the risk which both she and her child ran was infinitely greater than it would have been had the operation been done in the "quiet interval" after either the second or third attack.

The conclusion, therefore, to which I think we must come is that all cases of acute disease, involving either the appendix vermiformis, the Fallopian tubes, or the gall-bladder and bile ducts, during pregnancy, should be treated as though the pregnancy did not exist. By so doing I believe we shall be acting in the best interests of our patients and their unborn children also. I do not propose now, at all events, to refer at length to those cases which I previously spoke of as *mechanical* complications during pregnancy. It has been abundantly demonstrated that the operations both of ovariectomy and myomectomy can be safely done on pregnant women without interfering with the pregnancy.

Mrs. M., aged 30 years; children, four, at full time; no miscarriages. Patient was seen, in consultation with Dr. McMaster, of Penrith, near Sydney, N.S.W., on December 26th, 1901. She was then suffering from an acute attack of appendicitis; had been ill for five days. There was severe abdominal pain, chiefly localised in right iliac region—marked "guard tension" of abdominal muscles on right side of abdomen. Uterus

enlarged to about the size of a six months' pregnancy. The bowels had been that day relieved as the result of an aperient and enema. *Vaginal* examination confirmed the fact of the six months' pregnancy, and showed the presence of an inflammatory mass high up in the right posterior quarter of the pelvis, which was continuous, with a tender swelling in right iliac region. Temperature varied (as shown by chart) between 99° and 103° F. Uterus quiet; no abnormal contractions.

History—The patient had had three previous attacks of undoubted appendicitis. The first, two months before the present pregnancy, *i.e.*, eight months ago; this was a slight attack; then another more severe attack four months after the first attack, and a third, two months after the second, *i.e.*, when she was about four months pregnant. During the interval between the second and third attacks the patient had consulted a surgeon and a physician in Sydney, and had been advised, *because she was pregnant*, that no operation should be undertaken.

On December 29th, 1901, the patient came to Sydney and was admitted to a private hospital. She stood the journey of forty miles in the train very well.

Operation, December 30th, 1901.—Under ether anesthesia, usual oblique incision in right iliac region was made; the deeper layers of the abdominal wall were edematous. (In this instance because of the altered physical conditions due to the pregnancy the incision was not made at the outer border of the rectus sheath, but through the oblique muscles, the fibres of which had to be divided, as simple separation did not give sufficient room.) There were adhesions involving the colon, omentum, small intestine, and appendix. The right half of the broad ligament was greatly thickened and edematous, as well as the right ovary and Fallopian tube, the ovary being almost black in color. The appendix when separated and stripped from surrounding adhesions was found to be swollen and gangrenous. It was removed close to the caput cecum coli. The right ovary and Fallopian tube were also removed, the separate vessels being picked up and ligatured and the top of the broad ligament over-stitched with catgut. A small gauze drain, with gutta percha tissue round the middle portion, was placed in position, and the abdominal incision closed in layers, catgut sutures being used.

Convalescence was quite uneventful, temperature never reaching 100° F.

The pregnancy went on to full time, and the patient was safely delivered of a living child, the line of incision remaining sound.—E. T. THRING, F.R.C.S. (Eng.), Sydney, in *The Australasian Medical Gazette*.

SOME IMPRESSIONS OF THE RECENT CONGRESS OF GERMAN SURGEONS.

BY DR. ROSWELL PARK.

Editor *Buffalo Medical Journal* :

SIR,—It has occurred to me that a brief account of the meeting of the German "Gesellschaft für Chirurgie," or Surgical Association, whose sessions, extending over four days, have just been completed, might be of some passing interest to your readers. This is the thirty-third annual meeting, therefore it will be seen that it is an older institution than our American Surgical Association. It is, however, in one respect, less select, since its membership is unlimited, and it is open to all those who confine themselves to surgical work; whereas the American society is limited, at present, to one hundred and twenty-five, it being the intent that only those who have already made their mark in surgery shall be considered as candidates. There are advantages in each way of doing things. For my own part I have always thought that a judiciously selected but unlimited membership list brings the greatest good to the greatest number. In this matter, however, I have so far been in the minority, though I have urged the "open door" policy.

The founders of the German society were Langenbeck, Bilroth, Folkmann, Bruns, Bardeleben, Simon, Gurlt, Thiersch and Esmarch, and a picture of these men, whom we all delight to honor, hangs in the surgical clinic of the General Hospital. I have had the honor of being one of the four or five regular American members for a number of years, but have attended very few meetings. These are held during the week following Easter, which is vacation time in all the German Universities, so that a large gathering is always possible. There are some four hundred and fifty members, and the program for the meeting included about one hundred and fifty papers. Thus it will appear to be an exceedingly active body of men. All of the surgeons of whom we ever hear belong to it, as well as many others.

Meetings are always held in Berlin, since here the society owns its own home. It stands on the grounds of the University Surgical Clinic; has an auditorium that will seat nearly five hundred, a very valuable library, numerous portraits, a museum, and all that can ever be needed for its purposes. The building, not including the land, cost one hundred and twenty-five thousand dollars, of which amount the grandmother of the present Kaiser contributed a very generous amount. Here meet numerous local and more national medical societies; the Langenbeck

House, as it is called, is a sort of national surgeon's headquarters, somewhat corresponding to the Royal College of Surgeons of London; only the society has nothing to do with licensing or governing the practice of surgery.

Here, too, met during the past week the German Association of Orthopedic Surgeons, the meeting lasting only one day, under the presidency, this year, of Dr. Heusner, of Barmen. They had a program replete with interest, the principal subject for discussion being contractures of joints, while congenital dislocations, especially of the hip, were treated of by a number of writers. Lorenz, of pseudo-American fame, was not present. I was not a constant attendant, but I could not gather that *his* method of reducing congenitally displaced hips has won any great esteem over here. To be sure, however, the newspapers here are not generally on his side; neither is to be taken very seriously—at least not favorably—by the men here with whom I have talked.

To this orthopedic association belong about a hundred members. I note that among these the principal *operating* orthopedists belong to the surgical association, while those who work mainly or entirely with massage, apparatus and gymnastics form a sort of group by themselves, as in the American Orthopedic Association. It is curious how men seem amiably separated according as their tastes and acquirements lead them to rapid operative or slow non-operative methods. The operative method of treating lordosis or angular curvature was, however, not mentioned; were it still received with favor I think it would have been otherwise.

Inasmuch as the capacity of the auditorium is limited practically to the membership, admission to the surgical association was given only to members and invited guests; and then it was overcrowded, even at the opening session. The president, this year, was Prof. H. Braun. The first papers were by Körte, Franz, Riese, Lexer and Hoffmann, and concerned the surgery of the arteries and their surgical anatomy, especially in the osseous system. The most interesting portion of the morning was the demonstration by Hoffa, who is well known to us as an orthopedic surgeon, and by his book on fractures and dislocations, of some twenty cases, selected out of a large number, in which he had practised tendon plastic or transplantation methods. His demonstration was most interesting and most convincing as to the value of the proceeding in many instances of paralytic deformity and loss of function.

The features of the first afternoon were papers on the method of preventing collapse of the lung during operations within the thorax. Sauerbruch, of Breslau, exhibited a pneumatic cabinet in which may be enclosed the head of a patient and the anaesthetiser, while the air pressure is raised a little; or within which

conditions may be reversed, so that the head of the patient is outside, while the operator and his assistants operate on the thorax from within the cabinet under a slightly reduced barometric or manometric pressure. The former is a temporary matter and submits the anesthetiser to a condition like that under which men work in caissons. The latter is quite new and experimental.

Mikulicz, in whose clinic this cabinet has been once tested, reported the loss of his patient. A much simpler method of establishing similar conditions was described by Petersen and Brauer, of Heidelberg, who also reported the loss of the only patient operated by their procedure. Both methods were demonstrated after the meeting, upon dogs, and both beautifully illustrated what was claimed for them—*on animals*. Whether either of them is practical or practicable remains to be shown.

The balance of this afternoon session was devoted to the usefulness of the X-rays in malignant disease, and to the nature of this disease. Petersen read a paper on the inoculation and implantation of cancer, but made it no clearer than before that the surgeons have been much more ready to accept the parasitic theory than the pathologists who work only in the dead-house and at the desk, *i.e.*, that cancer is an infectious disease. Other opinions to the same effect were distinctly voiced by various speakers in public and private.

What can be done in the treatment of these cases by Röntgen rays and by radium was then illustrated by Lassar, the eminent dermatologist, who exhibited a remarkable collection of some forty or fifty patients thus treated. They all were cases of superficial lesions, some original, some recurrent. Of some of them he had microscopic sections, while of all he had beautifully colored wax models, showing the condition before commencing treatment. The results were beautifully demonstrative of the benefits obtainable in certain cases, especially the inoperable. And yet Lassar is himself unwilling to speak of them without great reserve—which was quite noteworthy. I do not think such a demonstration could be made anywhere else in the world; yet in spite of this and in the face of all these facts, there was a caution in his speech which should find many imitators. With us the temptation is too strong to regard two or three apparent successes as a final demonstration that X-rays will cure cancer. Nor was any attempt made to show that these lesions are not best treated by a clean excision, especially when seen reasonably early. Lassar, moreover, took pains to set forth numerous instances in which little or no benefit accrued—for example, in epithelioma of the tongue, where the lingual lesion might perhaps improve, but the deep infiltration surely would progress. Nevertheless, he showed a number of

cases of recurring cancer of the breast, especially the disseminated and ulcerating forms, which had been greatly improved. Of radium he had but little to say, though that little was rather favorable.

The first evening was devoted to demonstrations with the projecting lantern. Krause, Lexer, and Hoffa all showed lantern slides, those of Lexer on the distribution of the blood-vessels in the bones being especially beautiful and exciting the greatest admiration. He injects the arteries with a mercurial preparation and then subjects the specimens to the Röntgen rays.

The second morning was practically devoted to the surgery of the upper abdomen. Kehr, who boasts that he has built up his little town of Halberstadt, reported on five new operations which he had practised on the biliary passages; *i.e.*, resection of both ducts and a hepatico-duodenostomy, hepato-cholangio-enterostomy, ligature of the hepatic artery for aneurism, gastro-duodenostomy after closure of the upper part of the duodenum, and implantation of a pancreatic fistula in the gallbladder with a subsequent gastrocystotomy. I find that by some of the German surgeons Kehr is not taken very seriously, while by others, he is—very seriously. Körte, of Berlin, had a most interesting paper on the relations of biliary and pancreatic diseases; Ehrhardt talked entertainingly about the peritoneal infections, which arise from the biliary passages, and the venerable Bardenheer, of Cologne, spoke on pancreatic hemorrhages. He, by the way, some years ago wrote a large book on the traction or extension treatment of fractures, which, as everyone at home knows, is absolutely of American origin.

The balance of the day was devoted to a miscellaneous programme, which included many subjects, frequently illustrated with patients, and always with specimens or drawings.

The annual dinner was held at the Savoy at 5.30 p.m. In this respect our German friends set a good example. Only four speeches were made, and the company had separated by half-past eight. The advantages of such an arrangement are obvious.

The third day's session opened with a series of papers on bone surgery by a dozen different writers. This was followed by a sort of symposium on surgical diseases of the kidney, in which Kümmel and Krönlein dealt especially with tubercular lesions, and showed some remarkable specimens. Calculous disease received considerable attention. Ahrens reported a nephrotomy of a solitary kidney, while Barth showed a patient with horseshoe kidney upon which he had done an exploratory incision. Several writers then dealt with decapsulation of the kidney for Bright's disease—a method evidently not popular

over here, for, so far as I gathered, no one mentioned it save to condemn it.

The third afternoon session was devoted to the peritoneum, stomach and intestinal canal. Mikulicz discussed the possibility of increasing the resisting power of the peritoneum; Payr reported on mesenteric thrombosis following intraabdominal operations, and numerous papers were read on ulcer of the stomach, cancer of the pylorus and intestines, and the operative measures to be instituted for their relief. The writers were of one accord in at least this respect—that all ulcerative lesions of the gastro-intestinal tract were best treated by operation of some kind.

The fourth morning session began with the apparently inevitable subject of appendicitis, which was discussed especially by Lauenstein, Federman, Cordua, Karewski and Sonnenburg. These are the men in all Germany who are, perhaps, most competent in this direction. Sonnenburg told me that he had himself operated on nearly eighteen hundred cases, which puts him on a plane with our best American surgeons, and entitles him to respectful hearing. He certainly has had larger experience with this condition than that of scores of his colleagues combined. During the session Brentano showed the specimen of a remarkable case of Hirschsprung's disease; *i. e.*, congenital reduction in length and enlargement of caliber of the intestinal canal. It came from a boy of fourteen, who suffered from coprostasis to such extent that at one single time twenty-seven pounds of fecal matter were taken away from him. During the final afternoon session a variety of papers were read, one of them on so-called chorion-epithelioma of the testicle, by Holländer, while specimens and drawings were as numerous as ever.

Prof. Krönlein, of Zürich, was elected president for the ensuing year. He will be a great improvement upon Dr. Braun, of Göttingen, the retiring officer, who is old, feeble, toothless and hard to hear or understand, and who seemed to have little power of preserving good order during the meetings.

Altogether the meeting has been to me one of great entertainment. There has been little new, and nothing of tremendous interest, but there has been evinced a notable degree of research work and those rare, germanic traits of industry and never-tiring zeal. I have been making comparisons with the similar meetings of our own American Surgical Association, and do not feel that we need consider ourselves one whit inferior in any respect. Our meetings are more dignified, the papers are equally scientific, and our members much less prone to indulge in personalities or slighting and even insulting behavior. My regard for German surgery was comprehensive enough before I attended this meeting. I cannot say that it has been particularly enhanced thereby.

The American surgeons certainly lead the world to-day, and can teach their foreign colleagues many things. Some of the most progressive and least prejudiced of the continental surgeons are beginning to realize and acknowledge this, and a number of them are coming over to our World's Fair. Let us welcome them and impress them so far as we can, but let us not repeat the Lorenz fiasco. After all it repays our students to come to the continent, for they may learn what to avoid as well as what to do. It seems to me that the greatest advantage attendant upon studying surgery in the German clinics is the frequency with which one may follow cases from the operating table to the autopsy room, where their perplexities are so often cleared away.

The Anglo-American Medical Society meets every Saturday night in the Central Hotel, when I had the pleasure of addressing some fifty of my fellow countrymen. Every American coming here to study should ally himself at once with this excellent organization, which can be of the greatest service to him. It is the only labor union I know of which serves to bring out the best work of the men who belong to it as well as of the various teachers in Berlin, who are anxious to do all they can to win the commendation and patronage of its members.

Berlin, April 10, 1904.

Progress of Medical Science.

MEDICINE.

IN CHARGE OF W. H. B. AIRNS, H. J. HAMILTON, C. J. COPP
AND F. A. CLARKSON.

The Detection of Early Tubercle of the Lungs.

Owen (*British Medical Journal*) emphasizes the fact that phthisis is a disease of essentially intermittent or remittent character, and that if the lungs of young people were the subject of as much solicitude as their teeth, the prevalence of the intermittent and insidious onset of pulmonary tuberculosis would be more generally recognized. Very often what is considered the initial attack is really not so, and were it not for a hæmoptysis in some cases, we would have considered the illness as a temporary indisposition. In examining a patient Owen proposes, after inspection, a thorough auscultation, leaving percussion and palpitation till the last. The pitch of tubular breathing heard in early tubercle of the apex, is nearly always low—much lower than in pneumonia. Harsh breathing associated with voice changes, is of more serious importance than harsh breathing without such changes. Vocal fremitus is of little use in the diagnosis of early lesions. Both light and deep percussion should be systematically practised. If the dulness is more marked with light rather than deep percussion, it is probably caused by a thickened pleura: if the reverse obtains it suggests a deep-seated consolidation. Moist sounds in a tuberculous lung do not necessarily indicate a breaking down of tissue, for they also accompany the earliest stage of the grey tubercle. Clicks at the end of inspiration are diagnostic of phthisis, but of themselves tell nothing definite of the condition of the lung. By making the patient cough we can eliminate the moist sounds due to bronchial catarrh. Measurement of the apices is also an important aid.

F. A. C.

A Delicate Test for Arsenic.

Abbo, the director of the Hygienic Institute of Turin, found that a fungus, known as *Penicillium horricaulis*, would develop with great rapidity an odor of garlic when grown on any substance containing arsenic. He could detect, by this means, minute traces in flour, in the urine of patients treated with arsenic, and even in illuminating gas. The reaction was marked with the one-millionth part of a grain of the poison. This interesting mould grows well on potato, and as it is easily kept there is no reason why it could not be applied in private practice

F. A. C.

Purified Antitoxins.

Antitoxin consists of serum-albumin and serum-globulin, and serum-globulin has been separated again into at least three compounds—fibrino-globulin, euglobulin and pseudo-globulin. For some time it has been known that the antitoxic bodies are not associated with all the elements which go to make up the serum. Pick found that the fibrino-globulin and the serum-albumin possess no antitoxic properties, while either the euglobulin or the pseudo-globulin contain all the antitoxin, depending upon the animal used and the germ inoculated. He found, for instance, that the diphtheria antitoxin from horse's serum is contained in the pseudo-globulin, while in goat's serum it is found only in the euglobulin. In the antistreptococic serum from a horse both the antitoxin and the agglutinin are precipitated with the euglobulin. The practical application of these will be that the useless and inert substances can now be eliminated, and the serum administered in a more concentrated form.

F. A. C.

SURGERY.

IN CHARGE OF EDMUND E. KING, GEORGE A. BINGHAM, C. B. SHUTTLEWORTH
AND F. W. MARLOW.

Surgical Treatment of Nephritis.

The surgical treatment of nephritis has been receiving a good deal of attention of late, and a few words on this important subject about which we shall no doubt hear much more in the near future are deemed not to be out of place, but to be worthy of our consideration.

Attention seems to have been directed to this subject mainly on account of the beneficial results which so frequently follow exploration of the kidney in cases where renal pain, accompanied by hematuria or even pyuria, exists as the most prominent symptom, and where often the diagnosis of the existing pathological condition is only doubtfully presumed. Such a result has, undoubtedly, been most frequently observed in cases where a calculus has been diagnosed, but after thorough exploration has not been found, and yet subsequent marked improvement in the patient's condition has taken place.

In recent operations, and, likewise, in experiments, the part of the kidney which has received most attention is the capsule. This is, for the most part, an inelastic structure, and so when congestion of the renal parenchyma occurs, owing to an inflammatory process, the resulting distension is painful, and especially would this be so if, in addition, the capsule becomes thickened and sclerosed.

In acute nephritis Harrison has performed capsulotomy for the relief of congestion, and has compared the condition with an acute glaucoma. Likewise, in chronic nephritis Pousson has performed capsulotomy, comparing the condition with a chronic glaucoma. Complete capsulectomy is advocated by Edebohls in order to obtain fresh vascular supply in surrounding adhesions, and so overcome any mechanical anemia and interference with the collateral circulation which may be brought about by a thickened and sclerosed capsule, the existence of vascular adhesions subsequent to such an operation having been demonstrated experimentally by Claude and Balthazard.

Cases treated successfully by capsulectomy have been reported by Jaboulay, who thinks that improvement following such operations occurs too rapidly, to depend upon newly established vascular supply, and advances the hypothesis that all these operations, whether of the nature of nephrotomy, capsulotomy or capsulectomy, produce a vaso-motor modification of the renal circulation as a result of traumatism inflicted on the sympathetic system situated in the renal pedicle.

Such operations have been undertaken with encouraging results in acute and chronic parenchymatous nephritis, and in chronic interstitial nephritis, but, so far, it would seem that the results have been the least encouraging in the acute parenchymatous form in which the indications for operation, as stated by Maraglians, are constant, severe, fixed pain, severe hematuria, and especially threatening anuria.

E. W. M.

OPHTHALMOLOGY AND OTOTOLOGY.

IN CHARGE OF J. T. DUNCAN, M.B., M.D., C.M.

The Non-Operative Relief of Eye-strain for the Possible Cure of Epilepsy.

In the State of New York there is a special institution for the care exclusively of epileptic persons, known as the Craig Colony. In this colony are some eight hundred patients. The medical superintendent of the colony is Dr. Spratling. In 1892 he consented to an experiment being made in the relief of eye-strain in a number of patients. He selected 78 patients, and Drs. Gould and Bennett were allowed to correct the refraction of these patients, or rather of 68 of them, 35 men and 33 women

The following is the gist of Dr. Spratling's report:

The 68 patients, 35 men and 33 women, began wearing glasses

September 1, 1902, and with few exceptions continued to wear them until September 1, 1903.

A record of each seizure and its type was kept in each case by the physician in charge. Occasionally glasses were broken or destroyed as the result of an epileptic seizure, but they were replaced as soon as possible, always within a few days.

All physicians and nurses at the Colony understood that the test was of great value, and no one left a stone unturned to carry it out in the accurate and painstaking manner required.

The table of results presented shows the following:

1. The number of attacks each patient had during the three months prior to the use of glasses.
2. The number of attacks each patient had during the three months following the use of glasses.
3. The number of attacks each patient had during the six months following the use of glasses.
4. The number of attacks each patient had during the twelve months following the use of glasses.

FEMALES.

No.	NAME.	Number attacks 3 months before using glasses.	Number attacks 3 months after using glasses.	Number attacks 6 months after using glasses.	Number attacks 1 year after using glasses.	REMARKS.
1	M. A.	59	59	119	239	Attacks less.
2	F. B.	9	14	25	66	Attacks increased.
3	A. B.	0	0	0	3	Attacks increased.
4	G. B.	19	19	19	35	Attacks increased.
5	M. C.	7	7	21	43	Attacks increased.
6	A. C.	79	165	301	316	Attacks increased.
7	L. C.	23	52	0 ¹		Attacks increased.
8	L. DeR.	22	4	45	57	Attacks less.
9	E. D.	1	3	3	5	Attacks increased.
10	R. DeR.	0	0	0	0	No attacks in 15 months.
11	F. D.	0	0	0	0	No attacks in 15 months.
12	K. D.	2	5	9	28	Attacks increased.
13	L. D.	202	105	344	578	Attacks same.
14	A. D.	14	14	17	33	Attacks same.
15	C. E.	0	0	0	0	No attacks in 15 months.
16	N. E.	4	10	19	59	Attacks increased.
17	M. G.	37	42	73	161	Attacks increased.
18	M. G.	6	0	7	16	Attacks less.
19	V. G.	1	0	0 ²	3	Attacks increased.
20	A. H.	17	23	36	107	Attacks increased.
21	I. H.	0	0	0	0	No attacks in 15 months.
22	N. J.	7	4	8	19	Attacks increased.
23	M. J.	1	3	4 ³		Attacks increased.
24	C. M.	26	32	61	145	Attacks increased.
25	D. N.	48	59	89	159	Attacks less.
26	M. N.	50	59	81	149	Attacks less.
27	V. P.	12	14	21	62	Attacks less.
28	A. P.	17	50	93	168	Attacks increased.
29	L. R.	1	6	12	28	Attacks increased.
30	A. R.	12	21	40	82	Attacks increased.
31	D. S.	3	2	6	13	Attacks same.
32	C. S.	12	8	17	31	Attacks increased.
33	K. V.	7	11	17	51	Attacks increased.
34	H. V. H.	2	2	3	7	Attacks less.
35	M. W.	12	13	29	59	Attacks increased.

MALES.

No.	NAME.	Number attacks 3 months before using glasses.	Number attacks 3 months after using glasses.	Number attacks 6 months after using glasses.	Number attacks 1 year after using glasses.	REMARKS.	
1	G. D. B.	63	29	Dis. after three months.		Attacks less.	
2	F. B.	2	1	22	1	75	Attacks increased.
3	O. B.	12	8	No attacks in ten months.			Attacks less.
4	G. B.	7	0	28	59		Attacks increased.
5	W. B.	6	2	8	24		Attacks same.
6	J. C.	14	21	36	55		Attacks same.
7	W. C.	11	112	250	387		Attacks increased.
8	J. W. D.	23	11	19	41		Attacks less.
9	W. D.	23	8	19	41		Attacks less.
10	G. E.	0	9	9	11		Attacks increased.
11	A. E.	0	1	3	12		Attacks increased.
12	G. E.	3	3	3	16		Attacks increased.
13	C. G.	9	16	29	36		Attacks same.
14	A. J.	6	4	15	40		Attacks increased.
15	W. K.	0	0	0	0		Discharged in 9 months.
16	W. P. M.	4	1	3	14		Attacks same.
17	V. M.	3	4	12	19		Attacks increased.
18	L. M.	306	222	622	1033		Attacks same.
19	J. McF.	0	0	0	0		No attacks in 15 months.
20	T. McJ.	24	24	43	72		Attacks same.
21	W. O.	3	34	59	102		Attacks same.
22	H. P.	35	33	33	23		Attacks same.
23	M. Q.	11	3	23	31		Attacks same.
24	J. R.	13	3				Died.
25	G. S.	24	14	29	70		Attacks same.
26	J. S.	25	32	71	0		Attacks same.
27	C. S.	14	25	185	0		Attacks same.
28	G. V. K.	2	3		0		Attacks same.
29	E. W.	4	10	17	31		Attacks increased.
30	C. C.	33	56	107	195		Attacks increased.
31	J. K.	0	3	6	13		Attacks increased.
32	C. W.	0	0	0	0		No attacks in 15 months.
33	C. W.	25	31	61	116		Attacks increased.

Dr. Spratling discusses these results and then concludes :

"Personally, I deeply regret that the experiment so carefully and scientifically made by Drs. Gould and Bennett, did not yield better results. At the same time, it strengthened my convictions that epilepsy is not a 'single prescription disease,' so to speak—the the correction of the abnormalities of the eye alone is not any more likely to cure it than are surgical measures directed against the brain, from which so much was at one time hoped for, but from which we now expect so little."

ADDENDUM BY DR. GEORGE M. GOULD.*

In reference to the article which Dr. Spratling has been so courteous as to show me before publication, I would like to say :

1. I have had 6 cases in my private practice in which per-

* Published after submission to Dr. Spratling and with his consent.

manent cure of epilepsy has been effected by glasses alone. Many other cases have been reported. I know of two oculists who have similar unreported cases. About half of the 68 patients whose eyes were examined at Craig Colony had unsymmetrical astigmatism, an enormously high percentage of a defect which, as all admit, is intensely injurious to the nervous system. These facts lead to the conclusion that eye-strain is a cause of epilepsy in at least a small proportion of cases.

2. The total patients examined	68
Number having no attacks for three months prior, or 3 months after, and which should have been omitted	8
	<hr/>
	60
Died or left off glasses	3
	<hr/>
	57
Same number of attacks prior or after	8
	<hr/>
	49
Attacks lessened in 3 months	19
	<hr/>
Attacks increased in 3 months	30
The 19 patients whose attacks were lessened, had, during the 3 months prior to the beginning of the experiment, attacks	861
During the 3 following months	479
	<hr/>
Showing a decrease of over 44%	382

Moreover, this lessening of the number of seizures in 3 months of 19 patients by 382 does not comport with the statement in the official report which says that "only one patient out of the 68 (should be 57) experienced any benefit in their disease while wearing glasses. I would like to ask if any therapeutic experiments, or if all combined made at the Colony, have lessened the number of seizures in 3 months in 19 patients by 382? I am astonished at such good results and never expected such high percentages of benefit from the test. Instead of "disappointing" it seems to me the reverse.

According to the report there was 1 cure in 57 of the patients tested. How does this compare with the officially reported cures at the Colony since its foundation? To October, 1902, there have been admitted 1,286 patients, and of these, 16 had been cured by all the methods of treatment. This is 1 in 80. By the treatment of the eyes alone, 1 in 57 has been cured. Thus the ocular treatment alone has proportionally cured nearly

one-third more cases than all the combined methods pursued at the Colony. Except in the sense that all the methods of cure tried at the Colony are "disappointing," the results of the ocular test are scarcely to be called so. There is a story in Matthew xviii., verses 12 and 13, that might be called to Dr. Spratling's attention. It may also apply to epileptics with eye-strain.

SUMMARY.

Two mistakes were made in conducting the experiment: 1. Young patients, and those only with less injured nervous systems should have been chosen. 2. Resident or frequently visiting opticians and oculists should have been insured to make the retestings, readjustments, etc., most necessary. Despite these faults, together with incomplete statistics, etc., 19 out of 57 patients, for the only comparable terms given of 3 months showed a reduction of the number of seizures of 382 (44 per cent.), and 1 in 57 was cured against 1 in 80 by all other methods of treatment that have been tried at the Colony. From the result of the experiment at Craig Colony I judge that the permanent residence at such institutions of an expert ophthalmologist would result in great monetary saving on the part of the State. Spectacles would certainly lessen the special disease, and the number of seizures. Even if they would not do so they would tremendously lessen headache, digestional troubles, etc. For mere humanity's sake they should be ordered. The habit of depreciation and ignoring the eye-strain factor is both cruel and unscientific.

OBSTETRICS AND GYNECOLOGY.

IN CHARGE OF ADAM H. WRIGHT, K. C. McILWRAITH, FRED. FENTON AND
HELEN MACMURCHY.

The Treatment of Post-partum Hemorrhage.

Prof. H. Fritsch (*Deutsche Med. Woch.*, Jan. 1, p. 18).—In post-partum hemorrhage treatment should proceed on a settled plan, and time should not be wasted in trying useless methods. Prophylaxis consists in proper management of the third stage of labor. If the uterus is squeezed or massaged directly after the child is born the placenta partially separates, the uterus is unable to contract evenly, and hemorrhage is inevitable. When after-pains occur, the fundus may be gently rubbed for ten to twenty minutes after delivery. It is remarkable that in no reported case in which the uterus has not been touched, as in

concealment of birth, has the mother died of post-partum hemorrhage. But if from any cause there has been hemorrhage, the uterus becomes atonic. Probably hemorrhage is more often the cause of atony than the result. In cases of atony in which the woman is perhaps already pulseless the following procedure is safe and certain: The accumulation of blood in the uterine cavity is expressed, and the hands are passed between the recti, which are usually easily pushed aside, so as to reach the back of the uterus, which is raised as high as possible, forcibly ante-flexed, and compressed against the superior and posterior surfaces of the pubes. The internal os then lies exactly above the pubic portion of the ilio-pectineal line. The abdominal walls immediately after delivery are easily forced behind the uterus as deeply as the pelvic brim. The resulting funnel-shaped pouch of skin and muscle is firmly plugged with folded towels, linen, or if sufficient is available, with large pads of cotton wool, until the uterus is immovably fixed against the anterior abdominal wall and the pubes. A roller bandage is applied over the padding which is thus forced behind the uterus towards the pelvic inlet. The body of the uterus then lies above and in front of the symphysis pubis. The method has the following advantages:

1. By compression of the abdominal cavity blood is retained in the upper half of the body even more effectually than by direct compression of the abdominal aorta and bandaging the legs.

2. Hemorrhage is impossible as the uterine walls are so pressed together that the uterine cavity is obliterated.

3. Hemostasis is immediate. If the uterine cavity is plugged large quantities of blood escape during the operation and are absorbed by the tampon itself. Prof. Ritch has seen cases in which after completion of plugging the woman was found to be dead.

4. No time is lost in disinfecting the hands as no internal manipulations are required.

5. The pad once in place, no further disturbance of the patient is necessary, and there are no uterine plugs to be removed.—*Medical Review.*

Editorials.

UNIVERSITY OF TORONTO CONVOCATION HALL.

We understand that the proposed Convocation Hall for the University of Toronto will shortly be erected. Through the efforts of Dr. R. A. Reeve, Dean of the Faculty, assisted by other members of the Alumni Association, a large sum of money has been subscribed, which, with the addition of the Government grant, will amount to over \$100,000.

It was at first contemplated to use brick, but it is now hoped that a handsome stone building will be erected. The main hall in the building according to the plans is arranged in the form of an amphitheatre, in such a way that no seat is more than sixty feet from the centre of the stage. The total seating capacity is 1860. On the ground floor the inner circle will seat 470, the outer circle rising from the floor will seat 440. The first gallery will accommodate 360, and the second gallery 460. The platform will seat 120, and the special boxes ten more. On each side of the platform will be retiring rooms 34 by 23 feet. On the ground floor there is a spacious lobby running from one end of the stage to the other, behind the outer circle, affording many entrances to that and to the inner circle, and off it are a number of cloak rooms. The first gallery is really the continuation of the outer circle, and gives that impression from the stage. Around both galleries are wide corridors, so arranged that entrance and exit will always be easy. In the rear of the main hall there is a large room 180 by 50 feet, capable of seating 500 persons. This smaller room can be used for banqueting purposes, or for meetings which are not large enough to require the main hall.

The whole building is excellently designed in accordance with the best modern ideas.

THE PROPOSED NEW BELLEVUE HOSPITAL, NEW YORK.

We learn from the *New York Medical Journal* that the new Bellevue Hospital, which is shortly to be erected in that city, will be a magnificent structure. The plans were first made public by Dr. Brannan, President of the Bellevue Hospital Board of Trustees, in an address to the students of the Columbia University, April 22nd.

The preliminary work of the architects in drawing plans cost \$75,000. The building is designed to occupy three full city blocks from Twenty-sixth to Twenty-ninth streets, and from First Avenue to the East River. The extra land alone will cost \$1,000,000. And in addition to the property to be purchased the structure will require two additional acres, to be cleared by changing the bulkheads along the water front. The building is expected to cost not less than \$14,000,000. It is said it will be the largest, handsomest and most completely equipped hospital in the world, and will accommodate 2,500 patients. The main or central part of the building will be about 150 feet from the river in front, and an equal distance from First Avenue on its western side, and large wings on both sides will run east and west. The total length of the wings on Twenty-sixth and Twenty-ninth streets will be 715 feet. The appearance of the hospital from the river and from First Avenue, where the main entrance will be, are practically identical, excepting that owing to the slope towards the river the building will be one storey higher on that side.

Roof gardens will be used by convalescent patients, who will be carried directly to the roof in seven elevators. These roof gardens will have wards accommodating one hundred patients. The roof will be surrounded by a four foot parapet.

It is not expected that there will be a demand on the hospital's full capacity as soon as it is built, on the contrary, it is expected that the new hospital will meet the demands made by the city's growing population for a considerable time, and besides it will be possible to add four more pavilions when they are needed.

TORONTO'S ISOLATION HOSPITAL.

The Isolation Hospital of the city of Toronto is in its way a model. The only institution upon this continent which in any way compares with it is the Willard Parker Institution of New York, which does somewhat similar work to that of the Riverdale Hospital of this city. The Toronto institution is the outcome of the old building which stood for many years near Broadview avenue as the Smallpox Hospital, when Dr. Riddel acted as the first Health Officer of the city prior to the passing of the present Health Act, back in the seventies. That building was a well constructed, small affair, intended to furnish limited accommodation for smallpox patients, and it did good work until it was superseded by the present building, and was ordered to be burned by the Municipal Council during Mayor Kennedy's regime. The old Smallpox Hospital was used by Dr. Allan, Dr. Sheard's predecessor, for housing contagious diseases, diphtheria and scarlet fever, but its construction and arrangements were wholly inadequate to meet such a work.

In 1892 the local Board of Health of Toronto obtained from the Ontario Government special legislative enactment permitting the present site to be used for purposes within the meaning of the Act, and they at once had plans prepared, and constructed the Isolation Hospital building to which a wing has just been added. This building was designed and constructed under the arrangements of Mr. Henry Simpson, architect, and is a fairly good building provided with two extension wings, the front portion of the building being occupied with the executive rooms, whilst above them are provided wards. This building was practically finished when the present Medical Health Officer took charge, and has been occupied ever since in doing the work of a contagious disease hospital. Within later years the accommodation was too limited, and after a great deal of discussion permission was obtained from the Ontario Legislature sanctioning the construction of the present addition. As it now stands there is practically a separate building for scarlet fever and diphtheria, with a capacity for upwards of two hundred patients, which, it is hoped, will be ample provision for many years to come.

ONTARIO MEDICAL LIBRARY ASSOCIATION.

The Ontario Medical Library Association since its formation has been located in the Ontario Medical Council Building. It is expected that a building in the Queen's Park will soon be purchased for the purposes of the Association.

We are requested by the trustees of the association to correct a mis-statement which appeared in one of the Toronto daily papers, to the effect that "the Ontario Medical Association, the Clinical Association and several other medical associations, decided to establish a club in Toronto for the use of the profession. It has been felt for some years that a social club for the doctors would be most desirable, and it is expected that the organization will have a large membership, resident and non-resident."

The trustees wish it to be understood that the objects of the medical organization which contemplates leasing the Thorne residence in the Queen's Park are educational rather than social. It is consequently misleading to refer to the organization as a club. It will be a medical institute and library, founded on the lines of a similar association in Birmingham, England.

The residence referred to, if leased, will be used only for literary and scientific purposes. There will be from time to time lectures by specialists in various branches of medical study, and it is probable that before long a museum will be established.

ONTARIO MEDICAL ASSOCIATION.

The twenty-fourth annual meeting of the Ontario Medical Association will be held in Toronto in the new Medical Building of the University of Toronto, June 14, 15 and 16, under the presidency of Dr. J. F. W. Ross. The Committee on Papers and Business, under the chairmanship of Dr. Albert Macdonald, has nearly completed the programme.

A very pleasing feature of the meeting will be the tenth class re-union of 1894, University of Toronto, under the presidency of Dr. W. J. McCallum. Between thirty and forty

graduates have already signified their intention of coming to the city to meet as a class, and also attend the sessions.

The Committee of Arrangements, under the chairmanship of Dr. Allen Baines, is providing a plan of entertaining, which it is hoped will be acceptable to the visiting members and guests.

The provisional programme includes the following list of papers:

"Prophylaxis of Diabetic Coma," Dr. John Caven, Toronto.

"Uncertainties of Diagnosis and the Necessity of Early and Vigorous Treatment of Diphtheria," Dr. McMahon, Toronto.

"Anemias More Than Ordinarily Severe," Dr. Frank Trebilcock, Enniskillen.

"Modified Smallpox," Dr. Chas. Hodgetts, Toronto.

"Electro-Therapeutics," Dr. Lipsey, St. Thomas.

"Functitional Heart Murmurs," Dr. Rudolph, Toronto.

"A Case of Landry's Paralysis," Dr. Hugh McColl, Milton.

"Inflammation of the Laryngeal Apparatus," Dr. G. H. Burnham, Toronto.

"A Discussion of the Subject of Life Insurance from the Standpoint of the Expectancy of Life in Conditions of the Various Systems," to be participated in by Dr. E. Ryan, Kingston; Dr. R. J. Dwyer, Toronto; Dr. H. R. Frank, Brantford; Dr. B. L. Riordon, Toronto.

"A Restatement of the Attitude of the Profession Toward Placenta Previa," Dr. McIlwraith, Toronto.

"Myxomatous Degeneration of the Chorionic Villi," Dr. C. J. Hastings, Toronto.

"Occipito-Posterior Positions in Obstetric Practice," Dr. A. A. Macdonald, Toronto.

"Anomalies in Fetal Development, with Exhibition of Specimens and Descriptions of Cases," Dr. J. Peters, Hamilton, and Dr. F. J. R. Forster, Caistorville.

"Clinic upon Diseases of the Skin," Drs. McPhedran and H. B. Anderson, Toronto.

"An Exhibition of the Methods of Intestinal Anastomosis, dealing especially with the Elastic Ligature," Dr. N. A. Powell, Toronto.

"Tumors of the Prostate Gland, Etiology, Symptoms and Pathology of," Dr. F. W. Marlow, Toronto, and "Surgical Relief of," Dr. G. A. Bingham, Toronto.

"Lithotomy *versus* Lithotrity," Dr. Chas. B. Shuttleworth Toronto.

"Thiersch's Method of Skin Grafting," Dr. Primrose, Toronto.

"Report of a Case of Congenital Dislocation of Both Hips Treated by Lorenz Method and Exhibitions of Photos, Skiagraphs, and of Patient," Dr. H. P. H. Galloway, Toronto.

"Some Cases Illustrating Difficulties of Differential Diagnosis and Treatment of Tumors," Dr. Wm. Oldright, Toronto;

"Ophthalmia Neonatorum," Dr. Perry G. Goldsmith, Belleville.

Of the distinguished visitors who are to be present, Sir Frederick Borden will discuss "The Evolution of the Medical Department of the Militia of Canada and the Possibilities of its Future Development," and Sir Wm. Hingston will give a paper dealing with the subject of "Cancer."

The London Medical College in Affiliation with the Western University.

The following gentlemen have passed the final examination and have been admitted to the degree of M.D. in the University: J. Agnew, Wingham; W. G. Anderson, Thorndale; G. M. Campbell, Belmont; J. G. Gunn, Ailsa Craig; W. H. Keen, St. Mary's; J. T. Lefever, Dunnville; A. J. Manard, Belle River; C. F. McGuffin, London; A. McMillan, London; D. McMillan, London; F. B. Patterson, Yarmouth Centre; J. H. Ross, London; A. W. Seighon, London; C. O. E. Smith, London; E. Spence, Mosley; H. G. Taylor, London; A. Turner, Southwold; J. A. Wright London.

Dr. A. Primrose, of Toronto, read a paper on "Some Observations on the Surgical Treatment of the Chronic and Acute Nephritis," before the Montreal Medico-Chirurgical Society, April 15th. In the discussion which followed, Drs. Shepherd, Martin, Finley, Mills, Adami, Garrow and McCrae took part. It was generally agreed that decapsulation of the kidney relieved symptoms in certain cases of nephritis: after operation reformation of the capsule occurs, but the tissue replacing the original capsule cannot be expected to be perfect. If a form of cicatricial connective tissue, it must tend to contract. Dr. Primrose thinks that operation is more advantageous in parenchymatous nephritis than in the interstitial form.

Personals.

Dr. Fred. Kane of Dawson City, Y.T., visited Toronto early in April.

Dr. Graham Chambers, of Toronto, sailed from Quebec for England, May 21st.

Dr. Franklin Dawson, of Toronto, left home on a trip to Scotland, May 12th.

Dr. John Edgar King of Weston, has quite recovered from his recent attack of pneumonia.

Dr. Arch. J. Sinclair (Trin. '75), has been appointed Collector of Customs for the town of Paris.

Dr. Jno. L. Davison, of Toronto, left home May 15th on a trip to Great Britain and the Continent.

Dr. Bruce Riordon, of Toronto, returned to his home May 16th, after a visit to Chicago and St. Louis.

Dr. Jas. J. Brown (Tor. '87) of Owen Sound, who recently had an attack of pneumonia, has quite recovered.

Dr. Brefney O'Reily expected to sail from Liverpool for Canada on the Allan Steamer *Ionian*, May 26th.

Dr. Allen Baines and Dr. Clarence L. Starr of Toronto, are building on Bloor Street west, opposite McMaster University.

Dr. S. P. May of the Educational Department, Toronto, has been elected Hon. Vice-President of the Veterans' Association.

Professors A. B. Macallum and Jno. J. Mackenzie, of the University of Toronto, started for England in the latter part of May.

Mr. P. C. Larkin has been appointed a Member of the Toronto General Hospital Trust, in the place of Mr. Blakie, resigned.

Messrs. J. A. Carveth & Co., publishers and booksellers of Toronto, are now located in their new premises at 434 Yonge Toronto.

Dr. William Britton of Toronto has completely recovered from an attack of la grippe, which occurred after the death of his brother.

Dr. J. Russell, Superintendent of the Hamilton Asylum, and Dr. E. G. Wood, of Mitchell, Ont., have gone to Great Britain with the Canadian bowling team. They sailed from Montreal, May 26th, on the *Lake Manitoba*.

Through the munificence of Sir William Macdonald, McGill University will have a students' re-union building, costing \$100,000.

Dr. Duncan Anderson left for New York April 15th. He expects to take special courses in surgery in New York, Philadelphia and Baltimore.

Dr. Ernest Wills recently visited Toronto. He hopes to have the Sanitarium at Calgary, N.T.W. completed, and in good running order in a short time.

Dr. W. J. Chambers (Tor. '02) has recently returned from London, England, where he passed the conjoint examination for L.R.C.P. and M.R.C.S., England.

Dr. J. W. Scane, Registrar of McGill Medical Faculty, has been appointed Assistant Professor in Pharmacology in the place of Dr. Halsey, resigned.

Dr. Fred. W. Marlow (Fellow of the Royal College of Surgeons in England), of Toronto, will in his future practice give exclusive attention to general surgery.

Dr. Sheriff has been appointed Resident Physician of the Isolation Hospital, Ottawa, in the place of Dr. Campbell, resigned, who has gone abroad for post-graduate study.

Dr. G. W. Ross (Tor. '03) who has been doing post-graduate work in London, England, for some months, has returned home on a visit to his father, the Premier of Ontario.

Mr. A. P. Watts, formerly of the Chandler & Massey Company, has been appointed sole Canadian agent for William Wood & Company, Medical Publishers, New York.

Mr. A. McFadyen, formerly of J. A. Carveth & Co., has been appointed Manager of the Medical Book Department of the Chandler & Massey Company, 235 Yonge Street, Toronto.

The Trustees of The Toronto Western Hospital have purchased the site which it has occupied for the last twelve years. The block of land contains four acres. The hospital will be much improved and enlarged in the near future.

The Canadian Doctors, Hutchison and Armstrong of Montreal, Anglin of Kingston, McLaren of St. John, N.B., and Ingersoll Olmstead of Hamilton, who sailed from Boston for Genoa, April 9th, reached Vienna about the middle of May.

Dr. J. T. Halsey, formerly Assistant Professor of Pharmacology in McGill University, has been appointed Professor of Therapeutics and Clinical Medicine at Tulane Medical University, New Orleans, and will enter upon his duties there next fall.

Dr. J. Watson, who has practised for past twelve years in Unionville, has sold his practice to Dr. R. J. Trumppour, of Toronto. After spending three months in Edinburgh hospitals, Dr. Watson will resume practice at corner Ossington Avenue and College Street, Toronto.

Lord Strathcona has given \$20,000 to Manitoba University, to be expended on the Science Department. This generous gift will enable the university to proceed at once. A block of land will also be placed at the university's disposal sufficient to secure a large yearly revenue.

Dr. Geo. W. Badgerow of Toronto, has been reappointed for a second term of six months as Senior Resident Surgeon in the Golden Square, Throat, Nose and Ear Hospital, (founded by Sir Morell Mackenzie) London, England. He expects to return to Toronto about October 1st.

Dr. F. G. Beck of Port Arthur, after staying in Gravenhurst for a number of weeks came to Toronto in April much improved in health. After a visit of a week in Toronto, he returned to Port Arthur and expects soon to go out to Kamloops, B.C., where he is likely to remain for some time.

The following officers of the Central Medical Association were elected at the last meeting held at Peterboro': President, Dr. Halliday; First Vice-President, Dr. McNulty; Second Vice-President, Dr. Carmichael; Treasurer, Dr. Caldwell; Secretary, Dr. Naughton; Auditors, Drs. Scott and Amys.

The following appointments have recently been made in the University of Toronto: H. S. Hutchison, M.B., W. M. Meldrum, M.B., Assistants in the Chemical Laboratory; R. H. Mullin, M.D., Assistant Demonstrator in Pathology; F. W. Marlow, M.D., F.R.C.S. Eng., Assistant Demonstrator in Anatomy.

Dr. Douglas W. Montgomery, Professor of Dermatology, University of San Francisco, expected to leave for Chicago in the latter part of May. After passing through Toronto and Buffalo he will go to Atlantic City to attend the meeting of the American Medical Association, commencing June 7th. From Atlantic City he will return to Toronto to make a visit of a few days.

Dr. Charles S. Sherrington, Holt Professor of Physiology, University of Liverpool, England, who delivered the opening lecture in the new building of the Faculty of Medicine, University of Toronto, last fall, returned to Toronto about the middle of May. Professor and Mrs. Sherrington were entertained at dinner in the University dining hall, May 14th, by members of the medical faculty and their wives.

Obituary.

H. C. FEATHERSTON, M.D.

Dr. Herbert C. Featherston, of Toronto, died April 8, aged 25. After graduating from McGill University in 1902, he took a post-graduate course in Edinburgh, and received the double Glasgow and Edinburgh qualifications. He returned to Toronto in November last in poor health. The immediate cause of death was pleuro-pneumonia.

ISAIAH RIDER, M.D.

Dr. Isaiah Rider died in Toronto May 6th, aged 71 years. After graduating he practised for a time in Port Hope, and afterwards conducted an institution at Chippewa. He came to Toronto twenty-five years ago, but did not engage in active practice. He devoted himself chiefly to scientific and philanthropic interests, and was much liked by those who knew him intimately.

MRS. (DR.) WILLIAM BURT.

Mrs. Burt, wife of Dr. William Burt, died at her home in Paris, Ont., May 9th, 1904.

Book Reviews.

Nervous Diseases. By F. SAVARY PEARCE, M.D., Professor of Nervous and Mental Diseases in the Medico-Chirurgical College, Philadelphia. D. Appleton & Co. : New York and London, 1904. 91 illustrations ; 400 pp.

This book is written for a practical purpose, by a practical man, and hence contains none of those doubtful points in neurology, which make some of the larger works such dull reading. Yet each subject is dealt with fully, and all known facts are set down concisely and in such a way as to be easily referred to. The original illustrations introduced are excellent. Like so many books written nowadays, this, unfortunately, contains a great deal of compilation from other authors. However, for a short treatise on this intricate subject, Dr. Pearce's work has much to commend itself. F. A. C.

Tuley's Epitome of Pediatrics. A Manual for Students and Practitioners. By HENRY ESOS TULEY, A.B., M.D., Professor of Obstetrics in the Medical Department of Kentucky University, Louisville, Ky. In one 12mo volume of 266 pages, with 33 engravings. Cloth, \$1.00 net. Lea Brothers & Co., publishers, Philadelphia and New York, 1903.

This is another epitome of Lea's excellent series, and is fully equal to any that have gone before. It considers the whole subject of pediatrics most thoroughly, while the questions at the end of each chapter are of great use to a student preparing for examination. The various diseases peculiar to children are discussed very systematically and clearly. F. A. C.

Commoner Diseases of the Eye; How to Detect and How to Treat Them. By CASEY A. WOOD, C.M., M.D., D.C.L., Professor of Clinical Ophthalmology in the University of Illinois, etc., and THOMAS A. WOODRUFF, M.D., C.M., L.R.C.P., Professor of Ophthalmology in the Chicago Post-Graduate Medical School, Chicago, etc. 250 illustrations ; 7 colored plates. 500 pp. 5 by 8 in. Bound in green buckram, gold side-title and top. \$1.75 net. Published by Engelhard & Co., Chicago, Ill.

This book is specially written for the physician in general practice. It covers all the diseases likely to come before the physician, and covers them in a very practical manner. In addition to the chapters on diseases, it has good sections on the methodical examination of the eye, on refraction, on how to preserve the eyesight, on the relations of ophthalmology to general medicine, and especially good accounts of ocular headache and eye-strain. The chapters on remedies and operations are most admirable and will be exceptionally useful. The book is well illustrated, and will be most useful for those for whom it is intended. J. T. D.

Obstetrics for Nurses. JOSEPH B. DE LEE, M.D. Philadelphia, New York and London: W. B. Saunders & Co. 460 pages. \$2.50. Canadian agents, J. A. Carveth & Co.

The author of this interesting and complete work is professor of obstetrics in the North-Western University Medical School, Chicago, and has also had eight years' experience as lecturer on obstetrical nursing in five different training schools in that city. We have no hesitation in recommending the book to nurses as a satisfactory text-book on the subject, and many physicians beginning the practice of their profession, who feel that their obstetrical text-books are not sufficiently practical, will find this book of considerable importance. (We think, however, that a book on obstetrics should be very practical in character.) There are one or two places in the book where slight improvements will probably be made in later editions (*e.g.* page 202, "Used the measure on the human") and we do not altogether agree with the remarks of Dr. De Lee in regard to the washing of the infant's mouth, as found on page 147. But the general character of the book is excellent. Most of the illustrations are both new and good, and the explanations are always admirably clear.

We have received from Messrs. Saunders & Co., of Philadelphia, a list of new books and new editions which they have in active preparation for early publication.

Among the most important of these will be a new work, entitled "The Veriform Appendix and Its Diseases," by Howard A. Kelly, M.D., of Johns Hopkins Hospital, Baltimore. We understand that this book will contain over 400 superb illustrations, in the preparation of which the well-known artists of the Johns Hopkins University have spent many years.

Among the other books promised are the following:

Nothnagel's Practice of Medicine.

Diseases of the Intestines and Peritoneum. By DR. HERMANN NOTHNAGEL, of Vienna. Edited, with additions, by HUMPHREY D. ROLLESTON, M.D., F.R.C.P., of St. George's Hospital, London. Octavo volume of 1032 pages, containing 20 insert plates. Cloth, \$5.00 net; half morocco, \$6.00 net.

Tuberculosis and Acute General Miliary Tuberculosis. By DR. G. CORNET, of Berlin. Edited, with additions, by WALTER B. JAMES, M.D., of the College of Physicians and Surgeons, New York. Handsome octavo of 806 pages. Cloth, \$5.00 net; half morocco, \$6.00 net.

Epilepsy and Its Treatment. By WM. P. SPRATLING, M.D., Medical Superintendent of the Craig Colony for Epileptics at Sonyea, N.Y. Octavo volume of 528 pages, illustrated.

A Text-book of Pathology. By JOSEPH MCFARLAND, M.D., of the Medico-Chirurgical College, Philadelphia. Octavo volume of about 800 pages, beautifully illustrated, including a number in colors.

Clinical Diagnosis. By L. NAPOLEON BOSTON, M.D., Medico-Chirurgical College, Philadelphia. Octavo volume of 525 pages, containing 200 illustrations, including 25 colored plates.

- A Hand-book of Surgery.** By FREDERIC R. GRIFFITH, M.D., of New York. 12mo of about 450 pages, with 300 illustrations. Bound in flexible leather.
- Diseases of the Liver.** By HEMPHREY D. ROLLESTON, M.D. F.R.C.P., of St. George's Hospital, London. Octavo volume of about 1000 pages, beautifully illustrated, including a number of colored plates.
- A Text-book of Legal Medicine.** By FRANK WINTHROP DRAPER, A.M., M.D., of Harvard University Medical School, Boston, Mass. Handsome octavo of nearly 600 pages, fully illustrated.
- A Text-book of Materia Medica: Including Laboratory Exercises in the Histologic and Chemic Examination of Drugs.** By ROBERT A. HATNER, Ph.G., M.D., of Cornell University Medical School, New York City, and TORALD SOLLMANN, of the Western Reserve University, Cleveland, O. 12mo volume of about 300 pages. Bound in flexible leather.
- Examination of the Urine.** By G. A. DE SANTOS SAXE, Pathologist to Columbus Hospital, New York City. 12mo volume of about 300 pages, fully illustrated. Bound in flexible leather.
- A Text-book of Operative Surgery: Covering the Surgical Anatomy and Operative Technic involved in the Operations of General Surgery.** By WARREN STONE BICKHAM, M.D., of the College of Physicians and Surgeons, New York City. Second edition, revised. Octavo volume of about 1000 pages, with 559 beautiful illustrations, nearly all original. Cloth \$6.00 net; sheep or half morocco, \$7.00 net.
- The Practical Application of the Rontgen Rays in Therapeutics and Diagnosis.** By WILLIAM ALLEN PUSEY, A.M., M.D., of the University of Illinois, and EUGENE W. CALDWELL, B.S., of the Edward N. Gibbs Memorial X-ray Laboratory of the University and Bellevue Hospital Medical College, New York City. Second edition, revised and enlarged. Octavo volume of about 625 pages, with nearly 200 illustrations, some in colors.
- A Text-book of Kechano-Therapy (Massage and Medical Gymnastics).** By ALEX. V. GRAFSTROM, B.Sc., M.D., late of City Hospital, Blackwell's Island, N.Y. Second edition, greatly enlarged and entirely re-set. 12mo of 200 pages, fully illustrated.
- Materia Medica for Nurses.** By EMILY A. M. STONEY, Superintendent of the Training School for Nurses at Carney Hospital, South Boston. Second edition, thoroughly revised and enlarged. 12mo volume of 325 pages.
- Obstetrics and Gynecologic Nursing.** By EDWARD P. DAVIS, A.M., M.D., of the Jefferson Medical College, Philadelphia. Second edition, revised and enlarged. 12mo of 400 pages, fully illustrated. Bound in buckram.
- Text-book of the Practice of Medicine.** By JAMES M. ANDERS, M.D., Ph.D., LL.D., Professor of the Practice of Medicine and of Clinical Medicine, Medico-Chirurgical College, Philadelphia. Sixth edition, thoroughly revised. Handsome octavo volume of 1300 pages, fully illustrated. Philadelphia, New York, London: W. B. Saunders & Company, 1903. Cloth, \$5.50 net; sheep or half morocco, \$6.50 net. Canadian agents: J. A. Carveth & Co., Toronto.

This is the sixth edition of this unexcelled work in as many years. Such signal success must afford gratification alike to the author and to the publishers. In this edition the general plan and principles of classification adopted in the previous editions have been preserved. The many tabular presentations of points in differential diagnosis have been retained. Malaria, yellow fever, bacillary dysentery, cholecystitis, certain animal

parasitic diseases, and the use of the X-rays in diagnosis and treatment have been fully discussed, incorporating the results of the most recent investigations. Among the new subjects introduced are Paratyphoid Fever, the Fourth Disease, Trypanosomiasis, Orthostatic Albuminuria, Transcortical Aphasia, Adiposis Dolorosa, and Amaurotic Family Idiocy. Every affection has been treated separately, particular attention being paid to its clinical character, diagnosis and treatment. Evidently an immense mass of literature has been thoroughly digested, no pains having been spared to bring the entire work down to date, giving special reference to the daily needs of practitioners and students.

This is certainly one of the best text-books on the practice of medicine that we know of, and is admirably adapted for both student and general practitioner.

Selections.

SURGICAL HINTS.

Thick glue placed on a camel's hair brush, and then left for a few hours in contact with a foreign body in the ear, will often enable you to remove it quite easily.

In fractures and dislocations, one of the advantages of early passive motion is that it can be exerted much more gently than at a later date, when the stiffness has increased.

High rectal injections of normal salt solution are the best means of combating excessive thirst after abdominal operations. Washing out the stomach just before the patient awakens from anesthesia has a happy effect in preventing, to a great extent, the nausea following ether.

In operations on the gallbladder, it is well to remember that jaundice, particularly when it has lasted a long time, is attended with an increased tendency to hemorrhage. In this class of operations we must always remember that the bile is presumably infected, and that it must be kept away from the general peritoneal cavity and its contents.

How long shall we wash our hands before operating? The only answer to this is that we can never wash them long enough, since there is evidence that we have no means of entirely sterilizing them. Rubber gloves form the only logical remedy, and should be always used unless there is good reason to avoid them, either because the operator cannot as easily feel tissues and handle needles with them, or because the surgeon is so careful of his hands that he has a legitimate belief that they are as nearly sterile as possible.—*International Journal of Surgery.*

Tympanitis of Typhoid Fever.

Troublesome tympanitis interfering with respiration I have succeeded in relieving by giving:

℞ Sodii bromidi	ʒi.
Aq. dest.	ʒss.
Aq. flor. aur.	ʒij.

M. A tablespoonful every two hours; and ordering an enema of 1 ounce of glycerin to 2 to 3 ounces of hot water to be thrown into the rectum.—*Dr. Leonard Weber in Post-Graduate.*

Family Diabetes.

Martinet (*La presse Médicale*, February 10, 1904, p. 94) reports that in June, 1900, a man, aged forty-eight years, consulted him for symptoms which proved to be those of diabetes mellitus. The disease had followed an attack of influenza contracted in the previous February. The patient's father had died of diabetes also.

Several months later the writer was consulted by the patient's wife, a woman aged forty years. She was found to have exophthalmic goitre. The examination of the urine showed a large amount of sugar present. Martinet considers this a typical case of *conjugal diabetes*, although some objection might be taken to this opinion, owing to the not infrequent occurrence of glycosuria in exophthalmic goitre. He states that he observed four cases of conjugal diabetes in his practice during the year 1903, and does not believe that the condition is extremely rare.

At the beginning of this year the mother of the first patient, aged sixty-six years, came under treatment for a phlegmon on the right hand, which developed very rapidly after being pricked with a needle. The examination of this patient's urine also showed abundance of sugar. She lived with her son.

In this family the patient, his mother, and his wife had diabetes and his father died of the disease. The writer lays down the following axiom: If one discovers diabetes in one or several members of a family, the urine of all the other members should be examined for sugar, especially if the various members live together.—*American Journal of Medical Science*.

On the Use of Rubber and Thread Gloves.

Goepel (*Centralblatt für Chirurgie*, 1903, No. 42) states that in view of the fact that rubber gloves tear very easily and that thread gloves are very permeable, it is a good procedure to wear the latter over the former, which not only prevents the slipping of instruments, etc., but also has the following advantages: 1. It is a greater safeguard against infection, either of the patient by the operator or *vice versa*. 2. The hands can be used more freely and easily. 3. The gloves can be rapidly changed should necessity require. 4. The use of the thread glove does quite away with the slipperiness of the rubber, and so ligatures may be tied more easily and securely. 5. The thread gloves can be easily removed in any case where their roughness might injure the tissue and then be replaced when the danger is passed. 6. The time of the operation is shortened. 7. By their use repeated washing of the hands becomes unnecessary, as the gloves can be scrubbed while on the operator's hand, and this prevents chapping or eczema in those cases where the hands are very sensitive.—*American Journal of Medical Science*.