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Original Communications.

TREATMENT OF PLACENTA PRAEVIA*

BY DR. FREDERICK FENTON, TORONTO.

Associate in Obstetrics, University of Toronto; Obstetrician and Gynecologist to St. Michael's Hospital

For the purposes of this paper I propose to limit myself to the treatment of placenta praevia, and more particularly to the limitations of and indications for the various methods at our disposal for the management of these cases. Before a gathering such as this it is unnecessary to emphasize the necessity for asepsis in all manipulations and other minor points which would naturally be included in an article upon this subject. I will, therefore, stick closely to my text and make my remarks as concise as possible.

I am alive to the fact that, in obstetric emergencies, one is at times forced to do what circumstances will admit of and not what he recognizes would be the ideal treatment.

The circumstances in cases may be very different, and what would be best in one might be inadmissible in another case.

Doubtless the comparative infrequency of the complication (1 in 200 cases) is responsible for the fact that rupture of the membranes followed by vaginal packing and Braxton Hicks' method are practically the only plans of treatment one sees outside of hospitals.

At the time of its introduction Braxton Hicks' method was a very great advance over other methods of treatment then in vogue, and there will probably always be a large field for its employment owing to the circumstances and surroundings of many cases, but it is time that efforts be made to reduce the infant mortality in these cases, as it occurs under these methods of treatment. The reports vary from 40% to 80% mortality for infants and 10% to 35% for mothers. In Shauta's clinic from 1892 to 1905 there were 344 cases of placenta praevia. Twenty mothers died (5.85%); of the children, 192 perished.

Futh has collected reports of 726 cases in the neighborhood of Coblenz, in which 12 women died undelivered, 9 died during

*Read before Section of obstetrics and gynecology, Canadian Medical Association June, 1910.

delivery, and 122 died subsequently, making a total of 143, or 19.7%. In these cases 367 children were lost.

These latter cases belong to the period before the introduction of Hicks' method, whereas those reported from Shauta's clinic were mainly treated by that method. To this method of treatment the credit for the reduction of the maternal mortality from 20% to nearly 5% must be given. Unfortunately the death rate amongst the infants is higher with Hicks' method than had been the case with older measures of rupture of membranes and vaginal packing, etc.

The use of hydrostatic dilators has given a somewhat lower maternal mortality than Hicks' method (4.5%), and shows a decided improvement so far as the infants are concerned; in the Breslau clinic 75% of the infants were saved.

There is yet another method of treatment which still meets with a good deal of opposition in some quarters, but which I am convinced has a very important place in the management of many of these cases. With more extended experience it may yet become the recognized method where the child is living and well within the viable age. I refer to Cæsarean section.

Sellheim reports eight cases, in which all the mothers and infants were saved; Kronig has six cases, with no deaths of mothers and only one infant, a premature one, dead.

I desire to report two cases in which I have performed Cæsarean section for placenta prævia, after which I will discuss briefly the indications and limitations of the various methods in vogue for the management of these cases. Both cases occurred in my service at St. Michael's Hospital.

B. C., IX para, admitted November 2nd last, in an exsanguinated condition, having had severe hæmorrhages for two days before admission. There being no bleeding on admission, it was deemed unwise to at once proceed to delivery, lest even a small further loss of blood prove fatal.

She was about six months pregnant and the baby was living. Under these conditions the Church raises some objection to the termination of pregnancy, especially by those methods which in such a large proportion of the cases sacrifices the child.

In the absence of further hæmorrhage it was felt that the mother's interest would be best served by temporizing under strict observation, thereby giving her a chance to recover from the immediate effect of the hæmorrhages, before exposing her to the risk of a further loss by interference.

The first record I have of blood examination was made a

week after admission, when the R. B. C. were 1,000,000 per c.mm. and the Hb'n 15%. It was arranged that on the first sign of recurrence of bleeding the pregnancy was to be terminated, by Braxton Hicks' method if the baby had not reached a viable age, but by Cæsarean section if it had. About 11 p.m. on December 3rd a small hæmorrhage (about an ounce or two) occurred, and the child being within a few days of the seven months a section was done at once.

There was very little bleeding at operation, not more than in the ordinary abdominal section for other conditions.

The abdomen was filled with saline solution and the wounds in uterus and abdominal wall closed as speedily as possible.

The patient was returned to bed in good condition and made an uninterrupted recovery, except for a small sinus caused by the breaking of a silk-worm gut suture on attempted removal. The baby was delivered alive, but died in a few hours. This patient was confined to bed owing to anæmia for six weeks, but finally left the hospital two months from date of operation, still showing the effects of severe hæmorrhage, but having 3,450,000 R. B. C. and 30% Hb'n. She has since reported herself as quite well.

The second case, a III para, was operated on in April last. She had had two moderately severe hæmorrhages before admission and a more or less constant oozing ever since. She was a little over eight months pregnant and in good condition. After having had explained to her the relative dangers to herself and to the baby in the different methods of procedure, she elected to have a Cæsarean section done rather than expose the baby to the greater risk by turning.

In this, as in the previous case, there was a central placenta prævia. The mother made an uninterrupted recovery, and both she and the baby left the hospital in good condition within three weeks of operation.

The success which attended these two cases, with the very satisfactory reports from elsewhere, certainly justifies one in considering this method of delivery as a justifiable and valuable addition to our list of procedure in such cases.

In suitable cases, viz., those in which no attempts have been made at delivery or repeated vaginal examinations made, the operation is not attended by any more danger than the removal of an ectopic gestation. The danger of hæmorrhage is much less than in turning, the placenta being attached where there is no danger of its being encountered in the uterine incision, while on

removing the placenta one is able to grasp the uterus and directly control all bleeding. If necessary the lower uterine segment may be packed with gauze from above.

The performance of Cæsarean section for any purpose should not be lightly undertaken outside of a well-equipped hospital.

There are but four procedures which one need consider in the management of placenta prævia, viz.:

Rupture of membranes followed by vaginal packing;

Braxton Hicks' method;

Hydrostatic dilators followed by forceps, or version with immediate extraction;

Cæsarean section.

The first of these should, I think, be limited to emergencies where time has to be gained, as when one must transport a patient or await arrival of assistance. It should not be used as a means of treatment of a case throughout. The dangers of sepsis are greater than by other methods, and the slow oozing of blood extended over a long period of time may seriously lessen the patient's chances of recovery.

For all cases in which the child is not viable or is dead, where it is judged wiser to terminate, and as a rule prompt termination is the safe course to follow, Braxton Hicks' method is doubtless the plan to be selected, as also is it in cases after the seventh month even with a living child, in which the severity of the hæmorrhage is such that its immediate control must be secured to save the woman's life.

Where the child is living and viable the Colpeurynter or Cæsarean section are the means to be considered.

Where the cervix is not readily dilatable, and in primiparæ, Cæsarean section offers the best prospects, in multiparæ with dilatable cervixes the Colpeurynter offers sufficiently good prospects for both mother and child to have its claims advanced.

The nearer to full term the stronger the claim of Cæsarean section over the bag, and *vice versa*.

Where it is especially important to save blood, and that is the keynote of the successful treatment of placenta prævia, Cæsarean section is a means to be seriously considered, provided the circumstances and surroundings are such as to eliminate the chances of sepsis.

One other point I would like to draw attention to is the necessity for practitioners who are liable to be called to such cases being at all times prepared to do an intravenous or interstitial saline transfusion on short notice.

Where severe hæmorrhage has occurred it is not safe to do anything which may provoke a further loss of blood until the bulk of fluid in the vessels has been augmented, and for this purpose saline solution answers the purpose almost as well as blood itself.

Life may be maintained with the blood reduced to 15% or even less in corpuscular elements, but the blood pressure cannot be maintained without sufficient fluid in the vessels to fill them. I have seen two women lose their lives owing to the omission of this simple procedure before turning was attempted.

A woman who has engaged a doctor to attend her in confinement has a right to expect that he will be prepared to properly meet all recognized complications and emergencies efficiently, and the man who goes to a case of placenta prævia without a saline transfusion apparatus is not affording her the insurance which she has a right to expect from a legally qualified practitioner.

Where hæmorrhage has been severe, transfusion should be done before attempts at delivery are made by any method.

75 Bloor St. East.

APPENDICITIS IN CHILDREN*

By DR. J. WOOD, KINGSTON.

We know of no other subject in the range of medical science that requires more careful consideration from both the physician and surgeon than "Appendicitis in Children." The term "children" in this paper shall include all under fifteen.

For more than a century the ablest men of our profession have been devoting earnest thought and effort to the diagnosis and treatment of this disease, and yet it is to-day responsible for more deaths than any other acute abdominal lesion.

The history dates back almost a century. In 1812, Parkinson, a London physician, reported the first case of death from perforation of the appendix in a boy five years old. Villermay, in 1824, reported two deaths in children, after a brief illness, and in each case the autopsy showed a gangrenous appendix. In 1837, Bohr reported a case of perforated appendix in a boy ten years old, and Burn, in 1839, recorded a similar condition in a child of fourteen years.

About this time, Melier, a French physician, collected five cases, all of which occurred within a short period, and in his report of these he suggested:

1st.—These conditions may not be so rare as they are supposed to be.

2nd.—The appendix-cæci may be the primary seat of the disease.

3rd.—Chronic suppurative tumors in the right iliac fossa may result from a primary lesion and perforation of the appendix.

4th.—The possibility of surgical interference for these conditions may some day be conceived.

Melier's conclusions deserved greater recognition than was accorded them. He was evidently living in advance of his generation.

An important contribution to our knowledge of the subject was made by Goldback and Albers, who, after careful investigation of the origin and location of these inflammations, in the right iliac fossa, introduced the terms, Typhlitis, Per Typhlitis, Cæcitis, etc., to distinguish the several types of the disease. Up to this time the treatment of these chronic inflammations

*Read at meeting of Canadian Medical Association, Toronto, June, 1910.

of the appendix caeci was incision and drainage, but not before fluctuation appeared. In 1848, Hancock, an English surgeon, diagnosed inflammation of the appendix, and incised the mass without waiting for fluctuation, and to him must be accorded the honor of introducing the modern method of treating a diseased appendix.

Dr. Willard Parker, a well-known surgeon, of New York, was the next to report a series of four cases, treated by incision and drainage, one, at least, before fluctuation appeared. From his observation of these cases he concluded:

1st.—That nature endeavored to throw a protective wall around the abscess.

2nd.—That there was danger of this wall being ruptured by ulceration or over-distension.

3rd.—That “a timely incision should be made, neither too early nor too late—not before adhesions had fully formed, nor after a short period before the maximum formation of pus had been reached, that is, from the fifth to the twelfth day.” He further remarked that “gangrene and perforation were much more frequent in children than in adults, and were more dangerous because of the more rapid progress of the disease in children.”

Parker's paper, published in 1867, marked a great advance in the evolution of our knowledge of the true nature of disease of the appendix, its pathology and treatment. The Willard Parker operation came into general use, and the treatment became, more and more, a question of surgery. Up to this time, the writers were no doubt earnest seekers after the truth. They made careful and accurate observations, but they did not seem able to interpret or correlate the facts they observed. Their knowledge of typhlitis, peri-typhlitis and cæcitis was vague and indefinite, and their conceptions of the origin, the pathology and the location of these conditions were in the suggestive rather than the positive stage. It remained for Reginald Heber Fitz, of Boston, to dispel the mists, clear away the misconceptions, and bring order out of confusion. The essential features brought out in this paper (*Amer. Jour. Med. Sci.*, 1886 vol. 92, p. 32) were:

1st.—That all these obscure conditions, known as typhlitis, peri-typhlitis, cæcitis, etc., were only different stages of a morbid process, beginning in the vermiform appendix, and that the word “appendicitis,” used for the first time in this paper, was “coined” by him to call attention to inflammation of the appendix, as the primary lesion.

2nd.—That an early diagnosis was imperative.

3rd.—That operation should immediately follow diagnosis.

4th.—That the diseased appendix should be excised.

This paper, published twenty years later than Parkers, introduced a new and progressive era in the history of our subject. The literature of appendicitis has increased rapidly and our knowledge has been wonderfully enriched. More than 3,000 journal articles, besides books and monographs, have been indexed in the Surgeon-General's Library at Washington since 1896.

In the study of this literature one cannot but note the almost complete absence of any special reference to appendicitis in children. With few exceptions, recent writers have treated "appendicitis" as a disease common to all ages. Books written by Morris, Fowler, Deaver, Ochsener and others are repletè with information on other aspects of the disease, but not a page, or possibly even a paragraph, is found to differentiate appendicitis as it occurs in children and in adults. Among the exceptions, I may mention that Howard A. Kelley has given, in his 1909 edition of "Appendicitis and Diseases of the Vermiform Appendix," an excellent chapter on appendicitis in children, and for many of the facts in this paper I am indebted to this valuable work.

If we turn our attention to those special features which differentiate appendicitis in children and in adults, *anatomically* we find:

1st.—That the appendix in the child is relatively larger and longer.

2nd.—The walls are thinner; the meso-appendix is shorter, often less than half the length of the tube. This tends to kink or bend the appendix, and to limit the blood supply, especially to the distal half.

3rd.—The entrance from the cæcum is funnel-shaped, the lumen is larger, the mucous membrane smoother, and the valve of Gerlach often absent or ineffective, hence foreign bodies or morbid materials more readily find their way into the tube.

4th.—The lymphoid tissue in the appendix of the child is more abundant, and the blood supply is poor, hence destructive processes go on more rapidly and the liability to gangrene and perforation is greater.

5th.—The omentum is relatively smaller and less effective in walling off a gangrenous or perforated appendix.

Pathologically, we note:

1st.—These inflammations of the appendix induce a greater effusion of serum in children than in adults.

2nd.—That this effusion quickly becomes purulent.

3rd.—The occurrence of gangrene and early perforation is more frequent in the child.

4th.—That abscesses are more likely to form and to rupture in children than in adults.

5th.—That there is greater tendency to spreading peritonitis. (Sprengel found 46.8 per cent. among his cases.)

6th.—That intoxication of the system is more rapid and intense in children.

Clinically.—These differential features assume more than ordinary interest and importance. We have not time to discuss them in detail. We simply mention some of the general principles.

1st.—That appendicitis in the child is more sudden in its onset, rapid in its progress and intense in its symptoms than in the adult.

2nd.—That the unstable conditions of the nervous system (peculiar to children) may lead to confusion or error, and may delay or prevent a positive diagnosis.

3rd.—That abnormal conditions are frequently met with in children which render the clinical phenomena vague and misleading; for example, right-sided pleurisy or pneumonia may simulate appendicitis—the pain, tenderness and rigidity being located in the right iliac fossa. Or in abnormal positions of the appendix (common in children), the pain and other symptoms may be found on the left side of the abdomen, in the epigastric region or under the costal arch.

We feel that a due appreciation of the anatomical, pathological and clinical features already noted should enable us to not only differentiate appendicitis in children from the same disease in adults, but to set it apart as a subject for special and separate consideration in its diagnosis, its prognosis and treatment.

We are told by eminent authorities that “the diagnosis of appendicitis is generally easy.” This may be true in adults; it is not true in children. The recognition of appendicitis in the early stages, when operation would be successful, is extremely difficult. The cardinal symptoms of appendicitis—sudden acute pain in the right iliac fossa, tenderness over McBurney’s point, rigidity of the right rectus muscle, vomiting, elevation of temperature, acceleration of pulse, etc., which are quite constant

in the adult, are irregular, uncertain, and have little diagnostic value in the child.

The prognosis of appendicitis in the child ought to be good. Compared with the prognosis in the adult, it is bad, very bad. In 1907, the average mortality for children in six large clinics was 19.23 per cent., for adults it was 2.9 per cent.

Dr. J. B. Murphy says, "We should have no deaths from appendicitis"; but we have them. What are we going to do about it? Where does the responsibility rest for this terrible mortality, this veritable "slaughter of the innocents?"

From a careful review of the literature of appendicitis, and from observation, we have come to the following conclusions:

1st.—That the occurrence of appendicitis in children is much more frequent than it is generally supposed to be. Selter found that appendicitis was seven times more frequent before the age of fifteen than it was from fifteen to thirty.

2nd.—A large percentage of cases that occur are not diagnosed.

3rd.—A large percentage of cases are diagnosed too late for successful treatment.

4th.—That the current literature of appendicitis should be revised, and those features of the disease peculiar to children should be clearly set forth and strongly emphasized.

5th.—Our "diagnostic senses" should be awakened and trained to recognize the earliest, the initial symptoms of the disease.

6th.—Physicians and surgeons should be made to realize that an early diagnosis is imperative in the case of children.

7th.—That diagnosis should be followed immediately by operation.

263 King Street East.

TRACHOMA BODIES*

BY W. H. LOWRY, M.D., TORONTO.

The causative factor of trachoma is one that has been most elusive. We have known for a long time that trachoma is an infectious disease, and many observers have isolated different cocci, bacilli and fungi as being its cause, but none of these organisms have stood the test. Now, an organism, the nature of which is not too well understood, is being discussed by pathologists, and it seems a promising one, since the same factor is being found by observers in many countries.

In April, 1907, Halberstaidter and Prowazek described very minute bodies which they found in the epithelial cells taken from the conjunctiva of trachomatous eyes. A month or so later Greeff, Frosch and Clausen published observations of the same character, and since that time these bodies have been found by observers in Japan, Russia, Germany, Great Britain, the United States, Canada and Egypt.

These bodies which we will for the time call trachoma bodies are smaller than the smallest cocci, and are found in clusters of varying size and shape, in the protoplasm of an epithelial cell. Sometimes the clusters are close to the nucleus and cap an end of the nucleus, but more often there is a clear space of protoplasm intervening. The little granules which compose a cluster, or trachoma body, are so small that one cannot make out their definite shape. It appears that these bodies, commencing as a very small cluster of granules, gradually enlarge and invade the cell protoplasm until the latter is no longer to be seen, when the cell ruptures, and is taken care of by the leucocytes which in the meantime surrounded it. Sections of tissue to show the deeper cells of the conjunctiva have also shown the trachoma bodies.

As to their nature, these organisms are supposed to be somewhere between a protozoa and a bacterium. Prowazek suggests calling them "chiamadozoa," and he thinks they are of similar character as the organisms of scarlet fever, variella and hydrophobia.

Each observer has made control examinations of healthy con-

*Read at Canadian Medical Association, June, 1910.

conjunctivæ, and conjunctivæ infected with other diseases, and these bodies have not been present. Healthy conjunctiva of man and of apes has been infected with trachomatous secretion in which the trachoma bodies were present, and in each case typical attacks of trachoma were produced, showing similar bodies in the secretion. Unfortunately no one has yet been able to grow a culture of the organism.

These chlamadozoa, or whatever they are, are found best in the acute stage of the disease, and they become less numerous or disappear altogether when treatment is initiated. I have made examinations of three cases of acute trachoma, and of one case of follicular conjunctivitis. Each of the trachoma patients showed the organisms in small numbers, while I could find none at all in the other patient. Treatment had been given in each of the cases before smears were made, which probably accounts for the scarcity of trachoma bodies.

The method used was to scrape the conjunctiva with a knife or scoop, under cocaine anæsthesia, and spread the material obtained as thinly as possible, on a slide, dry with heat, then fix by keeping in alcohol for ten minutes; wash off with water, and stain for twenty-four hours in a 1-30 solution of giemsa stain. The nucleus stains dark purple, the protoplasm a light blue, and the trachoma bodies pinkish or a pinkish red.

Selected Articles.

THE MANAGEMENT AND TREATMENT OF CHRONIC BRIGHT'S DISEASE*

BY T. R. BRADSHAW, M.D., F.R.C.P. (LOND.),

Senior Physician, Royal Infirmary, Liverpool; Lecturer on Clinical Medicine, University of Liverpool.

In response to a request on the part of members of my class that I would deal more especially with the practical treatment of diseases, I gladly devote this lecture to the management and treatment of chronic Bright's disease.

At the outset I must, however, remind you that at the root of all successful treatment there must be an accurate diagnosis, without which our best attempts at medication or other ameliorative efforts are only blind gropings in the dark, and are as likely to do harm as good.

THE POSSIBILITIES AND AIMS OF TREATMENT.

Having established the diagnosis that our patient is suffering from a chronic disease of his kidneys, let us consider first what kind and degree of benefit we may hope to confer on him by treatment. We may generally assume that the patient has already been a sufferer from kidney disease for a longer or shorter time when he first comes under our observation: in a case of cirrhotic kidneys, the disease has probably been slowly coming on for years. It is plain, therefore, that permanent organic changes, destruction of secreting membrane or increase of fibrous tissue, or both, have been established, and that a *restitutio ad integrum* is not to be hoped for. Chronic renal disease is, strictly speaking, incurable.

On the other hand, the slow onset and progress of the disease show that the destruction of secreting kidney tissue is far from being complete, since complete destruction of the secreting tissue would be as incompatible with continued life as would be the existence of an impermeable stricture of the urethra. In effect we may conclude that the patient possesses kidney tissue capable of dealing more or less imperfectly with the average nitrogenous waste of the body, and that if the nitrogenous waste were reduced in amount it might be capable of eliminating it entirely.

We shall further probably find that the patient is suffering

*Delivered at the Liverpool Royal Infirmary.

from malnutrition manifesting itself as anæmia or in other forms—malnutrition presumably due to the retention of toxic products of which the origin and nature are not yet thoroughly understood.

The chief indications for treatment will therefore be (1) to arrest or retard the diseased processes that are going on in the kidneys; (2) to diminish the nitrogenous waste to such an amount as may be dealt with by the remaining kidney tissue; (3) to counteract the deleterious influence of materials retained in the economy; and (4) to improve the general nutrition.

LINES OF TREATMENT.

1. *Causal*.—In a large proportion, perhaps the majority, of cases the diseased process has originated and is maintained by the kidneys being called upon to excrete an excess of nitrogenous waste, so that our second indication will also meet the requirements of the first. In a certain proportion of cases urethral stricture or other lesion of the lower urinary passages is the starting-point of the disease, and always ought to be thought of as a possibility, and if found, properly dealt with. Syphilis is responsible for a special form of the disease, which Dr. J. R. Bradford has drawn special attention to; and I have seen symptoms of chronic Bright's disease entirely disappear under anti-syphilitic treatment in the case of a child which was suspected to have a syphilitic parentage. Amyloid disease calls for treatment, generally surgical, but is seldom met with nowadays. In cases which have arisen from an acute nephritis, from scarlatina, or from pregnancy, the exciting cause is clearly out of reach.

2. *General Management*.—In dealing with the other indications our first duty will be to regulate the patient's life, to decide whether or to what extent he is to continue his ordinary avocation, or whether he requires to lead the life of an invalid. Most cases first come under our notice owing to the occurrence of an intercurrent acute or sub-acute exacerbation, or of some complication, and then of course rest in bed is generally required for a time. In advanced cases with marked hypertrophy of the heart, headache, and liability to bronchial catarrh, we ought to urge the patient to retire from active work; but in this disease it is often difficult to convince the sufferer of the real gravity of his condition, and he may allege that our advice is a counsel of perfection which his circumstances make it impossible for him to accept, or that he would rather die in harness. In cases of less severity we should endeavor to restrain the activities of our patient, whether in work or pleasure, within reasonable bounds. We explain to him that he has a damaged organ which can work

very well at low pressure, but which is likely to break down under any unusual strain. The more ambitious walks of business or profession must be renounced; long hours of work must be curtailed; eight or nine hours of sleep must be insisted on; a certain time every day must be set apart for gentle exercise in the open air. Exhausting labor, whether at work or pleasure, must be prohibited. Some patients are continually testing their urine to see whether the albumin is more or less. This should be discouraged by telling them that the mere quantity of albumin is of no real moment. The practice may, on the one hand, produce groundless anxiety, or, on the other, lead to unwarranted laxity in carrying out the *régime* we have laid down. With the tendency to congestion and inflammation of internal organs, special precautions must be insisted on against chill, and, if circumstances permit, the cold months of the year should be spent in a mild climate.

With regard to dress there is nothing special to say beyond what applies in other states of delicate health. The clothing should be suitable to the season; woolen clothing should be worn next the skin; in winter, warmth should be secured without undue weight or interference with bodily activity. A warm bath followed by a cold shower should be taken every morning. In mild cases, riding and sports, such as golf, which do not involve excessive strain or fatigue, are to be encouraged, so long as the patient can be trusted not to exceed the limits of strict moderation.

3. *Diet.*—We come next to consider the important question of diet. In this we have certain broad principles to guide us, but in practice we find that a slavish attention to rules is not usually attended by the best results, that we have to feed the whole man no less than to spare his kidneys, that within limits every case requires its own dietary. It is obvious, from what we know of the physiology of the kidneys, that the first requirement to reduce their activity is to give them as little nitrogenous or other waste as possible to excrete. The majority of people in easy circumstances habitually consume more nitrogenous food than they require; a great part of this is never incorporated into the tissues at all, but is quickly changed into urea in the liver, or enters into other combinations—uric acid, creatinin, indican, trimethylamine, and other less-known bodies, some of which have considerable toxic properties, but which the normal kidney can readily excrete. Further, the flesh of animals consumed as food contains a certain proportion of those toxic bodies commonly included under the term *extractives*. The obvious inference from

these considerations alone seems to be that the proper diet for chronic Bright's disease is one in which the nitrogenous food is reduced to the minimum consistent with nitrogenous equilibrium, and that animal food should be withheld altogether. But in practice other considerations, such as ease of digestion, the maintenance of nutrition, and individual idiosyncrasy, have to be taken into account; and we find that no hard and fast lines can be adhered to, that each case must be dieted on its own merits, and that the diet may have to be varied from time to time.

During an acute exacerbation or in presence of some inflammatory complication, milk will be the staple article of diet, supplemented by some farinaceous stuffs, such as rice, corn-flour, or bread and butter. Beef-tea and broths are of doubtful value, and are contra-indicated on theoretical grounds. For a day or two a pint of milk daily may be sufficient; if it is desired to keep the patient on milk for a considerable time, two or three pints will be required. The advantages of milk as a staple food in this disease are its freedom from extractives, its easy assimilation as a rule, and the quantity of water it contains; it requires, however, to be supplemented by carbohydrates, and it is markedly deficient in organic iron. The chief objection to its use is that it is not the natural food of adults, that if long continued it leads to malnutrition and anæmia, that as a rule patients thrive better when they are allowed a greater latitude in their diet. This is not only true in the slighter and earlier cases; it may happen in those that are far advanced and seemingly hopeless.

I have a man now in 12 ward who seemed to be dying of chronic Bright's disease; in spite of rigid dieting he rapidly wasted, dropsy was great, his mouth became ulcerated. Finding that all our care was without avail, I said he might have anything in reason that he fancied, including some butcher's meat. He at once began to improve; his mouth got well, and he put on flesh.

As a rule we should aim, not at cutting off ordinary articles of food altogether, but at reducing their amount. One egg or a little fat bacon may be allowed at breakfast, and three ounces of lean meat at dinner. It is usual to order fish in these cases, but it has no special advantage over butcher's meat except as regards its digestibility; we shall do best by consulting the patient's own likes and dislikes, not forgetting the charm which lies in variety; and if the patient's principles suggest a weekly day of abstinence he will probably be all the better for practising it.

Bouchard strongly recommends boiled mutton, and I have often ordered it, with apparent advantage. As regards bever-

ages, it is plain that anything approaching excess must be forbidden. In patients accustomed to taking alcohol with their meals it is generally best not to withdraw it entirely. A little whisky, well diluted, is probably the best form, but in some cases light sound wine or even bitter beer answers well. On no account must alcohol be taken except at meals.

4. *Medicinal.*—In slight cases no medicine may be required, but if anæmia is present an occasional chalybeate course is advisable. One of the following may be given :

℞ Liq. ferri acetatis, min. xv.
Glycerin, ℥j.
Liq. ammon. acet., ℥ss.
Infan calumbæ. ad ℥j.
Bis in die sumend.
℞ Ferri sulph., gr. 1½.
Magn. sulph., ℥j.
Acid sulph. dil., min. x.
Aq. menth. pip., ad ℥j.

Ter in die.

℞ Ferri redacti, gr. ij.

Pone in capsulam. Bis in die capienda.

The bowels must be kept moderately open. The kind and amount of aperient must be determined on general considerations. In all cases where the arterial tension is high I give a mild mercurial purge at intervals of a week or ten days. My favorite formula is the following :

℞ Pil. hydrarg., gr. iij.
Ext. euonymi sic., gr. ½
Podoph. resinæ, gr. ʒ.
Pil. rhei co., gr. ij.
M. Ft. pil.

TREATMENT OF COMPLICATIONS AND SPECIAL SYMPTOMS.

It would not be possible within the limits of a single lecture to deal in detail with the treatment of all the symptoms and complications which may arise in the course of chronic Bright's disease. They must for the most part be treated on general principles, but with due regard to the impaired powers of elimination.

Anasarca.—A frequent symptom in all forms, except the pure cirrhotic kidney, is the presence of anasarca. If it is slight it calls for no special treatment; if it tends to increase it is desirable to withdraw chloride of sodium from the diet as much as possible. No salt is to be added to the food at table, and the bread and other articles of food are to be prepared without it. The following mixture may be prescribed :

℞ Theocin. sodium acetat., gr. v.
Caffein, gr. ij.
Ammon, beez., gr. v.
Aq. chlorof., ad ℥j.
M. Quartis vel sextis horis sumend.

Or, if the heart is dilated:

R Infus. digitalis, ℥j.
 Potas. c trat., gr. xv.
 Sp. chlorof., min. x.
 Infus. buchu, ad. ℥j.
 M. Sextis horis sumend.

Where the dropsy is so great that the patient is confined to bed, the best treatment is to make incisions into the subcutaneous tissue over the malleoli. Strict surgical cleanliness must be maintained, the legs swathed in absorbent cotton, and the wounds kept open by a gauze drain, or covered with smooth oil silk to prevent clogging with the cotton-wool. If the pudenda are swollen they must be examined daily, the scrotum being elevated by placing a large pad of cotton-wool beneath it. Puncturing the scrotum and prepuce, which is sometimes done, is not free from risk of sepsis; the physician may have to reduce the swollen prepuce by manual pressure to relieve the patient's difficulty in micturition and for the maintenance of cleanliness. The flow from the incisions is promoted by telling the patient to sit with his feet in warm water for an hour once or twice a day. In cases with much dropsy the most useful medicine is the well-known Baillie's pill:

R Pil. hydrarg
 Pulv. digitalis } gr. i.
 Pulv. scillæ. Sing }
 M. Ft. pil. Sextis horis copienda.

Effusion into the serous cavities should be removed by aspiration if extensive. Pleural effusion is frequently inflammatory and not merely dropsical, and should be treated accordingly.

Headache.—Headache is often the earliest and most persistent of the symptoms of chronic Bright's disease, and is no doubt of toxic origin. If it does not yield to the general line of treatment laid down in the early part of this lecture, five grains of calomel followed by a saline will often give signal relief. The common causes of headache—errors of refraction, dental caries—should be sought for.

Uræmia.—In threatening uræmia, 5 grains of calomel should be given immediately, and followed in three hours by a Seidlitz powder or a dose of Carlsbad salts. A warm bath repeated daily is useful. As regards the production of diaphoresis by hot air, where much dropsy is present it seems generally beneficial, and the effect may be increased by the hypodermic injection of one-tenth of a grain of pilocarpine. Where there is no dropsy, as in cases of cirrhotic kidney, I have never seen any good from hot-air baths, which seemed rather to exhaust the patient. Dry cups

to the loins are a time-honored and safe remedy. Epileptiform seizures may be relieved by bromide and chloral:

℞ Potas. bromodi aa ʒij.
 Chloral hydratis aa ʒij.
 Syrup. tolut. ʒss.
 Aq. cinnamoni, ad ʒvj.
 M. A sixth part to be taken ever third
 hour if required.

If the patient remains unconscious or unable to swallow, the bromide and chloral should be given by enema.

If uræmic convulsions persist in spite of these measures and the arterial tension is high, venesection offers the best chance of giving relief. Its chief application, however, is in acute cases, in which recovery of the kidneys may be looked for if the patient is enabled to tide over the immediate danger. In chronic disease it can at best only postpone the fatal issue for a time, and if employed at all ought not to be repeated.—*Medical Press and Circular.*

RANDOM MEDICAL NOTES IN EUROPE

BY GEORGE DOCK, M.D., NEW ORLEANS.

The thing that most impresses the traveller in Europe on his first visit is usually the finish of construction that he sees on all sides. Streets, bridges, private houses and public buildings have a solidity that strikes one as intended for ages. When he returns after a few years to the same places, however, the traveler is even more struck by the changes that have taken place. This is particularly true of Germany, where the growth of cities in the last twenty-five years has been so great. Private houses, single and apartment, are larger, more ornate, more modern. One may not always admire the taste, but one cannot deny the decorative, even monumental, effect. New city halls, new post offices, new schools and museums appear with bewildering frequency. Old and dingy quarters are torn down and replaced by handsome blocks and parks. A whole quarter may even have its topography changed to satisfy the demand for light, air or rapid transit. We can recall with patriotic pride magnificent structures in our own country—the mammoth hotels, buildings like the libraries of Washington or Boston, the museums of New York, Boston, Philadelphia and Pittsburg, the Harvard School, the Mt. Sinai Hospital and the Union Station in Washington. We may think with satisfaction that when Berlin wanted a modern public school building it took the design of one in Denver. After all, we see that even in so-called effete civilizations change and progress occur, and that no nation can be a laggard if it wishes to retain its relative rank, not to speak of forging ahead. Medical institutions are included in the category of changing conditions in Europe. New hospitals are built, old ones torn down, or enlarged and improved. New laboratories spring up. And in all these is a largeness of plan, a solidity of construction, an architectural beauty, that make them monumental. The interior has a completeness of detail and a perfection of fittings that make for the care of the sick, the work in the laboratories, the comfort and convenience of all those who are connected with the institution. I am not considering the work done. In many ways that does not agree with our ideas, I am now speaking only of construction. Costly equipment seems easier to get than it does here. So in the installation of Roentgen laboratories, the utilization of baths, of aërotherapy, mechanitherapy, sun light, etc., etc. New and expensive apparatus like the electro-cardiograph seem to be readily procured. Projection lanterns of the

latest pattern can be seen in every lecture room and clinical amphitheatre.

SCHOOLS EXPENSIVELY EQUIPPED.

These things are no doubt part of the general advance in countries long accustomed to build for the future. In part, as in the case of laboratories, they indicate changes in the methods of work. I well remember the place where Koch did his epoch-making investigation on wound infections in 1877, a small lecture room, in which in vacation some years later, I took my own first course in bacteriology. It was enough for the simple methods of those days, but the greater number of manipulations and all the chemical, physical and biological work that must be combined with cultures and inoculations makes large and well-equipped laboratories essential to-day.

There is also a commercial motive in the lavish expenditure for educational and scientific institutions. This is openly stated as the explanation of the bountiful provision for hospitals and laboratories in cities on political frontiers. It doubtless plays a part in keeping up the stream of foreigners, especially Americans. For it is interesting to see how that stream does keep up, though the attractions have changed. It is not long since the man who wished to cultivate the elements of medicine, like chemistry, histology, physical diagnosis, and pathology, later bacteriology, was obliged to go abroad for them. Now, in all the good American schools, there are better obligatory courses than any given in Europe to undergraduates. But the larger quarters, the better organization for advanced work, the concentration of clinical material and the rapid adaptation of new methods all tend to keep up the attendance of foreigners on the "other side."

Only actual inspection can convey an idea of the beauty and perfection of detail of laboratories like Wright's at St. Mary's, or the Serum Institute in Vienna. In the magnificent clinic of Von Rosshorn, the laboratories are as large as, and much handsomer than any I know in any of the universities in this country. It is often said such laboratories do not produce an adequate amount of work. If in many cases this is true, the remark in general is idle, and only illustrates that brick and mortar, or even glass and marble, do not alone make seats of scientific activity.

"Guy's" and "Bartholomew's" must always be interesting to medical students; the places where men like Bright and Addison worked, and where their records may still be seen, have all the charm that great historical association lends.

THE OLD CHARITE IN BERLIN.

Those who knew the old Charite in Berlin would not recognize it now. Many new buildings, models of North German architecture, have been erected around and beyond the original barracks. Though more crowded than in some other cities, the various buildings are so placed among trees as to seem isolated. The imposing Hospital for Infectious Diseases, and the Pathological Institute and Museum form part of the group. Pictures of the new buildings for the clinics on Monbijou Street, show how even the excellent quarters in the Ziegel Street have been outgrown. The most striking evidence of the large plan of hospital work in Berlin is the new Rudolf Virchow Hospital, in the northwestern edge of the city, yet convenient to the centre by trolley cars. Friedrichshain, in its pleasant park; Mozabit, with its quaint old barracks, the newer and more modern Urban and Charlottenburg hospitals seemed to be all the city would need as regards space, construction and organization. The new one shows what can be done with money, forthcoming in this case by reason of the resources of the "Krankenkassen." It was built in 1899-1906. Its 57 buildings, with 2,000 beds, occupying a part of 63.5 acres, laid out with trees and landscape gardening that make one forget he is at the edge of a growing city. The cost of building was \$4,775,000, or \$2,387 per bed, including equipment. Most of the buildings are one-storied, of stucco, and while nothing has been spent for decorations, the complex is imposing from its size and arrangement, the various services being distributed with reference to convenience of work. The heating and ventilation seem excellent. There are 95 telephones, 20 of which are on the city central, and a main central with lamp signals. The water supply is from wells on the premises, and the hospital has its own filter plant, ice-factory and machinery for aerating the water. All discharges are sterilized by steam or hot water before going to the sewer. Bath water is disinfected in the tubs. The material from the infectious wards and autopsies is disinfected with calcium chloride. All clothing of patients is disinfected on admission, and left in ventilated aseptic lockers until discharged. The laundry is most complete. Without going into details, let me mention that 12 women with machines are kept busy with repairs. The kitchen has all the labor-saving devices known, as well as a highly specialized force of men and women. The hydiatic and mechano-therapeutic departments are large and well equipped, the latter with apparatus of original design. The treatment is carried out by trained assistants, according to prescriptions. The X-Ray

and Finsen departments and photographic laboratories are well arranged. The Pathological Laboratory, under the charge of Prof. Hansemann, with its bacteriologic, chemical and biologic divisions, is more extensive than most university departments of pathology in this country. The whole is cared for by 12 higher medical offices: a prosector, a dentist, 38 assistant physicians, 19 volunteer assistants and 15 undergraduates. The only thing one can criticize is that it is not a teaching hospital.

Perhaps the most remarkable evidence of the importance of medicine in Berlin is the Empress Frederic House of Post-Graduate Study, not far from the north end of the Charite grounds. The large and imposing house is the centre for post-graduate study, which has been organized in Germany with characteristic thoroughness, in acknowledgment of the pioneer work in that line in America. Besides the headquarters for post-graduate instruction, especially in Berlin, and rooms for certain courses, there are large and well-arranged exhibits of everything relating to medicine and hygiene. One can see the instruments of various makers, medical preparations, hospitals and laboratory equipment, photographs of sanatoria and watering places. In another part are all sorts of plumbing supplies. Catalogue and well-informed, courteous attendants assist the visitor to see what he wishes. There is a collection of anatomic preparations arranged for the inspection of the public, and another for physicians only. Special exhibits are arranged from time to time. It would seem that in cities like New York and Chicago similar places would be highly successful in every way.

As the pictures show, the clinics and laboratories of Budapest are numerous, handsome, and well arranged. The new teaching hospital for Prof. Koranyi's clinic promises to be the best planned and best arranged of any I know, every detail having been worked out after inspecting the hospitals all over Europe. Not less interesting are the University buildings of Kolasvar, formerly Klausenburg. Finally, it is interesting to see a plan of the great "Policlinico" of Rome, begun in 1894, and still being added to, its main corridor one-half kilometer long. Anyone who visits it, as I did, in September, will see that a hot climate need not check scientific work, even if he does not recall the scientific and practical contributions of the great Baccelli and his colleagues.

SCHOOLS OF TROPICAL MEDICINE.

Among the most striking evidences of progress in medical teaching in Europe are the schools of tropical medicine. For

they show how even old countries' new conditions may be well and quickly met. The need for extensive cultivation of the study of the diseases of warm countries is obvious when we consider a few facts. Within a few years the white race has finally taken to itself almost all the hottest parts of the earth, and has penetrated further and further into them. In the same time, by a series of discoveries not less astounding than those in physical science, it has been shown that the danger of warm countries are largely avoidable, due as they are to living organisms, whose life-habits and mode of entrance into the bodies of men and lower animals are rapidly becoming known. In order, then, to live most securely in warm countries and to work there most effectively, it is essential to apply the most accurate knowledge of tropical diseases as regards early recognition, treatment and prevention. What can be done, especially in prevention, how much treasure and how many lives can be saved, how much unnecessary interference with commerce can be avoided by following medical advice I need not say. A still greater demonstration of the value of scientific medicine has been made in Cuba and in the Canal zone. The knowledge how best to do such work cannot be imparted in the already crowded courses of medical schools. It can be done in special institutions, which, of course, can often be combined with medical schools, and in many cases can be profitably combined with the university medical schools, whose zoölogists, chemists and other experts can so ably assist. In such places the future tropical physician, or the port or quarantine physician, can prepare himself for his work, and there investigations in problems still unsolved may be made. So we see that all countries with colonial possessions in the tropics have their special schools for the study of tropical diseases. The needs of commerce have led keen and hard-headed business men to foster these in practical places like Liverpool, London and Hamburg, and it is a striking thing that while so much is done there, we, with our great and important tropical climate and some of the most important tropical diseases, with incalculable but obviously great economic losses therefrom, have done practically nothing. I do not forget the great work done by the Public Health and Marine Hospital Service in practice and in scientific investigations, nor the many scientific discoveries of individuals. They make all the more conspicuous the need of well-equipped institutions in localities where facilities exist, especially in ports where tropical diseases occur or are likely to be imported.

THE HAMBURG SCHOOL.

Either of the English schools could furnish the theme for

an evening's talk—Liverpool with its record in sleeping-sickness alone, or London with Manson and only a part of all that he has done. I shall limit myself to a brief description of the Hamburg school, for it seems to be particularly instructive in many ways. It was organized in 1900, the old Sailor's Hospital in the centre of the city being adapted to the purpose. The funds were contributed by the city of Hamburg and the German Empire. Enlarged in 1906, it has already become necessary to enlarge the institution again, and work to that end is in progress. Besides the hospital, the Institute contains room for the offices of the Institute and the port physicians, laboratories for the hospital assistants, and a library and reading room, equipped with all the periodicals in tropical and naval medicine as well as in internal medicine and microbiology. The room for the practical courses has places for 24 fully equipped. There are adequate laboratories for chemistry, an operating room for animals, a protozoa laboratory, a "tropical room" kept always at a temperature between 77-86 degrees F., with a relative humidity of 60-70, where mosquitoes, flies and ticks, as well as snakes and other tropical animals can be kept. A museum accessible also to the public, photographic laboratories, with complete equipment, an apiary, an animal house, and a mosquito house should be mentioned.

In order to carry out the functions of training naval and tropical physicians and developing tropical medicine, courses are given. Since the beginning, 349 physicians have taken these courses, many of them foreigners. The brilliant and lamented Schaudinn was perhaps the most widely-known member of the staff. Nocht is the director, and there are also Fulleborn, Giemsa, van Prowazek and several others. As an example of the clinical material, there were for 1905-1906:

Malaria	1,578 cases
Dysentery-amebic	83 cases
Blackwater fever	71 cases
Beriberi	145 cases
Trypanosomiasis	2 cases

besides examples of most of the other tropical diseases.

Besides the work in the hospital and institute, scientific journeys have been made to Brazil, Africa, Egypt, Ceylon and India, assisted by the German steamship companies and firms engaged in various tropical trades. That the returns from such investigations will be immense, the record of the canal zone alone amply proves, for there can be no doubt that without the aid of scientific medicine, our engineers would have been as helpless as the French were before them.

OBSTETRICS AND GYNECOLOGY.

IN CHARGE OF ADAM H. WRIGHT, K. C. M'ILWRAITH, FRED. FENTON
AND HELEN MACMURCHY.

Treatment of Depression of Skull in Newborn Infant

Three or four cases of depression of skull or depressed fractures in newborn children having been reported in the *Journal* in the last twelve months or so, it may be of interest to record one in my own experience, which illustrates the simplicity with which such cases can be successfully treated.

After a tedious first labor, the child when born was found to have a depression in the left fronto-parietal region, about $1\frac{1}{2}$ in. or 2 in. in diameter. As it was hoped that recovery might occur spontaneously and the child seemed in no way affected by the condition, nothing beyond a fruitless manipulation was done till the tenth day. The child was then taken into our cottage hospital, where, with all needed help, I operated under an anæsthetic as follows:

I provided myself with an awl made from a large-sized knitting needle and an elevator made of stout wire with bowed handle and a point, somewhat flattened, bent to a right angle, so as to be about $\frac{1}{8}$ in. in length. I dissected back a small tongue of scalp, including the pericranium, over the centre of the depression, and cautiously bored through the skull. Inserting my elevator, I then easily drew the part into position. A suture and dressing were applied, and the child sent home in a few hours. Healing took place in the course of a week without the smallest complication.—W. R. Cossham, M.D. Aberd., M.R.C.S. Eng., Cirencester.—*British Medical Journal*.

Veratrum Viride in Puerperal Eclampsia

A very interesting article in support of veratrum viride in puerperal eclampsia is contributed by Dr. J. L. Archambault (*Albany Med. Ann.*, Feb., 1910). This drug combines the valuable properties of inducing vaso-dilatation and hypo-tension, profuse perspiration, copious diuresis, emesis, and often catharsis. Then the high blood pressure which allows of the free circulation of toxic products is eliminated and the very toxins to which the convulsive seizures and coma are attributable are re-

moved. The author recommends the exhibition of the drug in heroic doses. The fluid extract should be used hypodermically in 20 to 30 minim doses. To get the convulsions to stop the pulse must be slowed to 60 or under and kept there for not less than 24 hours. Since 1902 the author has substituted treatment with this drug for the induction of labor and the administration of chloroform.—*Medical Review of Reviews.*

Eclampsia and the Weather

Damp, bleak weather and the sultry and humid weather seem to have an influence on the incidence of eclampsia, as the writer shows by tables of the 262 cases of eclampsia at the Berlin Charité in the last four years compared with the weather charts. The cases in which the women present symptoms suggestive of toxæmia but without actual eclampsia should be taken into account in a study of the connection between meteorologic conditions and eclampsia. R. Schlichting (*Archiv. für Gynäkologie*, Bd. lxxxix., Nu. 2, 1910; *Journal American Medical Association*).

Incontinence of Urine Following Labor

Incontinence of urine which comes on immediately after labor due to swelling, etc., of the urethra and bladder neck, as a rule soon subsides without treatment. Later a careful examination should be made of all the pelvic organs, replacing a retroposed uterus when necessary, hastening involution of the pelvic structure by douches, tampons, pessaries, etc. In persistent or increasing incontinence some operative procedure is usually necessary. The nature of the operation should depend upon the condition of the urethra and bladder neck. The Frank operation, combined with an anterior and posterior colporrhaphy in cases where there is a relaxed and gaping vagina, and some appropriate operation for retroversion where this exists, will cure the average case of incontinence coming on after labor, and of not too long standing. In cases where there is a marked dilatation of the urethra and of long standing or cases where from necrosis the muscular wall of the neck of the bladder and urethra are wanting, Gersuny's operation seems to offer the best hope of cure. Pawlik's and Dudley's operations have likewise given good results at the hands of their originators.—G. Brown Miller (*Surgery, Gynecology and Obstetrics*).

Recurring Jaundice in Four Successive Pregnancies with Fatal Jaundice in Three Successive Infants

Dr. H. D. Rolleston, of London, reports the following case (*British Medical Journal*):

A married woman, aged 35, two months pregnant, came to St. George's Hospital on December 8th, 1908, in order to see if anything could be done to prevent the sequence of events which had characterized her three previous pregnancies. In each of these pregnancies she had become jaundiced about the sixth month, and subsequently suffered from itching of the skin. Throughout all her pregnancies she has had nausea, but has never had vomiting. She is always constipated, and this is much worse during her pregnancies. Her three children were all born six weeks before term, and, though not jaundiced at birth, rapidly became so, and died; the first, a boy, died at 5 months; the second, also a boy, at 5 months; and the third, a girl, at 16 days. She has not been able to suckle any of her children. She has never had jaundice or pruritus except during these pregnancies; she has not had biliary colic or enteric fever; and, as far as she knows, jaundice has not occurred among her own relations or in her husband's family.

During her fourth pregnancy she was treated with urotropin and salicylate of sodium, with a view of preventing infection and obstruction of the biliary tract, and the occurrence of grave jaundice in her infant. This, however, was not entirely successful, for she became jaundiced about the sixth month, and had pruritus, though she did not feel so uncomfortable as in her previous pregnancies. There was no enlargement of the liver or spleen. On June 3rd, 1909, a healthy 8 months boy was born. He did not show any sign of jaundice; when two and a half weeks old he was admitted into the hospital. There was nothing really the matter with him; the liver, spleen, and urine were healthy. He was seen again on March 1st and 10th, 1910, when he weighed 16 lbs. and was in very good health. He has never had any jaundice.

Treatment of Puerperal Infections

At a recent meeting of the Yorkshire Branch of the British Medical Association Dr. Oldfield read a paper on the treatment of puerperal septic infections. With regard to the specific treatment by vaccines and sera, the former had been found disappointing, but from the latter much could be expected if used in-

telligently. They should be given in large doses, 50 c.cm., repeated not more than twice, and early in the course of the disease, when an abscess had formed, serum was dangerous. Besides the specific treatment, a continuous lookout should be kept for local lesions, for on the prompt treatment of these depended good results. Of the various forms of local treatment, drainage held the first place, promoted at first by the propped up position and assisted by the giving of ergot and hot vaginal douches. It should be definitely assured in cases where these measures were not successful by inserting a drainage tube into the uterus, a malleable metal one being the best. Curettage, though often adopted and sometimes useful, was a risky proceeding, and in the later stages of the disease harmful. Uterine douching with salines might be tried for a few days when the lesion was uterine and did not extend beyond the uterus. The intravenous injection of mercuric chloride was useful in the early stages of bacteriæmia, operative procedures such as colpotomy, hysterectomy and ligature of veins, offered better chances than expectant treatment in special cases with definite indications. Posterior colpotomy was called for, in those rare cases where pus collected in Douglas' pouch and in general peritonitis. Hysterectomy rarely did any good except in suppurating myomata, uterine abscess, and uterine perforation. Ligature of veins in chronic puerperal pyæmia gave the patient much the best chance. It was harmful in acute cases. When both sides were thrombosed the ovarian and internal iliac veins should be ligatured. When thrombosis was confined to one side the ovarian and common iliac should be tied.—*New York Medical Journal*.

Editorials.

CANADIAN MEDICAL ASSOCIATION

The recent meeting of this Association, in Toronto, was in several respects remarkable. In the first place, it was, so far as members are concerned, a very decided "record-breaker," the number registered being over 430. The numbers in attendance during the last ten years were as follows: Winnipeg, 1901, 178; Montreal, 1902, 330; London, 1903, 302; Vancouver, 1904, 267; Halifax, 1905, 222; Toronto, 1906, 79 (B.M.A.); Montreal, 1907, 235; Ottawa, 1908, 228; Winnipeg, 1909, 334; Toronto, 1910, 434.

Fortunately, however, the unusually large attendance was only one of the interesting features of the meeting. The local committees were particularly fortunate in their choice of the many distinguished visitors who were good enough to accept their invitations to attend. The addresses delivered by these visitors at the general sessions were, perhaps, taking all in all, the best ever delivered before any meeting of the Canadian Medical Association. We refer especially to the addresses of Dr. Herrington, of London, England, on "Chronic Diseases of the Kidney," Dr. J. B. Murphy, of Chicago, on "The Surgery of the Joints," and Dr. Henry C. Coe, on "The Old and New Gynæcology." There was a remarkable similarity in these three addresses in certain respects. In all three the practice was united with the scientific aspects of the subjects in a manner satisfactory to all present. Each of these three addresses kept the rapt attention of the large audience from beginning to end.

Among other features of the general sessions which created intense interest were the very able discussions which followed the reading of Dr. Charles Hastings' report of the Milk Commission. Fortunately, a large number of our lay friends were present during the discussion, and took much interest in the remarks of the various speakers.

Another discussion which took place during the general

session was a symposium on "Exophthalmic Goitre," in which Dr. S. P. Beebe, of New York; Dr. Alex. McPhedran, of Toronto, and Dr. F. H. Shepard, of Montreal, took part, and which created much interest.

The members, especially in the Toronto District, were very much pleased to have the privilege of listening to a very able lecture on an exceedingly important subject of medical education, delivered by Dr. Connell, Dean of the Medical Faculty of Queen's University, Kingston.

As a matter of fact, the members were all delighted to know that Dr. Thomas G. Roddick is still taking a very active interest in the subject of Dominion Registration, and the hope generally expressed was that his great work would soon meet with the success which it so well deserved.

Of the work done in the sections it is impossible to speak in detail. It may be stated in a general way that the work in the Medical and Surgical sections was exceedingly interesting from start to finish on each day. The section on Obstetrics and Gynæcology was not quite so satisfactory during the first day, but we are told that in the later stages the papers and discussions were the best that have ever been heard on these subjects in Toronto. There was some delay in opening the section on Pathology on the first morning, but thereafter the meetings in that section were exceedingly interesting. The committee in charge of the section on the Eye, Ear, Nose and Throat worked faithfully during the year in their efforts to produce a good section. At the end of some months, however, reports were very gloomy. We are glad, therefore, to be able to say that there was a general consensus of opinion that the meeting of this section on Thursday morning was a very admirable one, and the attendance was unusually large.

Speaking of both the general and special sessions as a whole, we may say that things appeared to be better balanced in every way than they had been in previous meetings. We are pleased to say that the local committees did magnificent work. We think that no Entertainment Committee on any previous occasion did such good work as the committee for this year, under

the chairmanship of Dr. Riordan. Among the other committees which did splendid work was that of the Reception and Publicity, under the chairmanship of Dr. R. Bruce-Smith; the Local Finance and Exhibits, under the chairmanship of Dr. S. Johnson. In addition to the local committees, the members are greatly indebted to the profession of Guelph and the staff of the Agricultural College in that city for their entertainment at Guelph on the last day of the meeting.

The President, Dr. Adam H. Wright, during the past year worked with zeal and great understanding to bring the meeting to a successful issue.

KING EDWARD VII.

In our last issue we gave specific details respecting the last illness of our late Sovereign. We find from later reports that our information given at that time was correct.

It will be of much interest to our readers to refer to his physical condition previous to the time of his last illness. In youth and early manhood he had a remarkably strong constitution, and enjoyed very good health up to the year 1871; when he had a severe attack of typhoid fever, which brought him to the verge of the grave. His principal medical attendants at that time were Sir William Jenner and Sir William Gould, and it was generally supposed that his recovery was due to the skill and careful attention of these physicians. It was supposed that he made a complete recovery from this illness, but it is not certain that he was quite so strong physically in 1872 as in 1870.

In 1898, he slipped on a spiral staircase of Waddesdon Manor and fractured his left patella. The line of fracture was nearly transverse, and close to the upper margin of the patella; the gap between the fragments amounted to a little more than two inches. After this accident he was attended by Sir Francis Laking and the late Sir William McCormick. Lord Lister and the late Sir Thomas Smith were called in consultation, and the question of

operation received the most careful consideration by his medical attendants; but after weighing all the circumstances of the case, they decided against it. We may say that Lord Lister fully endorsed this decision. The royal patient made a good recovery, and no impairment to the usefulness of the limb was left. After this time he remained in good health up to the time of his serious illness in 1901, when he was under the care of Sir Frederick Treves.

His Majesty always took a great interest in the medical profession. He honored it by consenting to become an Honorary Fellow of the Royal College of Physicians of London in 1897, and by accepting a similar compliment from the Royal College of Surgeons of England in 1900, and also a similar honor from the British Medical Association at the annual meeting at Ipswich in the same year. He took a very deep interest in the various hospitals of the United Kingdom, and was ever ready to help them. He originated the well-known "Hospital Fund." He also gave his patronage to the crusade against tuberculosis. He was largely instrumental in the establishment of the Sanatorium for Tuberculosis at Midhurst, which was opened in June, 1906. He also took special interest in the reorganization of the Army Medical Service after the South African War, and expressed privately his approval of an article published in the *British Medical Journal* of Dec. 31, 1904, which dealt with the new principle of promotion by selection on the ground of merit instead of by mere seniority. He also was chiefly instrumental in the establishment of the Radium Institute for the investigation of the therapeutic properties of that substance.

We are indebted to the *British Medical Journal* for the greater part of the information contained in this article.

NURSES IN HOSPITALS FOR INSANE

The Ontario Government has inaugurated a new system regarding the nurses in the different Hospitals for the Insane in the Province. According to the new scheme the nurses will

undergo an annual examination, and, if they pass satisfactorily, will receive a diploma after the final. The object of the authorities is to increase the efficiency of the staffs. The nurses in the future will be remunerated according to their ability.

The plan has been in operation in the English institutions for a number of years, and has been found to work out very satisfactorily. The first written examination in Ontario was held in all the hospitals simultaneously by the Official Board of Examiners early in May. The oral examinations were held during the third week in May.

The Board consists of Dr. R. W. Bruce-Smith, Inspector of Prisons and Charities; Dr. Foster, Assistant Superintendent of London Asylum, and Dr. Young, of Rockwood Asylum, Kingston.

KING GEORGE THE FIFTH

Our present Sovereign probably knows more about the British possessions beyond the seas than any other man in the United Kingdom. It is only a few years since it was our good fortune to meet him in Canada on his memorable trip around the world. It was generally remarked that, in connection with the many public functions he attended and the many addresses he delivered, he never made anything like a break during his whole trip. We have every reason to believe that he is possessed of that sort of practical wisdom which was so highly exemplified in his distinguished father, and that he will take a very active interest in all things medical. He has already shown abundant evidence of the interest which he takes in matters pertaining to the public health and the relief of suffering, especially among the sick poor. He has been President of King Edward's Hospital Fund for London since its establishment in 1897. During these years he has studied hospitals very carefully and has on many occasions shown a very accurate acquaintance with all the details of the management of a modern hospital.

We are reminded by the *British Medical Journal* of an inci-

dent which happened in India in 1891, during the trip before referred to. During his stay in Calcutta, he on one occasion insisted on breaking through the official programme which had been drawn up, in order to visit the General Hospital, under the guidance of Sir Havelock Charles.

FLORENCE NIGHTINGALE

It is generally conceded that Florence Nightingale is one of the noblest women in the British Empire. The history of her one work during the Crimean War is well known to the whole English-speaking world. The following very interesting letter indicates the high respect which Queen Victoria entertained for this remarkable woman:

“Windsor Castle, January, 1856.

“Dear Miss Nightingale:

You are, I know, well aware of the high sense I entertain of the Christian devotion which you have displayed during this great and bloody war, and I need hardly repeat to you how warm my admiration is for your services, which are fully equal to those of my dear and brave soldiers, whose sufferings you have had the privilege of alleviating in so graceful a manner. I am, however, anxious to mark my feelings in a manner which I hope will be agreeable to you, and therefore send you with this letter a brooch, the form and emblem of which commemorates your great and blessed work, and which I hope you will wear as a mark of the high approbation of your Sovereign. It will be a very great satisfaction to me, when you return at last to these shores, to make the acquaintance of one who has set such a bright example to our sex.

“With every prayer for the preservation of your health,

“Believe me, yours sincerely,

VICTORIA, R.”

Florence Nightingale has lived for many years in a small house on South Street, London. For years she has been practically bedridden, none but her maid, her dearest relatives and

friends ever see her. She completed her 90th year shortly after the death of His Majesty King Edward. On her 90th birthday, King George honored her by sending her a message of congratulation. We are told they did not tell her the name of the King who sent it. They feared the shock might kill her; so she believed her beloved dead King, the Great Edward, remembered her in her old age.

NOTES.

The Royal College of Physicians of London last week granted licenses to practise to ninety candidates who have passed the examinations of the Conjoint Board. Amongst them was the name of Miss Dossibai Rustomji Cowasji Patell, the first woman licentiate of the ancient College in question.

THE CANADIAN MEDICAL ASSOCIATION

The forty-third annual meeting of the Canadian Medical Association was held in Toronto, June 1-4, in the buildings of the University of Toronto. On the evening of May 31st, a large smoking concert was given in St. George's Hall. On the morning of June 1, some of the section meetings were held. The Section of Medicine met in the Convocation Hall, Dr. H. B. Anderson, Chairman, and Dr. Brefney O'Reilly, Secretary. The Section of Surgery met in the Examination Hall, Dr. F. N. G. Starr, Chairman; Dr. Arthur Wright, Secretary. The Section of Obstetrics and Gynæcology met in the north hall of the Physics Building, Dr. S. M. Hay, Chairman; Dr. Clutterbuck, Secretary. The Section of Pathology met in the middle hall of the Physics Building. There were also meetings of these sections during the forenoons of June 2 and 3. In addition, there was a meeting of the Section of Eye, Ear, Nose and Throat in the south hall of the Physics Building during the forenoon of June 2.

The first general session was held in the Convocation Hall at 2.15 p.m., June 1. The retiring President, Dr. R. J. Blanchard, introduced the President-Elect, Dr. A. H. Wright. Short addresses of welcome were delivered by Hon. Dr. Pyne, Minister of Education; Acting Mayor Ward and President Falconer. The President delivered his address, taking as his subject "The General Practitioner."

Dr. Charles J. Hastings, Chairman of the Milk Commission, then read the report of his committee. He said that the reason for the existence of the Milk Commission lay in the present lamentably large infant mortality, and the fact that at least fifty per cent. of those who die under the age of five years do so from some kind of infantile diarrhoea or kindred preventable diseases, and that under the age of two years the proportion was ninety per cent. There was no problem in preventive medicine of greater significance than that of removing the dangers which exist in the ordinary market milk. Because one child had died from rabies, every dog in Western Ontario had been muzzled. Why were not some stringent measures taken to save the five thousand children under five years of age who, at a conservative estimate, might have been saved to Canada by preventive measures last year out of the ten thousand who died. Certificates were required before druggists, doctors and even undertakers could practise; but any

ignorant foreigner or man who was willing to do the work could come in and milk the cows and send out the milk which filled the coffins of the undertaker.

The commission had tried to secure legislation from the Dominion Parliament and the Local House. The Federal House was limited to the power of defining what certified milk and officially pasteurized milk were; but they had assured the Commission that when these definitions had been sufficiently adjusted by them to the satisfaction of Professor A. McGill, Dominion Analyst, they would be incorporated into the Adulteration Act. They had also tried to co-operate with the dealers, and they had found these, when properly approached, quite willing to do all they could. Two years ago a pint of certified milk could not be purchased in Toronto, while now 470 quarts are sold daily, as well as 36,448 quarts of officially pasteurized milk, 4,956 quarts of pasteurized cream, and nearly two hundred quarts from the plant of the Hospital for Sick Children. Altogether 42,074 quarts of what they could guarantee as being free from disease-producing germs were being sold daily in Toronto—almost one-half of its milk supply.

The Commission resented the statement that pasteurization paid a premium on dirt. The milk presented for pasteurization had to come up to a certain standard. Experiments at the Hospital for Sick Children had shown during the last week 30, 61, 8, 50 and 60 bacteria to the cubic centimetre after pasteurization. He had little hesitation in making the statement that, through the efforts of the Commission, working in co-operation with the Department of Inland Revenue of the Dominion Parliament, the local Houses, and municipal bodies and the dealers, they would, in a short time, have the safest milk supply of any country on the face of the earth.

Dr. Charles E. North, of New York, one of the highest recognized authorities on the question of pure milk, and water, and on sewage disposal in North America, said that the milk supply of the city of Toronto was better than that of most other cities on the continent, as outlined in the Commission's report. He himself was a member of the New York Milk Committee, which was organized with the sole object of improving the milk supply in the city of New York, because the Board of Health was limited in its efficiency by political restrictions and lack of money and medical commissions to certify milk. He strongly advised pasteurization in view of the issues involved. Part of the solution of the problem, he thought, lay in taking the dairy business out of the hands of the farmer, who could not be ex-

pected to be a dairy expert. He also mentioned a case of where 700 cases of scarlet fever were traced to one raw milk dealer. Out of three hundred guinea pigs he had injected with New York milk samples, half had died with raw milk and one with pasteurized milk, and that commercially treated, and none with certified milk.

Professor A. McGill, Dominion Analyst, then explained the necessity of specific definitions being given. The scientific definitions and the legal ones must be made alike. But there was little use defining pasteurized milk according to its processes legally if there was no recognized scientific method of discovering by tests whether these processes had been used. They could discover the bacterial contents in those milks, and go on that basis, if that were made the legal definition. Inspection of every plant would be very difficult and expensive in order to discover whether the processes had been followed.

Dr. Rutherford, Dominion Veterinarian, said that any abnormality in the cow as regards its health or diet, was liable to give rise to changes in the qualities and properties of milk, and so affect those who drank it. He mentioned a number of diets that would cause disturbing influences in the health of those who afterwards drank the milk of the cows partaking of them. Milk should never be taken from cows suffering from chronic sepsis or retention of the placental membrane, and the following diseases were communicable through the milk to human beings: Cow-pox, anthrax, rabies (possibly), foot-and-mouth disease, trembles, actinomycosis, and last of all and worst of all, tuberculosis. Scarlet fever, also, was traceable to cows.

Tuberculosis should be attacked in the cow, and as that was the most common method of its transmission to humanity, the stamping out of the disease amongst cattle would remove one of the great sources amongst human beings. Afterwards, when there were no tuberculous cows, the transmission of tuberculosis would cease to be a problem. The sale of milk from cows not known to be free from tuberculosis is a crime against society, and any community that permits the sale is accessory to the crime. "What, then," said Dr. Rutherford, "must we say about communities that continue to authorize the sale from cows known not to be free from the disease?"

Dr. C. J. Fagan, of British Columbia, told of what good results were flowing from their system of dairy inspection, and that on account of the tuberculin test the percentage of effective stock was on the increase.

Dr. Fraser, of Toronto, suggested that a much smaller time should be taken in getting the milk from the cow to the consumer.

A general session was held on the same evening, when Dr. W. P. Herringham, of London, England, delivered an address on "Chronic Bright's Disease."

Dr. R. A. Reeve, Chairman of the Executive Council, then read the report of that body. A recommendation was made to the Provincial branches that membership in full standing should be limited to those who also belonged to the Canadian Medical Association.

The Council also recommended that the Association should bring out a journal forthwith, with Dr. McPhail, of Montreal, as editor; and further recommended that the Association journal should absorb the *Montreal Medical Journal*. The report was received and adopted after some discussion.

DOMINION REGISTRATION.

Dr. T. G. Roddiek produced an amended bill on Dominion Registration, asking for the Association to accede to its various clauses. The clauses in which it differs from the one presented on a former occasion were read one by one, and accepted, with slight amendment. The principal change was that the Dominion Council should not fix the qualifications necessary for matriculation in the study of medicine, and for obtaining the Provincial license, this being regulated, as heretofore, by the Provincial authorities.

EXECUTIVE COUNCIL.

The following were elected for the ensuing year to the Executive Council: Dr. C. J. Fagan, Victoria, B.C.; D. Ingersoll Olmsted, Hamilton; Geo. E. Armstrong, Montreal; A. T. Shillington, Ottawa; James Bell, Montreal; F. N. G. Starr, Toronto; J. T. Fotheringham, Toronto; J. H. Elliott, Toronto; John Stewart, Halifax, N.S.; Dr. A. McPhedran, Toronto; Dr. R. A. Reeve, Toronto; Dr. Murray Maclaren, St. John, N.B.; Alex. McNeill, Charlottetown; J. D. Lafferty, Calgary, and F. G. Finley, Montreal.

The annual executive session of the Ontario Medical Association met at 10.30 and decided that their proportion of the \$5 fee paid the two associations should be 50 cents per member.

After the morning meeting of the various sections on Thursday forenoon, a large proportion of the members, their wives and daughters went to the foot of Bay Street and embarked on the steamer *Turbinia*, which crossed to Port Dalhousie. Lunch

was served on the boat, and an orchestra furnished music. The party, numbering about four hundred, were taken in special cars to the Clifton House, Niagara Falls, reaching that place about 5 o'clock. The party had time for some sight-seeing before dinner, which was served at 6.30. At the table of honor, Dr. Bruce Riordan, Chairman of the Entertainment Committee, presided. Dr. Adam Wright, President, was seated on his right hand, and Dr. Blanchard, the retiring President, on his left. On either side of those the Past Presidents of the Association were seated, facing the long room filled with small tables, at which were seated the members. After the excellent dinner had been done justice to by the hungry, Dr. Riordan called for a toast to "The King." Dr. Blanchard spoke at some length, and referred in enthusiastic terms to the reception given them in Toronto, and also said it was the most successful meeting of the Association in point of numbers and also of interest. He called for a toast to the President, Dr. Adam Wright, which was given with a tiger. Dr. Wright replied, and referred especially to the ladies. After singing "For He's a Daisy," the company repaired to the crimson ball-room, where music and dancing were enjoyed by the younger element. At 9 o'clock the cars left for Port Dalhousie, where the *Turbinia* was waiting, and the return journey across the lake was accomplished. An orchestra on board provided music, and hot drinks and light refreshments were served to a tired but highly delighted company.

Friday, June 3rd, was a very busy day. Meetings of the various sections were held in the forenoon; there was a general session in the afternoon, also a general session in the evening. There were two very important events in the afternoon. Dr. John B. Murphy, of Chicago, delivered the address in surgery, taking as his subject, "The Surgery of the Joints." After this there was a symposium on "Exophthalmic Goitre," opened by Dr. S. B. Beebe, of New York. Dr. McPhedran, of Toronto, considered the medical aspect, and Dr. Shepherd, of Montreal, the surgical aspect.

Dr. Henry C. Coe, of New York, delivered a most interesting address at the evening session on "The Old and New Gynaecology." In the course of it he expressed some satisfaction that the tendency to follow surgical fads and fancies seemed to be passing, and that a more conservative era had supervened. He thought that in the gynaecology of the future the surgical aspect would be less prominent, and more attention would be paid to diagnosis and all that it involved. He stated that no man had a

right to perform at the expense of a patient any operation which he could not do well; in other words, that none but a trained specialist should do it.

PROTECTIVE ASSOCIATION.

At the meeting of the Canadian Medical Protective Association Friday afternoon, on account of the illness of Dr. R. W. Powell, of Ottawa, who was unable to be present, Dr. Edmund E. King took the chair. The report showed 700 members to have joined the Association, which only found it necessary to defend one case of alleged malpractice during the year. The finances are in a flourishing condition. The same officers were re-elected.

Dr. John Stewart, of Halifax, N.S., submitted a long report to the Executive Committee, making important recommendations regarding the inspection of children in public schools: One recommendation was that the Minister of Education, or the Council of Education, should appoint a public inspector, and that each Province should have an expert medical adviser appointed to organize a complete system of medical inspection, and that these men should co-ordinate their efforts as far as possible with those of the public health service. The report also asked that the Canadian Medical Association approve of the system adopted by British Columbia this year for the medical inspection of schools. Then, in view of the large number of matters affecting public health, a Department of Public Health Inspection should be added to the permanent organization of the Canadian Medical Association.

The following officers were elected for the ensuing year:

President, Dr. Geo. E. Armstrong, Montreal; Vice-Presidents of Affiliated Societies, the Presidents of Provincial Societies, ex-officio; General Secretary, Dr. E. W. Archibald, Montreal; Treasurer, Dr. H. B. Small, Ottawa; Local Secretaries of Affiliated Societies, the Secretaries of Provincial Societies, ex-officio; Vice-President for Quebec, Dr. Simard, Quebec; Local Secretary, Dr. Campbell Howard, Montreal.

Finance Committee—Chairman, Dr. James Bell, Montreal; Dr. J. T. Fotheringham, Toronto; Dr. Murray Maclaren, St. John; Dr. S. J. Tunstall, Vancouver; Dr. F. N. G. Starr, Toronto; Dr. R. J. Blanchard, Winnipeg, and Dr. F. G. Finley, Montreal.

Special Committee on Medical Inspection of Schools—Chairman, Dr. John Stewart, Halifax; Secretary, Dr. Helen MacMurchy, Toronto; Dr. Jasper Halpenny, Winnipeg; Dr. A.

McPhedran, Toronto; Dr. C. J. Fagan, Victoria, B.C., and Dr. J. D. Lafferty, Calgary.

Committee on Medical Education—Chairman, Dr. R. A. Reeve, Toronto; Dr. James Bell, Montreal; Dr. F. G. Finley, Montreal; Dr. F. N. G. Stair, Montreal; Dr. Murray MacLaren, St. John, N.B.; Dr. C. J. Fagan, Victoria, B.C., and Dr. George E. Armstrong, Montreal.

Committee on Medical Legislation—Dr. A. T. Shillington, Ottawa, with power to add.

Public Health and Hygiene—Dr. A. T. Shillington, Ottawa, with power to add.

Amendments to Constitution and By-laws—Dr. H. B. Small, Ottawa, Chairman, with power to add.

Reports of Officers—Ingersoll Olmsted, Hamilton, with power to add.

Necrology—Dr. J. H. Elliott, Toronto, with power to add.

On the afternoon of June 3rd, the visiting ladies were taken out to Lambton Golf Club in ten automobiles and entertained in the Club-house.

On Saturday, June 4th, the members of the Association, with their ladies, went to Guelph as the guests of the profession of that city and of the President and staff of the Agricultural College. A special train of the Canadian Pacific Railway left the Union Station at eleven-thirty o'clock. The party, numbering over four hundred, were very pleasantly entertained at the Homewood Sanitarium, and at the Agricultural College. On the return trip the train reached Toronto about seven p.m.

The Twelfth Annual Conference of the American Hospital Association is to be held at the Planters' Hotel, St. Louis, Mo., September 20, 21, 22 and 23, 1910. The Association will be called to order by the President at 10 a.m. Tuesday, September 20th, in the convention hall of the Planters' Hotel, corner Fourth and Pine streets. After the address of welcome and the President's address, the following papers and reports will be presented:

1. "Relationship of Trustees to Superintendent," Dr. Henry M. Hurd, Johns Hopkins Hospital, Baltimore, Md.
2. "Private Rooms in General Hospitals," Dr. C. Irving Fisher, Presbyterian Hospital, New York City.

3. "The Training of Hospital Superintendents and Heads of Departments," Dr. F. A. Washburn, Superintendent Massachusetts General Hospital, Boston, Mass.

4. "Co-operation vs. Individualism in the Care of the Sick," Mr. Bailey B. Burritt, Secretary State Charities Aid Association, New York City.

5. "Preparation and Use of Detailed Reports for Smaller Hospitals," Mr. Walter Mucklow, Director, St. Luke's Hospital, Jacksonville, Fla.

6. "The Education of the Nurse in America," Dr. Richard O. Beard, Secretary, University of Minneapolis Hospital, Minneapolis, Minn.

7. "The Hospital as a Commercial Factor," Mr. Del. T. Sutton, Editor, *International Hospital Record*, Detroit, Mich.

8. "Methods of Raising Funds for a General Hospital," Miss Lucia L. Jaquith, Supt., Memorial Hospital, Worcester, Mass.

9. "Hospital Construction in St. Louis," Dr. Wayne Smith, Supt., University Hospital, St. Louis, Mo.

10. Report of Special Committee on Education and Training of Nurse Assistants for the Care of People of Limited Means in Their Homes and the Nursing of Patients Suffering from Chronic Diseases. Committee—F. A. Washburn, M.D.; Miss Mary Riddle, Charles H. Young, M.D.

11. Report of Special Committee on Bureau of Hospital Information and Permanent Secretaryship. Committee—Dr. S. S. Goldwater, Mt. Sinai Hospital, New York City; Dr. Henry M. Hurd, Johns Hopkins Hospital, Baltimore, Md.; Dr. P. E. Truesdale, Truesdale Hospital, Fall River, Mass.

12. Report of Committee on Hospital Efficiency, Hospital Finances and Economics of Administration. Winford H. Smith, M.D., Bellevue and Allied Hospitals, New York City.

13. Report of Committee on Hospital Construction. H. E. Webster, Royal Victoria Hospital, Montreal, Que.

14. Report of Committee on Uniform Accounting. C. Irving Fisher, Presbyterian Hospital, New York City.

15. Question Box. Chairman, Dr. R. W. Bruce Smith, Parliament Bldg., Toronto, Ont.

GRADUATES IN MEDICINE OF THE UNIVERSITY OF TORONTO, JUNE, 1910

HONORS—Adams, Fred., Cobocok, Ont.; Alexander, H. E., Fredericton, N.B.; Barker, P. W., Stratford, Ont.; Beeman, N. T., Kingsville, Ont.; Buck, F. H., Norwood, Ont.; Butterfield, R. M., Guelph, Ont.; Dickson, I. W., Toronto; Fafis, M. N., Bradford, Ont.; Follett, J. V., Western Bay, Nfld.; Geiger, W., Hensail, Ont.; Harrison, H. D., Toronto; Mann, J. B., Bridgenorth, Ont.; McDonald, Miss J., Vancouver, B.C.; Parker, G. P., Lunenburg, N.S.; Watt, J. C., Toronto; Weir, T. M., Rayside, Ont.; Whyte, M. B., Toronto.

PASS—Alexander, J. G., Dunnville, Ont.; Allen, D. W., Deer Park, Toronto; Alport, E. B., Orillia, Ont.; Arnold, W. C., Zephyr, Ont.; Ball, H. DeW., Toronto; Buck, H., Port Rowan, Ont.; Burnett, J. M., Armstrong, B.C.; Brewster, F. A., Beeton, Ont.; Campbell, J. P., Arthur, Ont.; Campbell, R. Gravenhurst, Ont.; Campbell, F. T., Govan, Sask.; Clarke, W. A., West Toronto; Clark, R. W., Ballyduff, Ont.; Clark, D. A., Toronto; Cruise, W. W., Port Dover, Ont.; Day, W. F. I., Simcoe, Ont.; Dickson, J. R., Waco, Texas, U.S.A.; Elliott, H. M., Mitchell, Ont.; Ellis, Stayner, Windsor, Ont.; Eyres, H. H., Lindsay, Ont.; Ferguson, W. E., Toronto; Gallie, J. G., Barrie, Ont.; George, H. C., Port Hope, Ont.; Gillam, G. J., Woodstock, Ont.; Gillespie, A. T., Galt, Ont.; Graham, R. R., Lobo, Ont.; Guest, Miss E. M., Elginfield, Ont.; Gunn, C. G., Lucan, Ont.; Hackett, W. L., Belfast, Ont.; Hall, M. E., Gore Bay, Ont.; Hamilton, G. H. R., Guelph, Ont.; Hanna, G. M., Brantford, Ont.; Harrington, M. A., Toronto; Hart, D. C., Yorkton, Sask.; Harvey, F. R., Arthur, Ont.; Henderson, R. H., Toronto; Holmes, S. M., Chatham, Ont.; Hopper, D. A., Toronto; Horton, E. M., Roblin, Ont.; Hurlburt, C. W., Regina, Sask.; Huxtable, E. W., Sunderland, Ont.; Humphries, R. E., Walton Ont.; Jackes, H. L., Deer Park, Toronto; Jamieson, R. A., Mount Forest, Ont.; Jamieson, D. B., Durham, Ont.; Jamieson, W., Wellandport, Ont.; Johnson, H. E., Randolph, Ont.; Johnson, R. E., Toronto; Jupp, J. B., Belwood, Ont.; Kelly, C. B., Guelph, Ont.; Kidd, G. C., Trenton, Ont.; Kirby, T. S., Arthur, Ont.; Lane, R. T., Sault Ste. Marie, Ont.; Lawson, A. S., Guelph, Ont.; Leahy, B., Douro, Ont.; Lees, H. DeW., Niagara Falls, Ont.; Lemesurier, A. B., Toronto; Livingstone, H. D., Listowel, Ont.; Loring, F. W., Nelson, B.C.; Lowrie, A., Tillsonburg, Ont.; Macaulay, B. N., Cairo, Ont.; Marlatt, C. R., Whaletown, Cortez Island, B.C.; Menzies, P. K., Toronto; Mitchell, H. H., Niagara Falls, Ont.;

Moorhouse, V. H. K., Toronto; Montgomery, W. G., Gorrie, Ont.; Montgomery, J. E., Barrie, Ont.; Montgomery, R. R., Wroxeter, Ont.; Morrison, N. A., Elmvale, Ont.; Murray, H. H., Toronto; McAllister, A., Hensall, Ont.; McArthur, E. C., Greenbank, Ont.; Maedougall, G. L., Toronto; McKay, R. A., Ingersoll, Ont.; McLaren, K. A., Ottawa, Ont.; McLay, S. M., Woodstock, Ont.; McLean, W. T., Toronto; Nedd, J., Georgetown, Brit. Guin.; Nettleton, J. M., Penetang, Ont.; Nicholson, W. F., Dundas, Ont.; Niemeier, O. W., West Toronto, Ont.; Pain, A., Hamilton, Ont.; Parr, R. L., Blackstock, Ont.; Paton, J. P., Merritton, Ont.; Pettinan, F. E., Nelson, B. C.; Pickard, T. R., St. Mary's, Ont.; Poirier, J. L., St. Catharines, Ont.; Proud, W. A., Hespeler, Ont.; Ritchie, A. B., Strathcona, Alta.; Ritchie, W. L., Beamsville, Ont.; Robertson, H. C., Shallow Lake, Ont.; Rogers, N. W., Barrie, Ont.; Selby, E. R., St. Isidore de Bellevue, Sask.; Sheard, Charles, Jr., Toronto; Sinclair, A. C., Toronto; Stevenson, W. O., Hamilton, Ont.; Stone, J. G. R., Parry Sound, Ont.; Streight, S. J., Oxford Mills, Ont.; Taylor, A. H., Goderich, Ont.; Thompson, F. J., Lucknow, Ont.; Thomas, J. T., Edgar, Ont.; Turofsky, H. A., Toronto; Upton, W. W., Bowesville, Ont.; Vernon, E. G., St. Mary's, Ont.; Williams, L. B., Toronto; Woodhouse, Miss C. F., Toronto; Wright, C. S., Campbellcroft, Ont.

MCGILL UNIVERSITY—FACULTY OF MEDICINE PASS LIST

The following gentlemen, 79 in number, have fulfilled all the requirements to entitle them to the degree of M.D., C.M., from the University. In addition to the primary subjects, they have passed a satisfactory examination, both written and oral, in the following subjects: Principles and Practice of Surgery, Theory and Practice of Medicine, Obstetrics and Diseases of Women and Children, Pharmacology and Therapeutics, Medical Jurisprudence, Practical and General Pathology, Bacteriology, Hygiene, Mental Diseases, and also Clinical Examinations in Medicine, Surgery, Obstetrics, Gynæcology and Ophthalmology and Otology, conducted at the bedside in the hospitals:

Allen, J. A. L., Hallville, Ontario; Allen, K. W., St. John, N.B.; Allingham, J. H., B.A., Fairville, N.B.; Amant, Harry, Chandlerville, Ill.; Anderson, W. M., Midgie, N.B.; Baldwin, W. J., A.B., Ogdensburg, N.Y.; Benner, F. A., Bayham, Ont.;

Black, V. E., B.A., Amherst, N.S.; Booth, G. E., Ottawa, Ont.; Boudreau, F. G., Merrickville, Ont.; Brown, D. M., Motherwell, Scotland; Burton, W. E., Bridgetown, B.W.I.; Carruthers, R. S. P., North Bedeque, P.E.I.; Champion, B. H., Summerside, P.E.I.; Chisholm, H. G., B.A., Antigonish, N.S.; Crease, A. L., Nelson, B.C.; Culver, C. W., Harrisville, N.Y.; Dakin, W. A., M.A., Pugwash, N.S.; Doyle, P. E., Hawkesbury, Ont.; Dunbar, D. A., Alma, P.E.I.; Dunnet, H. W., Ottawa, Ont.; Elliott, R., B.A., East Clifton, Que.; Ewert, C., B.A., Greta, Man.; Fraser, J. R., Lakefield, Ont.; Fraser, W. G., Pembroke, Ont.; Froomess, L. E., Montreal, Que.; Gallagher, J. B., B.A., Bath, N.B.; Gillis, S. H., Indian River, P.E.I.; Gilmour, W. N., Brockville, Ont.; Graves, C. A., Tillsonburg, Ont.; Hepburn, H. H., Edmonton, Alta.; Hepburn, W. G., Stratford, Ont.; Herbert, T. A., Barbadoes, B.W.I.; Hicks, C. R., B.A., Upper Dorchester, N.B.; Hutchison, G. W., Escott, Ont.; Keay, Arnold, New Glasgow, N.S.; Lavers, P. L., Georgetown, P.E.I.; Locke, J. A., Irena, Ont.; Lockwood, A. L., Westport, Ont.; Logie, H. B., B.A., Chatham, N.B.; Macaulay, A. E., St. John, N.B.; Mackintosh, A. E., Pugwash, N.S.; Macmillan, H., Vancouver, B.C.; Macmillan, S., Isaac's Harbor, N.S.; Maencil, A. L. H., Stanley Bridge, P.E.I.; MacPhee, J. A., B.A., Charlottetown, P.E.I.; McAlister, W. J., Winnipeg, Man.; McBurney, A., B.A., Sawyer-ville, Que.; McCracken, W. A., Cornwall, Ont.; McEachern, M. T., Fenelon Falls, Ont.; McNaughton, M. W., Moosomin, Sask.; Malcolm, R. B., St. John, N.B.; Marchant, H. B., Victoria, B.C.; Moodie, A. R., Perth, Ont.; Morse, D. G., Lawrencetown, N.S.; Mundie, G. S., B.A., Montreal, Que.; O'Brien, J. F., Fall River, Mass.; O'Callaghan, R. H. L., Woodlands, Surrey, Eng.; Park, J. E., New Glasgow, N.S.; Patten, L. A., Armstrong, B.C.; Peabody, H. S., Mansonville, Que.; Poole, Sidney B., New Westminster, B.C.; Piper, J. C., A.B., Bingham, Me.; Raphael, H. M., Ottawa, Ont.; Reed, E. H., East Whitman, Mass.; Richardson, J. W., Mountain, Ont.; Robinson, T. A., St. Mary's, Ont.; Scott, G. O., Ottawa, Ont.; Shephard, H. M., London, Ont.; Shillington, R. N. W., Ottawa, Ont.; Shiler, G. A., Jr., Litchfield, Ill.; Speer, R. B., Danville, Que.; Sinclair, F. D., B.A., St. Stephen, N.B.; Stewart, A., South Indian, Ont.; Strudwick, H. T., Jamaica, B.W.I.; Turner, J. S., Spanishtown, Jamaica; Walker, E. E. W., Hamilton, Bermuda; Wilson, G. T., B.A., Vancouver, B.C.; Youland, W. E., Jr., B.A., Biddeford, Me.

FOURTH YEAR—PRIZES AND HONORS.

Holmes' Gold Medal, for highest aggregate in all subjects

forming the Medical Curriculum—T. A. Robinson, St. Mary's, Ont.

Final Prize, for highest aggregate in the Fourth Year Subjects—H. Macmillan, Victoria, B.C.

Wood Gold Medal, for best examination in all the Clinical Branches—Sidney B. Peele, New Westminster, B.C.

Woodruff Gold Medal, for special examination in Ophthalmology and Oto-Laryngology—Sidney B. Peele, New Westminster, B.C.

Medical Society Senior Prize—D. M. Brown, Motherwell, Scotland.

QUEEN'S MEDICAL COLLEGE, KINGSTON

The class of 1910 started with sixty students, and only half that number have finished in the five years' course. The list of graduates and prize-winners is as follows:

DEGREES OF M.D. AND C.M.—W. E. Anderson, Ph.G., Kingston; R. R. Barker, Forfar; J. T. Beete, Henrietta, B.G.; L. C. E. Beroard, Ottawa; E. S. Bissell, South Augusta; G. L. Campbell, Pembroke; J. E. Charbonneau, B.A., Hawkesbury; B. J. Dash, Barbadoes, B.W.I.; J. A. Dougan, Lindsay; J. M. Dunn, Elgin; D. L. Fee, Camden East; R. M. Ferguson, Smith's Falls; A. H. Gannon, North Sydney, N.S.; J. A. Houston, Belleville; J. N. Gardiner, B.A., Kingston; T. M. Galbraith, Thornbury; W. Hale, B.A., Gananoque; J. Jackson, Souris, Man.; Dennis Jordan, B.A., Kingston; G. E. Kidd, B.A., Prospect; I. F. Longley, Lumsden, Sask.; H. C. Mabee, Odessa; J. D. Neville, Deloraine, Man.; G. W. Meyer, Vancouver, B.C.; S. M. Polson, M.A., Kingston; J. A. Polson, Kingston; J. G. Shaw, B.A., Regina, Sask.; H. R. Thompson, Ph.G., Morristown, N.Y.; T. R. Whaley, Soper-ton; A. B. Wickware, Ph.G., Morrisburg.

THE PRIZE LIST.

Faculty Prize in Anatomy—C. R. Graham, B.A., Arnprior.

Faculty prize \$25 for highest mark on second year examinations in Anatomy, Physiology, Histology, Chemistry and Materia Medica—G. W. Burton, Govt. Shemogue, N.B.

Faculty prize for highest percentage of marks on second year examinations in Materia Medica—G. W. Burton.

The Dean Fowler Scholarship for highest percentage of marks on work of the third year—C. M. Crawford, B.A., Kingston.

Faculty prize for best written and practical examination in third year Pathology—C. M. Crawford, B.A.

COLLEGE OF PHYSICIANS AND SURGEONS. 459

The Chancellor's Scholarship, value \$70, for highest percentage on four years' course, tenable only by those who take the examination of the Ontario Medical Council—Stuart M. Polson, M.A., Kingston.

Prize of \$25 given by Dr. W. C. Barber for best examination in Mental Diseases—H. R. Thompson, Ph.G., Morristown, N.Y.

Medal in Medicine—W. E. Anderson, Ph.G., Kingston.

Medal in Surgery—S. M. Polson, M.A., Kingston.

House surgeoncies in Kingston General Hospital recommended in order of merit: W. E. Anderson, Ph.G., T. M. Galbraith, G. E. Kidd, B.A.; next in order, E. S. Bissell.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO—FINAL EXAMINATION

Nearly All of the Successful Candidates Are From Ontario and
Many From Toronto.

The following candidates have passed the final examination of the College of Physicians and Surgeons of Ontario. The graduates are from Ontario, except where it is otherwise stated:

W. F. M. Adams, Toronto; N. G. Allin, Bowmanville; G. W. Anderson, Toronto; J. R. Anderson, Ailsa Craig; G. Barclay, Winchester; P. W. Barker, Stratford; G. Belfie, Gananoque; J. S. Boyd, Simcoe; A. G. Brown, Toronto; C. E. Brown, London; R. M. Butterfield, Guelph; J. A. Charlebois, Fournier; J. R. N. Childs, London; D. A. Clark, Toronto; D. V. Currey, Toronto; L. C. Conn, St. Catharines; J. D. Cunningham, Sarnia; D. W. Davis, Brockville; W. Davis, Onondaga; W. E. C. Day, Shallow Lake; L. A. Douglas, Yarmouth Centre; J. G. Dwyer, Kingston; G. N. L. Earle, Omemee; H. G. Emerson, Wheatley; J. M. Fettes, Le Mars, Iowa; S. M. Fisher, London; T. M. Galbraith, Thornbury; J. L. Graham, Ottawa; M. J. Haffey, Toronto; A. K. Haywood, Toronto; C. A. Harvie, Orillia; J. J. Healey, Toronto; B. H. Hopkins, Lindsay; E. K. Henderson, Toronto; W. G. Hutcheson, Port Rowan; T. O. Hutton, Berlin; G. Hyland, Toronto; D. Jamieson, Glenora; E. F. Jeffries, London; J. A. Johnston, Strongsville; H. J. James, Linden, Wis.; C. B. Kelly, Guelph; W. G. Leggett, Toronto; H. C. L. Lindsay, Strathroy; R. W. Lynn, Calgary, Alta.; R. D. Lane, Kinlough; J. C. J. Lamin, South Mountain; J. W. Lennox, Toronto; P. K.

460 COLLEGE OF PHYSICIANS AND SURGEONS.

Menzies, Toronto; W. S. Millyard, Goderich; W. J. M. Marcy, Valens; E. A. W. Morgan, Oakville; S. Gordon Mills, Toronto; O. W. Murphy, Portland; C. J. McBride, Egbert; V. McCormack, Vivian; J. J. F. McCann, Perth; J. A. McEwen, Hensall; R. J. McEwen, Moffat; F. B. McIntosh, Williamsburg; J. F. McKee, Toronto; N. J. McKinley, Sealey's Bay; W. T. McLean, Toronto; R. McTavish, La Vallee; F. J. O'Connor, Campbellford; W. E. Pearson, Weston; R. S. Pentecost, Toronto; T. R. Phipps, London; F. P. Quinn, Ottawa; J. S. Quinn, Tweed; C. F. W. Ross, Peterboro; V. B. Shier, Kirkton; J. A. Simpson, Sarnia; J. S. Simpson, Maynard; J. L. Stapleton, London; J. W. Sutherland, Ottawa; A. E. Sutton, St. Thomas; A. H. Taylor, Goderich; N. L. Terwillegar, Oshawa; J. J. Thompson, Toronto; J. O. Walker, Toledo; J. C. Watt, Toronto; E. R. Wells, Barrie; R. W. Wesley, Newmarket; E. G. Worley, Hailey's Station; M. B. Whyte, Toronto; R. Wightman, Lancaster; Catherine F. Woodhouse, Toronto; L. B. Williams, Toronto.

INTERMEDIATE EXAMINATION.

The following candidates have passed the intermediate examination: F. Adams, Cobocok; E. B. Alport, Orillia; G. W. Anderson, Toronto; J. L. Anderson, Ailsa Craig; W. E. Anderson, Kingston; W. C. Arnold, Zephyr; P. W. Barker, Stratford; C. E. Brown, London; F. H. Buck, Norwood; H. Buck, Port Rowan; R. M. Butterfield, Guelph; G. E. Butterwick, London; R. W. Clark, Ballyduff; J. A. Charlebois, Fournier; D. A. Clark, Toronto; L. Conn, St. Catharines; D. V. Currey, Toronto; D. W. Davis, Brockville; W. Davis, Onondaga; W. F. I. Dey, Simcoe; I. W. Dickson, Toronto; J. G. Dwyer, Kingston; M. N. Faris, Bradford; G. D. Fripp, Ottawa; T. M. Galbraith, Thornbury; J. G. Gallie, Barrie; W. Geiger, Hensall; H. C. George, Port Hope; A. T. Gillespie, Galt; R. R. Graham, Lobo; W. L. Hackett, Belfast; M. E. Hall, Gore Bay; F. R. Harvey, Arthur; H. D. Harrison, Toronto; A. K. Haywood, Toronto; J. J. Healey, Toronto; E. K. Henderson, Toronto; R. H. Henderson, Toronto; E. M. Horton, Roblin; W. G. Hutchison, Port Rowan; T. O. Hutton, Berlin; E. W. Huxtable, Sunderland; G. Hyland, Toronto; H. L. Jackes, Toronto; G. P. Jackson, Toronto; D. Jamieson, Glenarm; G. L. Jepson, London; H. E. Johnson, Randolph; J. B. Jupp, Belwood; C. B. Kelly, Guelph; R. T. Lane, Sault Ste. Marie; J. C. J. Lannin, South Mountain; W. G. Leggett, Allanford; J. W. Lennox, Toronto; H. C. L. Lindsay, Strathroy; A. Lowrie, Tillsonburg; G. L. Macdougall, Toronto; J. B. Mann, Bridgenorth; P. K. Menzies, Toronto; S. G. Mills, Toronto; W. S.

Millyard, Goderich; R. R. Montgomery, Wroxeter; W. G. Montgomery, Gorrie; O. W. Murphy, Portland; V. McCormack, Toronto; J. A. McEwen, Hensall; W. H. McFarlane, London; F. B. McIntosh, Williamsburg; J. F. McKee, Toronto; N. J. McKinley, Seely's Bay; K. A. McLaren, Ottawa; W. T. McLean, Toronto; J. M. Nettleton, Penetanguishene; O. F. Niemeier, Toronto; W. E. Pearson, Weston; R. S. Pentecost, Toronto; T. R. Phipps, London; T. R. Pickard, St. Mary's; J. L. Poirier, St. Catharines; F. P. Quinn, Ottawa; C. F. Ross, Peterboro; J. S. Simpson, Maynard; J. L. Stapleton, London; W. O. Stevenson, Hamilton; S. J. Streight, Oxford Mills; J. W. Sutherland, Ottawa; A. H. Taylor, Goderich; F. J. Thompson, Lucknow; J. J. Thompson, Toronto; M. J. O. Walker, Toledo; J. C. Watt, Toronto; T. M. Weir, Rayside; E. R. Wells, Barrie; R. W. Wesley, Newmarket; M. B. Whyte, Toronto; R. Wightman, Lancaster; C. F. Woodhouse, Toronto; E. G. Worley, Hailey's Station; C. S. Wright, Campbellford.

MEDICAL EDUCATION IN CANADA

There has just been published under the Carnegie Foundation for the advancement of Teaching a most comprehensive and detailed report on Medical Education in the United States and Canada. It is a large volume of over 360 pages. It presents a historical survey of the whole subject, and a detailed study of present conditions, together with a characterization of each of the 150 medical schools on this continent. Each school was visited. The general characterization of the medical schools of Canada and details of those in Ontario and Quebec are as follows:

GENERAL CONSIDERATIONS.

In the matter of medical schools, Canada reproduces the United States on a greatly reduced scale. Western University (London) is as bad as anything to be found on this side the line; Laval and Halifax Medical Colleges are feeble; Winnipeg and Kingston represent a distinct effort towards higher ideals; McGill and Toronto are excellent. The eight schools of the Dominion thus belong to three different types, the best adding a fifth year to their advantage of superior equipment and instruction.

At this moment the needs of the Dominion could be met by the four better English schools and the Laval department at

Quebec. Toronto has practically reached the limits of efficiency in point of size; McGill and Manitoba are capable of considerable expansion. The future of Kingston is at least doubtful. It could certainly maintain a two-year school; for the Kingston General Hospital would afford pathological and clinical material amply sufficient, up to that point. But the clinical years require much more than the town now supplies. Its location—halfway between Montreal and Toronto, on an inconvenient branch line—greatly aggravates the difficulties due to the smallness of the community. The rapid development of the Northwest Territory will undoubtedly hasten the growth of the Winnipeg school; other institutions will in time be established nearer the Pacific coast as the country grows in population.

The legal standard in the Dominion has not thus far been high; but it has practically been elevated a year by the general movement to prolong the course to five years. Meanwhile, the high quality of instruction offered by McGill and Toronto to students who enter on less than a four-year high school education proves that our trouble in the United States has been at bottom not less one of low ideals than of low standards. Indeed, where ideals are low there are no standards; and where ideals are high the standard, even though low, is at any rate so definite that it furnishes a sure starting-point towards a clearly-apprehended goal. The low standard school in the United States has had no such starting point and no such goal.

KINGSTON: POPULATION 20,000.

(3) Medical Department of Queen's University. Organized 1854. The relation of the medical department to the university is anomalous, marking a period of transition that is likely soon to result in complete integration.

Entrance Requirement: Heretofore somewhat below that of the Arts department of the University, though students must comply with the requirements of the Province in which they expect to practice. The medical course covers five years.

Attendance: 208, 71 per cent. from Ontario.

Teaching Staff: 38, 16 being professors.

Resources Available for Maintenance: Income in fees, \$19,978. A fixed percentage of fees is annually expended on buildings, equipment, and maintenance. The remainder belongs to and is disbursed by the medical faculty.

Laboratory Facilities: The laboratory building is new and the equipment is adequate to intelligent routine work. At present, physics, chemistry and physiology are taught in the uni-

versity, in return for which the university receives a part of the fees of the students instructed. Full-time professors in anatomy and pathology are provided by the medical school. A museum is in process of formation. There is a small collection of books and periodicals in the faculty room, open to students.

Clinical Facilities: The clinical facilities are limited. The school relies mainly on the adjoining Kingston General Hospital, in which its faculty practically constitutes the staff. The average number of beds available is 80, but they are well used. In addition to ward work, students are required to work up individual cases in correct form, including the clinical laboratory aspects. There is a ward for infectious diseases. Obstetrical cases are too few. Post-mortems are secured mainly at the Rockwood Insane Asylum. Two supplementary hospitals provide additional illustrative clinical material. The opportunities for out-patient work are slight.

Date of visit: October, 1909.

LONDON: POPULATION, 41,500.

(4) Western University Medical Department. Established 1881. Practically an independent school.

Entrance Requirement: Nominal. The student, for his own protection, is expected to fulfil the requirements of the place in which he intends to practice. The medical course covers four years.

Attendance: 104.

Teaching Staff: 20, of whom 8 are professors, 12 of other grade.

Resources Available for Maintenance: Fees, amounting to \$11,590 (estimated).

Laboratory Facilities: These consist of a single room called the laboratory of pathology, bacteriology, and histology, whose equipment consists of microscopes and some unlabeled specimens—no microtome, cut sections, incubator, or sterilizer being visible—a wretched chemical laboratory, and an ordinary dissecting room. There is no outfit for physiology, pharmacology, or clinical microscopy, and no museum deserving the name. There are a few hundred books locked in cases to which the janitor carries the key.

Clinical Facilities: These are entirely inadequate. They are confined almost wholly to a small number of beds in the municipal hospital.

The school has no dispensary.

Date of visit: October, 1909.

TORONTO: POPULATION, 328,911.

(5) University of Toronto Faculty of Medicine. Established 1887. An organic department of the university.

Entrance Requirement: The Junior Matriculation Examination, strictly enforced. The course covers five years.

Attendance: 592.

Teaching Staff: 68, of whom 27 are professors, 41 of other grade. Ten professors, with fifteen assistants, give their entire time to teaching and research.

Resources Available for Maintenance: The department is supported out of the general funds of the university, its cost being considerably in excess of fees received. The latter amount to \$64,500.

Laboratory Facilities: The laboratories are in point of construction and equipment among the best on the continent. Increasing attention has recently been devoted to the cultivation of research. There are both general and departmental libraries, an excellent museum, and all necessary teaching accessories.

Clinical Facilities: The school has recently perfected a very intimate relationship with the new Toronto General Hospital, by which its faculty obtains complete control of the clinical advantages of some 500 beds. Students have free access to all wards, clinical laboratory, dispensary, etc. Other large local hospitals—general and special—are also available.

Date of visit: March, 1909.

MONTREAL: POPULATION, 467,730.

(6) McGill University Medical Faculty. Established 1824. An organic department of the university.

Entrance Requirement: The University School Leaving Examination, strictly enforced. The medical course covers five years.

Attendance: 328.

Teaching Staff: 99, of whom 19 are professors, 80 of other grade. Ten instructors devote their entire time to teaching.

Resources available for Maintenance. The department has separate endowments aggregating \$350,000, and is assisted out of the general university funds. Its fees amount to \$43,750; its budget, \$77,000.

Laboratory Facilities: The laboratories having been recently injured by fire, the school is now waiting completion of its new buildings, for which ample funds have been secured. Meanwhile its temporary quarters, well equipped for both teaching and research in all departments, show what energy and intelligence can

accomplish in the face of disaster. The anatomical and pathological museums are among the most famous on the continent. The school possesses an excellent library, and all necessary teaching accessories.

Clinical Facilities: These are excellent. The school enjoys a most favorable relation to two large hospitals, of about 500 beds, besides several other institutions. Students work freely in all the wards and clinical laboratory.

The dispensary service is large and admirable.

Date of visit: March, 1909.

(7) Laval University Medical Department. Organized 1878. The university connection is not intimate.

Entrance Requirement: Indefinite, depending on the prospective location of the student.

The medical course covers five years.

Attendance: 217.

Teaching Staff: 8.

Resources Available for Maintenance: Fees, most of which are distributed among the teachers.

Laboratory Facilities: Chemistry is given by the university. Anatomy is limited to dissecting. A single laboratory with meagre equipment is assigned to pathology, bacteriology and histology. There is a library and a small collection of specimens, not all labeled.

Clinical Facilities: The school has access to two hospitals, containing together 250 beds. The dispensary has a fair attendance.

Date of visit: March, 1909.

QUEBEC: POPULATION, 70,000.

(8) Laval University Medical Department. Organized 1848. An organic part of Laval University.

Entrance Requirement: Indefinite, depending on the student's prospective location. As most graduates locate in the Province—French being the language of instruction—they must comply with the Provincial requirement. The medical course covers five years.

Attendance: 92.

Teaching Staff: 22.

Resources Available for Maintenance: Fees and an appropriation by the university.

Laboratory Facilities: Instruction in chemistry and physics is provided by the university; in the medical building recent, though not extensive, laboratory provision is made for anatomy,

histology, bacteriology and pathology. There is no experimental physiology or pharmacology. A library for students and a museum have been started lately. The buildings are admirably kept.

Clinical Facilities: Clinical instruction in medicine, surgery and pediatrics is given at the Charity Hospital (Hotel Dieu) to the free wards of which the faculty serves as staff. The amount of material is limited in quantity; the staff rotates monthly. The hospital contains a clinical laboratory, in which instruction is given in connection with ward work. The fifth year, now required, and a proposed reorganization of staff and teaching arrangements promise to improve the instruction. Obstetrical opportunity is abundant.

The dispensary has a sufficient attendance.

Date of visit: October, 1909.

Personals

Dr. James Third, of Kingston, has left for a brief trip through Europe.

Dr. William W. Ogden is removing from Spadina Avenue to Bloor Street West.

To be Physician to His Majesty's Household—Sir Robert William Burnet, M.D.

To be Sergeant-Surgeons to His Majesty—Sir Frederick Treves, Sir Richard Havelock Charles.

To be Physicians in Ordinary to His Majesty—Sir Francis Henry Laking, M.D.; Sir James Reid, M.D.; Sir Richard Douglas Powell, M.D.

To be Honorary Surgeons in Ordinary to His Majesty—Rickman John Godlee, F.R.C.S.; Anthony Alfred Bowlby, F.R.C.S.; Sir William Watson Cheyne, F.R.S.

To be Physicians Extraordinary to His Majesty—Sir Thomas Barlow, M.D.; Sir William Henry Allehin, M.D.; Bertrand Dawson, Esq., M.D.; Sir Alan Reeve Manby, M.D.

Dr. W. Lehman, formerly of this city, is now in Vienna paying particular attention to obstetrical work.

Drs. Gibb and Willinsky, Toronto; Gunn, Kenora; and Kelly, Hamilton, are taking courses in Vienna, Austria.

Dr. Allen Baines left for England about the middle of last month. He will attend the British Medical Association meeting to be held in London.

Dr. G. Sterling Ryerson has left for Paris, where he will spend some weeks in studying radium therapy under Drs. Wickham and Degrais. He expects to return by September 1st.

Dr. F. A. Clarkson, of Toronto, having spent six weeks at the celebrated post-graduate clinics in Vienna, will visit Paris and London, and return to Toronto about the first of October.

Miss Robina Stewart, of Pittsburg, has been appointed Medical Superintendent of the Toronto General Hospital Training School for Nurses in the place of Miss Mary A. Snively, resigned.

Miss Stewart is a Canadian by birth, her early home being in Guelph, where her father resided. She received her nurse's training at the Johns Hopkins Hospital, Baltimore, where she graduated in 1901.

She remained there four years after graduating, during which time she was head nurse of the private wards in the hospital. She then left for the Middle West, where she studied the methods of various Training Schools for Nurses. For the last four years she has been in charge of the Training School for Nurses, of the Alleghany Hospital, Pittsburg.

Dr. C. A. Hodgetts has been appointed a Medical Officer for the Dominion Conservation Commission. He was recently honored when in Washington by being elected President of the Executive of the State and Provincial Boards of Health.

Dr. Adam Wright was tendered a dinner by about 40 of his personal friends prior to sailing for England, where he will attend the meeting of the British Medical Association, after visiting the Rotunda Hospital, Dublin, will visit the principal cathedral cities of England. He is accompanied by two of his daughters, and expects to return to Toronto about the middle of August.

Dr. J. A. Amyot, director of the laboratory of the Provincial Board of Health, has been appointed by the Board of Governors to be Professor of Hygiene at the University of Toronto, to succeed Dr. Wm. Oldright, who resigned earlier in the year. Dr. Amyot has been Associate Professor of Hygiene for some time, and the promotion will not interfere with his duties for the Provincial Board of Health.

The following promotions were made on the staff: Dr. W. H. Piersol, to be Associate Professor of Histology and Embryology; Dr. K. C. McIlwraith, to be Associate Professor of Obstetrics.

Obituary.

WILLIAM ALEXANDER HACKETT, M.B.

Dr. W. A. Hackett died suddenly at his home in Grimsby, May 25th. Dr. Hackett graduated M.B. from the University of Toronto in 1894. He first located at Stony Creek, and after practising for some years in that village, he went to Grimsby, where he practised up to the time of his death.

WILLIAM STEWART DOWNEY, M.D.

Dr. W. S. Downey, of Chicago, Ill., died suddenly in that city, June 1st. He was educated at Victoria Vollege, Cobourg, Ont., and graduated B.A. from that Institution in 1863, and M.D. in 1865.

After graduating he practised in St. Catharines for a number of years, and then went to Chicago, practising there until his death.

OSCAR C. DeWOLF, M.D.

Dr. DeWolf, who was Commissioner of Health of the City of Chicago for 12 years, died March 28, 1910, at his home in Chester Centre, Mass. During his Commissionership in Chicago, he made several visits to Toronto. While a resident of Chicago, he was Professor of State Medicine and Public Hygiene in the Chicago Medical School.

DR. WILLIAM HENRY GRAHAM

Dr. W. H. Graham died June 21st at his home, 1 Clarence Square, Toronto, as the result of an attack of pneumonia. He was ill but three days. He was born in Toronto 61 years ago.

He graduated from the University of Toronto and became a member of the College of Physicians and Surgeons in 1871. A wife and four children survive him.

ROBERT KOCH

Robert Koch, the famous bacteriologist, and one of the leading figures in medicine, died May 27 at Baden-Baden, of heart disease, in his sixty-seventh year. Since the passing of Pasteur and Virchow, Koch has been undoubtedly the most widely known man in the medical sciences, and his death marks the passing of an era. The rise of Robert Koch from an obscure practitioner of medicine to the position of one of the greatest benefactors of mankind, with the coveted title of Professor and the directorship of a special Institute for Infectious Diseases, was almost meteoric.

Robert Koch graduated in medicine from the University of Göttingen in 1866, and 12 years later, while a practitioner in a country town, published fundamental researches on anthrax and upon wound infections. In 1882 he published what was undoubtedly his greatest work—the discovery of the cause of tuberculosis and the use of solid media for the cultivation and isolation of bacteria. His work on the tubercle bacillus was remarkably complete and little short of marvelous, when one considers the difficulty with which this organism is cultivated and stained, and the comparatively primitive methods of that time. The introduction of solid media for the culture of bacteria was a stroke of genius stimulated by the necessities of his work. It is upon these two achievements, especially, that Koch's fame will rest.

The *St. Louis Republic*, speaking editorially of Koch, says:

“An eloquent American astronomer once characterized the change wrought by the spectroscope in the astronomer's attitude to the mysteries of the stars. He pictured the watcher of the skies standing under the spangled vault, looking up at the wheeling hosts with the steady gaze of comprehending recognition, and saying: ‘All hail, Aldebaran, I know thee! Hail, Betelgeuse, I know thee!’”

“No less epoch-making is the work of Robert Koch in another realm—one that touches the burdens of humanity much more nearly than can any knowledge of the stars. Thanks to his researches, humanity can front the deadly apparition of tuberculosis, can face that pestilence that comes to us from Asiatic coasts, with the courage of knowledge instead of the terror begotten by baffling mystery, the panic of the dread unknown. ‘I know thee’ says the pathologist of to-day, in the face of these awful foes of the race.

“The first great step in the conquest of disease is to know the foe and locate the seat of his power; the discovery of a specific is the next. It is perhaps not too much to say that the first task is the more difficult of the two, since to take it successfully is to reveal the path along which the curative agent must be sought. Already the prophylaxis of consumption and Asiatic cholera has greatly increased in effectiveness by reason of Koch’s bacteriological discoveries; it would be strange if this generation of men should wholly pass without the discovery of specific curative agents.

“This has been a great age in the medical world. Virchow and Koch and Klebs and Loeffler have taken disease out of the thaumaturgic realm and revealed to us its real character. We know now that we are fighting not phantasms created by our own fears or influences of stars, or mysterious ‘evil airs,’ but micro-organisms as in diphtheria and tuberculosis, or degenerate cell growths as in cancer.

“Of Robert Koch it may be said that he lengthened the span of human life, substituted knowledge for bewildered ignorance, and buttressed the courage of the race in the reasonableness of the natural order.”

Book Reviews

Minor and Operative Surgery, Including Bandaging. By HENRY R. WHARTON, M.D., Professor of Clinical Surgery in the Woman's Medical College, Philadelphia. New (seventh) edition, enlarged and thoroughly revised. 12mo, 674 pages, with 555 illustrations. Cloth, \$3.00, net. Lea & Febiger, Philadelphia and New York. 1909.

That this work has reached its seventh edition is in itself a compliment to the author. We hope in the eighth edition, however, to see some changes: Keep more to minor surgery, bandaging, detail, etc., and omit much of the operative procedure, major work. The technique and methods have to be too curtailed to be of value. It is an epitome. What is needed in this direction is a work for the student and young practitioner on minor work. On page 233 the illustration is obsolete. No graduate for the last ten years would recognize it is a needle-holder. If it is advisable to illustrate needles, and we think it is, do it thoroughly, and describe what the different ones are used for, and why. We fear that Murphy would hardly think justice had been done his method of continuous rectal saline by the description on page 619. The eversion in sac in hydrocele, as described is most obscure, and misnamed. The eversion, or bottle operation, the simplest and best, is not described at all. We are not finding fault, but pointing out what we consider to be defects which should be corrected.

The Principles of Pathology. By J. GEORGE ADAMI, M.A., M.D., LL.D., F.R.S., Professor of Pathology in McGill University and Pathologist to the Royal Victoria Hospital, Montreal; late Fellow of Jesus College, Cambridge, England; and ALBERT G. NICHOLLS, M.A., M.D., D.Sc. F.R.S. (Cam.); Assistant Professor of Pathology and Lecturer in Clinical Medicine in McGill University; Out-patient Physician to the Montreal General Hospital; Assistant Physician and Pathologist to the Western Hospital, Montreal. Vol. II., Systemic Pathology; 1,084 pages, 310 engravings and 15 plates. Lea & Febiger, Philadelphia and New York.

In this, the second volume, we have dealt with the pathologic changes as they affect the many systems of the body. These are taken up in order—Cardiac, Respiratory, Alimentary, Nervous,

Glands, Urinary, etc., etc.—each most exhaustively considered. The bulk of the volume must not deter one from reading it. The reading is easy; the writing is in an easy style, so different from the usual volume on pathology. The authors, while not departing from the generally accepted division of the subject, have certainly served the details to us in a much different manner. It is not a student's work; he has not the time; but his training should place him in a most enviable position to grasp all that is newest and best in the science, not hampered by too much condensation, nor expanded beyond the necessity of completeness of description. It is too bad that this work cannot be adopted as a text-book, but no student could master its details in the time at his disposal, and the examiner would have too wide a field to exercise his prerogative. To be able to write such volumes is not only an evidence of great scientific attainments, but of great literary ability. To be able to impart scientific information on a subject usually so dry is a rare gift, and we, as Canadians, can justifiably be proud that the most complete work on the Principles of Pathology is from the pens of professors in a Canadian university. The typography, paper, binding, and, by no means least, the illustrations, are of the very highest standard.

Correspondence.

THE STATUS OF MEDICAL MEN UNDER THE NEW INSURANCE BILL

To the Editor of THE CANADIAN PRACTITIONER AND REVIEW:

DEAR SIR,—For upwards of three years this Act, in some form, was before the Parliament of Canada. Ample time was, therefore, taken to consider every section, and note carefully its bearing upon the interest affected. There was thus given also an opportunity for those who wished to offer any suggestions or raise any objection to place their views before the Government.

When the Life Insurance Bill was laid on the table of the House of Commons it at once became apparent that there were three clauses that were very objectionable from the standpoint of the medical profession. These clauses were in the first draft, and are still in the Act as passed by Parliament.

Under "Interpretation" or the definitions at the beginning of the Act we have:

(h) "Officer" includes the manager, secretary, treasurer, actuary and any other person designated as "officer" by the by-laws of the company.

In section 98, sub-section 4, dealing with life insurance companies that were in operation when the Act came in force, we read:

"The manager of the company may be a director of the company, but no agent or paid officer other than the manager shall be eligible to be elected as a director. The words "paid officer" in this sub-section do not include the President and Vice-President, or the President and First Vice-President, if more than one, elected under the provisions of sub-section 9 of this section.

The next clause to which objection was raised by many medical men deals with life insurance companies that may be organized after the passing of the Act. It is as follows:

Section 146, sub-section (F): "The manager of a company may be a director, but no agent or paid officer other than the manager shall be eligible to be elected as director. The words "paid officer" in this paragraph do not include the President and Vice-President, or the President and the First Vice-President, if there is more than one Vice-President elected under the provisions of paragraph (K) of this section."

It became quite apparent that the purport of these clauses would prevent any medical practitioner from being a director of the company for which he acted as medical adviser, if for such advisory work he received any remuneration.

Medical officers of the various companies in Toronto held a meeting and appointed Dr. T. F. McMahon and myself to lay their views before Hon. W. S. Fielding, the Finance Minister, and the Committee on Banking and Commerce, which was then engaged in the consideration of the bill, clause by clause, and also in the hearing of the opinions of those interested in the bill. Dr. McMahon and I visited Ottawa and laid the views of the medical directors, given us personally or by letter, from all over Canada, before the Finance Minister, Mr. Fielding, and the said committee. What we said on that occasion is to be found in the proceedings of the House of Commons, and will stand upon its own merits.

In addition to this many letters were written to Mr. Fielding and the other members of the Government, and to prominent members of the Opposition, and also to many members of the Senate. All this had no effect, and the Insurance Bill was put through both the Commons and the Senate in the form as quoted in the foregoing clauses.

In the spring of 1909 it was expected that the bill would then be put through both Houses of Parliament. In addition to every effort that had been made, I sent the following telegrams:

“Toronto, 13th May, 1909.

“*Sir Wilfrid Laurier, Ottawa:*

“I challenge the right of Parliament to say that the medical profession of Canada cannot be trusted. The Insurance Bill states this. It allows other classes to receive salary and sit on the boards, but forbids medical men doing so. The bill should be amended to remove this glaring injustice.

“JOHN FERGUSON.”

“Toronto, 13th May, 1909.

“*Hon. W. S. Fielding, Ottawa:*

“The Insurance Bill a great injustice to medical men of Canada. It declares them unworthy of trust and cannot sit on boards of companies if they receive any remuneration for services. Other classes may receive salary and sit on boards. This is taking away a privilege when no good can be accomplished thereby.

JOHN FERGUSON.”

The bill was laid over, however, for that session, and came up again during the session of last winter. As the bill came

back from the Senate it contained the objectionable clauses, so far as medical men are concerned. I then wrote Hon. W. S. Fielding, who had charge of the bill, as follows:

“Toronto, 5th March, 1910.

“*Hon. W. S. Fielding, Ottawa:*

“DEAR SIR,—The Insurance Bill is now about complete. On the whole it is a good bill, and will do much for the interests of these great financial companies.

“There is one phase to which I wish again to call your attention. The bill provides that only the President, the Vice-President and the Manager may be on the board and receive a salary.

The effect of this is to force the medical directors off the boards of their companies, because these gentlemen receive a remuneration for their services.

“It does seem too bad that an entire class should be placed under the ban of the law in this way. The Act means that no doctor, because he is paid for his services, may sit on the board of his company.

“Business men, lawyers, etc., may fill the offices of president, vice-president, and manager; draw salaries and sit on the boards of their companies. Not so with the doctor.

“This is not fair, and I ask you if you think it is? If it is not fair and just, then change the bill to do the right thing by the medical men.

“Yours truly,

“J. FERGUSON.”

The medical profession is now put in possession of the facts. So far as the Act is concerned, the meaning is quite plain that there is not a doctor in Canada that does not come under the penal terms of this Act. No matter what his interest in a life insurance company, by way of stock or insurance may be, the law states that he cannot sit on the board of directors, if he receives any salary for his responsible duties as medical officer of his company. The manager may receive any salary the company pleases to pay. So may the president and vice-president. These gentlemen, in the eyes of the law, can be trusted to do their duty, and that the remuneration they receive will not blind their eyes; but not so in the case of the doctor. As soon as he receives a salary, he can no longer be trusted. He cannot hold a seat on the board.

There is, perhaps, one loophole through which the doctor may escape the penalties placed upon the whole medical profession

by this Act. The first clause which I have quoted states that the word "officer" includes the manager, secretary, treasurer, actuary, and any other person designated as "officer" by the by-laws of the company.

If the medical advisor of any company can induce his board to pass a by-law to the effect that he is not an "officer," indeed, may be ranked with the office-boy in status, then, perhaps, he may escape technically the meaning of this Act. This is still doubtful, and may remain so until the courts decide a case. One thing is clear, namely, the medical advisor of a life insurance company, if he is dignified with the title of an "officer," cannot occupy a seat on the board. No other class is so treated. While the bill was before the House of Commons and the Senate, a number, including the writer, made every effort to have the objectionable clause deleted from the bill, but without avail. Therefore it is that the whole medical profession is placed in a class by itself, and, in the eyes of the Life Insurance Bill, a disqualified class; or one of the rank of the office-boy; that is, if the doctor is to hold a seat on the board of his company and receive any salary, he cannot be called an "officer."

I am, yours truly,

JOHN FERGUSON.

264 College St., Toronto.

Selections.

Pernicious Vomiting of Pregnancy

Adam H. Wright, Toronto, Canada, refers to Dr. Whitridge Williams' demonstration of the nature of the disturbances of pregnancy which cause toxæmia and pernicious vomiting. Chemical examination of the urine in such cases shows a decrease in the amount of nitrogen excreted as urea and an increase in the amount excreted as ammonia. Wright reports a case in which the ammonia coefficient rose to 14 per cent., though Williams has expressed the opinion that if the ammonia coefficient rises to 10 per cent. the patient's life is endangered and the pregnancy should be terminated. The treatment instituted by Wright was as follows: It was found that a hypodermic injection of one-quarter of a grain of morphine had no effect, and it was thought that a large dose might quiet those nerve centres, which, like so many specks of dynamite, were causing a vicious circle of explosions within the digestive tract, and especially in the stomach. Consequently one-half grain of morphine was administered hypodermically; and, shortly afterward, calomel was given, one grain every hour for four doses. This treatment produced satisfactory results. The patient had some sleep during the night, and felt fairly well the next morning—better than she had felt for a month before. The nausea returned, however, during the forenoon, and she had a very bad afternoon. It was then decided to give larger doses of morphine. Accordingly one-half grain was administered hypodermically at 9 p.m., one grain of calomel was given by mouth half an hour after, and as the morphine had not produced sleep another quarter-grain was administered between 10 and 11 p.m. The patient had a comfortable night, slept well, and felt comfortable and happy the next morning. As the nausea returned each afternoon this treatment was continued for five more nights, with such excellent results that on the seventh day from the commencement of this treatment the patient had no nausea or vomiting. During this week she had five grains of morphine administered hypodermically, and eleven grains of calomel by the mouth. Although at this time (October 7) the general condition was vastly improved, the ammonia coefficient was still fairly high—8.2 per cent. After this less morphine was administered at bedtime for five days, after which it was stopped entirely. Calomel was given occasionally during the remainder

of the pregnancy. After November 1 the patient enjoyed excellent health until she reached full term, May 8. In accordance with my custom during the last five years, of inducing labor at term or within two or three days after, labor was induced May 10, when a healthy child was born. At the time of writing (nearly nine months later) mother and child are both well.—*Journal A. M. A.*

Pharmacology of Agar-agar

An interesting article on this subject appears in *American Druggist*, 56, 291. After mentioning the history of the substance, its composition (chiefly the carbohydrate gelose), its use as a culture medium and in toilet preparations, the article proceeds to explain its modern uses in habitual constipation, quoting Gompertz's satisfactory results in administering the substance to patients in 15 gram doses morning and evening. The article closes with mention of the fact that the proprietaries Cascara-agar Jelly and Regulon are combinations of the substance with extract of cascara sagrada; that Laxigen consists of agar, sugar and phenolphthalein; and that Rhamnagar consists of agar and extract of buckthorn.—*Ex.*

The Use of Oil in Abdominal Surgery

Experimental and clinical evidence has lately been brought forward of the value of introducing a sterile oil into the peritoneal cavity both for the purpose of delaying absorption of the toxins of peritonitis and for the prevention of post-operative adhesions.

Wilkie (*Surgery, Gynecology and Obstetrics*, February, 1910), in his work has found sterile vaseline oil to be one of the best agents for the purpose, for unlike most oils it can be sterilized at a high temperature without decomposing and is absolutely uniritating.

With regard to post-operative adhesions, the following are the writer's conclusions, based on experimental evidence:

1. After aseptic abdominal operations without rough handling of viscera, adhesions are little likely to form.

2. Simple abrasion of peritoneal surfaces without infection may, but seldom does, lead to permanent adhesions.

3. Infection of the peritoneal cavity may clear up and leave no permanent adhesions.

4. Abrasion of peritoneal surfaces in infective cases generally leads to permanent adhesions.

5. When denuded surfaces are left after breaking down abdominal adhesions, the introduction of sterile oil into the belly cavity lessens the chances of re-formation of the adhesions.

6. When sterile oil is introduced into the peritoneal cavity at the same time that an experimental peritonitis is produced it has very little beneficial effect on the course of the disease. Glisson has shown, however, that if the oil is introduced some hours before the infecting organisms, it exerts a distinct protective influence by raising the defensive powers of the peritoneum.

7. The ileus which occurs so frequently and is so fatal in cases of general peritonitis is partly due to a weakening of the peristaltic power of the wall of the gut by toxæmia, but added to this there is the mechanical obstruction due to multiple soft adhesions; these, indeed, are the predominating factor and can, to a large extent, be prevented by the widespread diffusion of oil between the intestinal coils at the time of operation. In addition this tends to prevent the formation of localized purulent pockets and promotes free general drainage.—*Birmingham Medical Review*.

An Excellent Investment

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