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## THROMBOSIS OF THE FEMORAL VEINS FOLLOWING ASEPTIC LAPARATOMY.

BY

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It is my purpose to report the following case, not on account of any peculiarities associated with the diagnosis or treatment, but entirely because of an unexpected and unpleasant complication, occurring after convalescence had become well established.

Mrs. V., æt. 35, consulted me in November, 1902, regarding a double hernia.

The History that she gave indicated that the rupture on the left side had been present for twelve years, during which time she had worn a truss, which had only imperfectly retained the protrusion, especially during heavy work. On the right side the hernia had only been present a few weeks, was gradually becoming larger, and was the seat of considerable pain.

On examination a condition of bilateral oblique inguinal hernia was found, the mass descending easily on both sides during straining efforts, and being as easily returned.

Excepting this condition the patient was in perfect health, there was no discoverable cardiac, renal or pulmonary lesion, no anemia, nor were there any varicosities of the superficial veins of the lower extremities. Operation was advised, but owing to extraneous causes was not carried out until the third week of January in the present year.

At that time Bassini's operation with McEwen's treatment of the sac was done on both sides under one etherization. The round ligaments were found large, and inseparably blended with the sac wall. They were accordingly dissected from their pubic attachments, and puckered up with the sac.

Contrary to my expectations the operation on the right side proved much the more difficult, the sac being more adherent to surrounding structures, and a small part being divided off by a septum to form a small hydrocele with insignificant fluid contents. For these reasons

there was much more handling of the tissues, and more extravasation of blood on the right side than on the left, the time occupied being quite twice as long.

The whole operation was carried out under the strictest aseptic technique, including the use of rubber gloves. A flat table was used and there was neither Trendelenburg position, nor flexion of the knees or hips.

A moderately firm double spica bandage was applied, but as this caused some little irritation it was replaced after the first day by a many-tailed bandage firmly pinned across the hips, and this owing to its tendency to slip was changed for adhesive strips.

Early convalescence was entirely uneventful, and the temperature never went above 100F., nor the pulse above 90; the wounds were not dressed until the tenth day when the stitches were removed, primary union having occurred throughout on both sides in the most satisfactory manner. I may be pardoned for emphasizing the fact that there was absolutely no redness, induration or tenderness around either of the wounds. On the next day some slight pain was complained of in the right groin but it disappeared without treatment.

On the twelfth and thirteenth days considerable sharp shooting pain was complained of in the left groin, popliteal space and calf of leg. On the fourteenth day a hard indurated tender cord could be made out occupying the position of the upper end of the long saphenous vein. A diagnosis of venous thrombosis was made, the leg elevated, and moist heat applied to assist in the establishment of the collateral circulation. Up to this time there had been absolutely no fever; on this day, however, the temperature rose to 99 2-5F., and on the next to 101 deg., at which height it was maintained for nearly a week. The pulse rate was increased in proportion but was not elevated before the temperature as Singer's (1) investigations would tend to show occur in phlegmasia alba dolens. The condition ran a more or less benign course, the temperature becoming normal on the twenty-third day, but considerable pain and stiffness in the leg persisted for some weeks longer. During the height of the process there was considerable œdema in Scarpa's triangle, but at no time was there any at the ankle.

The condition was then in short an extensive venous thrombosis involving the left saphenous and femoral veins, following two weeks after an aseptic operation, with typically aseptic wound healing. Moreover it occurred on the left side, where the less extensive operation had been done, where there was less handling of the parts and less hæmorrhage, but where a truss had been more or less constantly worn for twelve years.

It is not my intention to go into an extensive discussion of the various theories to explain venous thrombosis, which have been advanced from time to time, as for instance by Hunter, Virchow, and Brucke, but on looking into the literature of the subject I find that there are a few articles dealing specifically with this special condition, such as those of Schenck (2), Willy Meyer (3), Coe (4), and Van der Veer (5), in English; and of Lennander (6), of Upsala, Strauch (7), of Moscow, Wyder (8), and Leopold and Mahler (9), in German.

All of these authors consider more or less briefly the question of the special etiology of this condition, aside from the question of the etiology of thrombosis in general.

Infection, mechanical obstruction to the circulation, as by tight bandages, loaded bowels, flexed thighs, traumatism during operation, as by retractors, causing the formation of more or less extensive hæmatomata, are among the commonest causes on which special stress is laid.

Strauch after considering his cases remarks:—"It appears therefore that the specific working of the ether, plus the high pelvis position has brought about this unpleasant complication."

Lennander believes that the possibility of compression of the respective veins by the dressing, as also the possible coagulation of blood in the veins of the lower extremity as the result of constipation, should be avoided. He further considers that the condition is partly at least due to mechanical obstruction of the circulation, and advises elevation of the foot on the bed after operation, and maintenance so during the whole time of convalescence, as a preventive measure.

The majority of the writers on the subject consider that infection is the most probable cause, though as Meyer puts it; "the infection need not start from the operative field, but may originate elsewhere, especially in the intestinal tract." Schenck concludes that "the facts that they have not followed pus cases, and that the condition occurs occasionally after operations on the appendix, gall-bladder, or right kidney, cases in short where the site of operation is more or less removed from the site of the thrombosis, are points difficult to explain under the theory of infection." This criticism may be offered of Schenck's conclusion—that the very cases he cites as illustrative of the improbability of infective origin, are themselves often infective. Thus in both Willy Meyer's appendix cases more or less acute peritoneal inflammation was present, and Meyer consequently agrees with those who consider infection to be a causative factor of the complication under discussion; and he points out the possibility that a few bacteria coli, or staphylococci

may have lain dormant in adhesions, and been stirred into life by the manipulatory efforts connected with the operation.

In speaking on this point it is interesting to note that at a discussion recently held before the Paris Society of Surgery (10), M. Jalaquier, and M. Brun both reported three cases of left femoral thrombosis occurring in the course of appendicitis, and connected, not with the operation itself, but with the condition calling for operation, since in two cases the only operative measures used were the evacuation of abscesses. The editor of the *New York Medical Journal* says (11) in this connection, "left femoral thrombosis may yet come to be regarded as of diagnostic significance in obscure cases in which only the possibility of appendicular inflammation can be affirmed."

In a large percentage, however, of the cases to which I refer, neither wound infection nor inflammatory disturbance in other parts of the body, enters into the subject, since nearly all the wounds follow a typically aseptic course, as in the case reported, and in many at least, there is no evidence of infective conditions elsewhere. In the above case also the fact that the pain and induration caused the diagnosis to be made, before there was any distinct elevation of temperature shows that an infective origin is improbable. The bowels had been well cleared out and were maintained so, after the operation, so that distension of the sigmoid with faecal mater and absorption therefrom is not probable as a cause. Again the fact that out of Schenck's forty-eight cases only four occurred before the tenth day, would seem to cast doubt on any infective nature, since we should expect this to manifest itself earlier.

Moreover, that the elevated temperature is not in itself evidence of an infective origin is pointed out by Meyer in these words: "in the case of a thrombosis, changes in the blood within the thrombosed vessel, as well as in the tissues immediately surrounding it, may have set in, and from these areas poisonous albuminoid substances may be absorbed by the system, and thus produce rise of temperature and increased action of the heart."

In considering Schenck's case, one is struck, as he was, by the large percentage following operations for the removal of tumours, especially since, as he says, these are not the cases in which there is the most traumatism, the most loss of blood, or the greatest chance of infection. Twenty-eight of his cases, or fifty-eight per cent. followed the removal of large tumours, myomata or ovarian cystomata, while in addition, five followed radical operation for carcinoma uteri, and one, including a hysterectomy for pelvic inflammatory disease, a total of thirty-four cases, where it is possible to conceive that there was very distinct alteration in the pressure relations before and after the operation. Of the total this

represents seventy-one per cent. Feeling that this change of pressure might have some causative influence in at least a share of the cases, I have so far as possible looked up the reports with the following results:—

AUTHOR.	No. of Cases.	CONDITION.	SIDE.	RESULT.
Schenck .....	4	Perineal repair.		Recovery.
	19	Hystero-myoinectomy.		"
	9	Ovarian cystomata.		"
	5	Hysterectomy for carcinoma.		"
	3	Suspension.		"
	4	Suspension with repair.		"
	1	Hysterectomy for inflammation.		"
	3	Miscellaneous.		"
Lennander .....	5	Appendectomy.		"
Willy Meyer .....	2	Appendectomy.	Left.	"
Strauch.....	1	Hystero-myomectomy.	"	"
	1	Right ovarian cyst.	"	"
	1	Large tumour of left ovary.	"	"
Van der Veer....	1	Angioma of lobus Spigelii.	"	"
	1	Large bilateral ovarian tumours.	"	"
	1	Large fibroid, filling pelvis.	"	"
	1	Recurrent Appendicitis.	"	"
Coe .....	1	Perineal operation with removal of both adnexa.		
	1	L. oophorectomy, appendectomy.		
	1	Cyst of l. ovary, appendectomy.		
	1	Left dermoid, filling abdomen.		
	1	Cyst of ovaries.		
	1	Operation for inversio uteri.		
	1	Trachelorrhaphy.		

Sixty-nine cases, divided as follows:—Appendectomy, eight; perineal, five, while for the removal of abdominal tumours, whether benign, malignant or inflammatory there were forty-four or sixty-four per cent.

The reports of Wyder and of Mahler and Leopold were also consulted, but they are concerned rather with the occurrence of post operative pulmonary embolism, arising both from crural and pelvic thromboses, most frequently the latter.

In this connection I must recall the fact that in the above reported case a truss had been worn for many years, and was only permanently removed at the time of the operation. Again the bandages owing to some degree of restlessness on the part of the patient, were only lightly held in place and exercised no pressure over the wound. Adding then this case to the above there are seventy cases, forty-five of which or sixty-five per cent. followed conditions of decreased pressure.

If, however, we subtract from these seventy cases those in which, as for instance the appendix cases, there was undoubted infection in other parts of the body, we have left sixty-two cases of which forty-five or seventy-three per cent. were dependant on operations which brought about conditions of lessened local tension.

All of the writers on this subject have emphasized the late occurrence of this complication. Of Schenck's cases twenty-five occurred between the twelfth and the sixteenth day, and this perhaps may be taken as the average period.

Mahler and Leopold in their article call attention to the fact that when a large neoplasm is removed the intra-abdominal pressure sinks and the pelvic veins become dilated. This condition cannot but predispose to the formation of thrombi in these veins since all the surroundings are favorable, injured vessel walls from trauma, and slowed current from the dilatation. Hence we may suppose that thrombi form, and gradually spread from smaller to larger vessels, until either the internal or the external iliac vein is involved. It would of course take some considerable time for this condition of slowly spreading thrombosis to reach the larger vessels hence the usual late occurrence of the complication.

Another hypothesis which might be advanced would be that the decreased pressure allowed the exudation of large amounts of serum and blood into the tissues, which former coagulated and finally became organized, thus producing a secondary or late pressure on the veins.

Regarding the treatment of this state when it arises, nothing new can be offered. Elevation of the limb, and moist heat to favour the formation of the necessary collateral circulation seem best to meet the indication. Lennander's suggestion as to prophylaxis by elevation of the foot of the bed would seem difficult to carry out. Moreover it would assuredly make nine hundred and ninety-nine patients uncomfortable in order that one might have a little better chance of escaping this complication. Again Van Buren Knott (12) reports 326 cases of laparotomy treated post-operatively by elevation of the head of the bed (Fowler's position) without any increased tendency to phlebitis. If, however, the above quoted facts are of any value, and if deductions can be safely drawn therefrom, it would seem advisable to support the abdomen rather more definitely than is usually done, especially after the removal of large tumours. After hernia operations it would appear to be well to exercise a certain degree of direct pressure over the wound area, probably most comfortably carried out by a well applied spica of crinoline.

From a consideration of the above statements it is probable that the following conclusions may be safely drawn:—

(1). No one etiological factor is alone responsible for the occurrence of this complication.

(2) The role of infection in otherwise non-infective cases, does not appear to be an important one.

(3) Conditions of sudden decrease of pressure dependant on the operation, probably have a causative influence.

(4) Treatment should be prophylactic, as by avoidance of unnecessary traumatism, of hæmorrhage, or of suddenly decreased tension, as by having the wound area well supported by firmly applied dressings.

(5) So far as I am aware there has been no mortality in the reported cases, but the occuranec of pulmonary embolism in a certain proportion warns us that this termination is not an impossible one.

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### PYO-NEPHROSIS OF LEFT KIDNEY—NEPHROTOMY; RENAL CALCULUS OF RIGHT KIDNEY—NEPHRO-LITHOTOMY.

BY

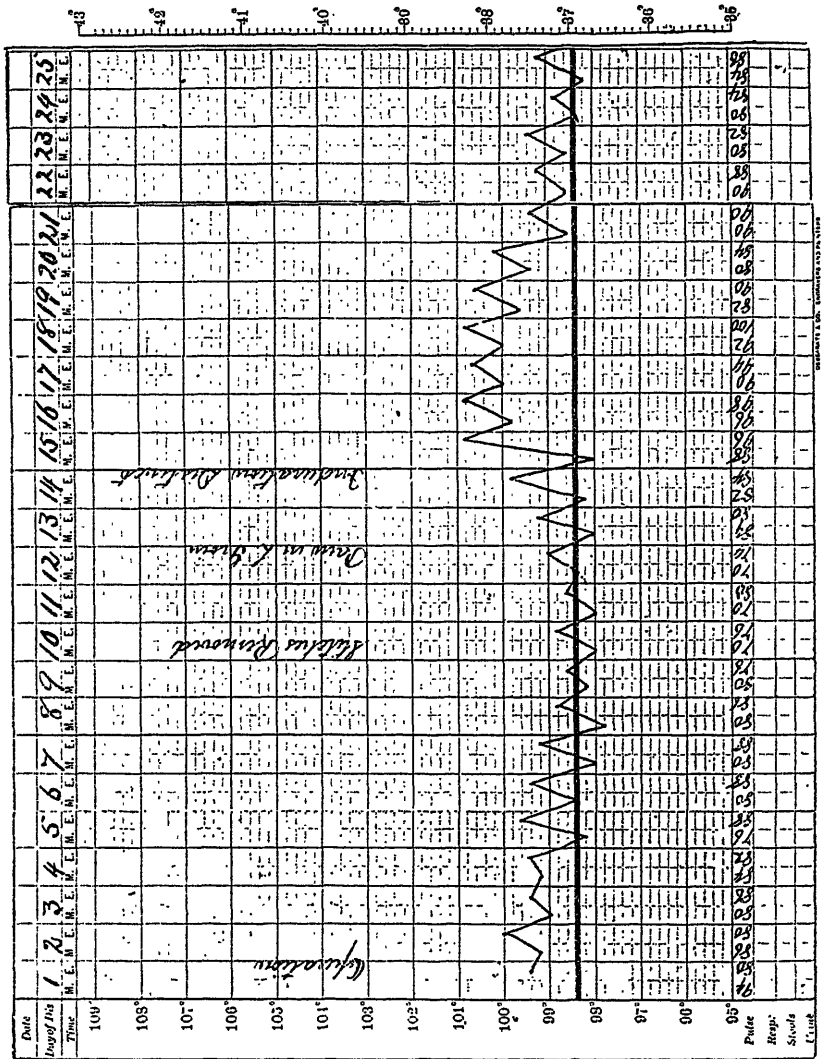
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Mrs. D., age 34, married, was admitted to the Victoria General Hospital on February 18th, suffering from a large tumor in the left hypochondriac and left lumbar regions. The following history was elicited from her: Born in England, but lived in Nova Scotia for the past twenty-two years; was married fourteen years ago, has five children living and one dead, until after the birth of her last child patient generally enjoyed good health, she had been threatened with abortion the first four months of her three last pregnancies and she has had a good deal of difficulty with her three last confinements. Four months before her last child was born she suffered greatly from irritability of the bladder, and noticed blood in the urine, but had no pain in voiding it, nor afterwards. The urine was very foul and contained a whitish deposit and ropy mucous. Her physician ordered her to bed, and put



her on appropriate treatment, but her condition remained unchanged, till after the birth of her child when the urine became normal in colour, but the sediment remained. Since the birth of her child on the 5th November, she has had pelvic pains, chiefly in the left iliac region, and



a feeling of weight, also a dragging sensation in the lower part of the stomach. Exercise aggravated these symptoms. About three weeks before being admitted to the hospital, she experienced a chilly feeling with flashes of heat, and anorexia, she vomited occasionally, she also

suffered from back-ache which was worse on walking about, and had an occasional attack of indigestion and flatulence after food.

Patient looked healthy when she was admitted to the hospital. Her appetite was poor, she had no pain on micturition, but she had at times a constant desire to make water, and had had to get up often at night for that purpose. Bowels were fairly regular, the circulatory and respiratory systems were normal. Patient had a large tumour in the left hypochondriac and left lumbar regions, and it extended from the lower ribs down to a little below the umbilicus. It was as large as a child's head, and extended a little to the right of the mesial line of the abdomen. The tumour caused a distinct prominence. Percussion elicited a dull note, but there was no evidence of fluctuation. The dull note remained unchanged with the changed positions of the patient. The mass was painful and tender on percussion and practically immovable, and the muscles over it were quite rigid. She was unable to lie comfortably on the healthy side.

We kept her under observation for ten days, getting her ready for operation during which time the urine was examined on various occasions. The quantity of urine voided on an average every twenty-four hours was about 40 ounces. It contained an enormous amount of pus; fully half of it was pus.

The following is the result of an analysis made of the urine on two different dates:—

February 19th, urine foul-smelling and turbid; colour straw; reaction, alkaline, Sp. Gr. 1015; albumen present: heavy whitish deposit abundant: crystals, calcium oxalate; pus abundant; blood cells and epithelial also present; no casts.

February 23, colour opaque yellow; odor foul; reaction, faintly alkaline; Sp. Gr. 1022; large amount of albumen present after two filtrations; about half the amount of urine voided in twenty-four hours was a thick pus coloured deposit; pus cells present in abundance; no casts.

February 24, patient is passing an enormous quantity of pus with the urine.

February 26. Amount of pus in urine remains unchanged, pain and tenderness on left side still.

Operated on the 28th of February and removed from the left kidney about  $1\frac{1}{2}$  pints of very foul smelling pus. Chloroform was the anæsthetic used. The usual incision for a lumbar nephrotomy was made. It began at the outer edge of the erector spinæ,  $2\frac{1}{2}$  inches from the spinous processes, and extended outward, downward and forward parallel with and half an inch below the 12th rib. On dividing the muscles and fasciæ, and making my way through the circumrenal fatty tissue, I

came down upon a well defined cystic tumour. There was little or no evidence present of perinephritic inflammation, old, or recent.

The kidney which was converted into a unilocular cyst was cut into, and its contents evacuated, and the abscess cavity was well irrigated with warm boracic solution. The secreting substance of the kidney was apparently all gone, no trace of the origin of the ureter was found. In view of the conditions present, I did not consider it advisable to make any prolonged search for it. I then inserted a good sized rubber drainage tube into the kidney and brought the anterior and posterior ends of the incision together with a few sutures, and dressed the wound, antiseptically; bleeding was very slight. Patient stood the operation well. The further progress of the case was uneventful till the 17th March, when the patient complained of pain and tenderness in the right lumbar region at MacBurney's point. On examination a tumour was felt here, but on account of the tenderness of the mass and the rigidity of the abdominal muscles, it could not be mapped out.

From the 28th of February till the 17th of March, her temperature ranged between normal and 99.5.F. and her pulse between 80 and 100 and good. The quantity of urine voided on the following dates was: On 28th February, 10 oz.; on March 1st, 33 oz., and on the 2nd of March, 49 oz. From this date until the 27th March, the quantity voided daily, amounted to 32 or 33 oz. on an average. The amount of pus present became gradually less, but never disappeared, altogether.

The following records were made by the house surgeon: March 19th, patient doing well, pain and tenderness in *right* lumbar region persist. It looks as if there was another abscess on this side.

March 26. Discharge from wound is now clear and has a urinous odor. Urine about the same as for some time past.

March 27. Tumour in the region of the right kidney, can be felt distinctly, but the tenderness is so great that it is impossible to make out anything definite about it without an anæsthetic. Since the operation the quantity of pus diminished from  $\frac{1}{2}$  to 1-12 the bulk of urine voided.

Performed nephro-lithotomy on the 28th March, four weeks after the first operation. The anæsthetic used was chloroform. Upon the abdominal muscles being relaxed thoroughly I examined the tumour bimanually before proceeding with the operation. It occupied the right lumbar and iliac regions, and its surface was smooth and indurated, and the mass was three times the size of a normal kidney. The lower end of it extended to the brim of the pelvis on the same side. In shape it was oblong and very slightly moveable. It was now evident the tumour was not a pyo-nephrotic kidney, which I thought it might be before I was able to make a careful examination of it under an anæsthetic.

I turned the patient at once upon the left side with a pillow under the loin and exposed the right kidney by the usual incision for a lumbar nephrotomy. Its surface was smooth and glassy and had a dark-red hue. In appearance it looked like a healthy kidney, but much larger and very congested. There was no evidence of inflammatory adhesions in the circumrenal tissue. On removing from the field of operation all the perinephritic fat, I examined the organ carefully, its surface was, hard, smooth and even and in isolated spots somewhat doughy. The kidney was then explored with a needle which elicited a distinct grating noise. The point of the needle came against a hard, firm, unyielding substance. I now laid the kidney open by making an incision about three inches in length along its convex border, and grasped the organ with its contained calculus, with my right hand in front of the abdomen and pressed it upward and backward against the finger and thumb of my left hand which were held firmly on the edges of the wound in the kidney. In this way the stone was slowly and gently squeezed out of its bed without inflicting any undue damage on what was left of the secreting substance of the organ. It was a bimanual procedure. The calculus was firmly adherent to the substance of the kidney. Forceps were of no avail to dislodge it. Roughly the stone measured  $4\frac{1}{2}$  inches in length, 3 inches in width and  $2\frac{1}{2}$  inches in thickness and weighed  $13\frac{1}{2}$  oz. (av.) It was oval in shape. A terrific gush of blood immediately followed the removal of the stone and the patient became suddenly collapsed, whereupon I quickly grasped the kidney in my right hand and introduced my left into the wound to plug it up and so check the hemorrhage, but it had little effect upon the bleeding. It was venous oozing. Something more had to be done to save my patient, so I speedily run three of my fingers up into the cavity of the kidney and to my surprise I found I had come upon a mass of gravel. I scooped out quickly 28 small calculi each the size of a small sized bean and faceted, and also blood clots, and packed the cavity firmly with sterilized gauze. This controlled the hæmorrhage. In the mean time every thing possible was being done to rally her by means of artificial heat, hypodermic injections of brandy and of strychnine nitrate, and by enemata of concentrated coffee and brandy and by bandaging and elevation of the lower extremities. In a few moments the patient rallied a little and two or three stitches were hurriedly inserted into each end of the lumbar incision and the wound dressed antiseptically. A large pad was placed over the kidney under the abdominal bandage to keep pressure upon the organ and the patient was removed to the ward in a very weak condition. Her respirations were, however, good and regular although slow, but the pulse was very small and frequent. It was very unsteady. At times it was fairly good in volume, but in a few minutes afterwards it

could not be counted. Injected one pint of normal saline solution into the rectum after which the pulse temporarily improved in volume and regularity. This was at 1 p.m. At 2.15 the pulse again became very small and she was given subcutaneously in the pectoral region one pint of normal saline solution and at 2.30 atropine gr. 1-120, morphine sulph gr. 1-12, and nitrate of strychnine gr. 1-30, hypodermically. Her temperature was 99° F. and pulse between 150 and 160, and very small. At 4 p.m. the nurse made the following record:—"Pulse still too weak to count and quite regular." At 4.15 the following enema was given:—brandy, one ounce, spr. ammon. arom, half ounce and concentrated coffee three ounces; 6 p.m., pulse stronger and patient resting quietly; 7 p.m., pulse much stronger. For the first six hours after the operation gr. 1-30 of strychnine nitrate was given hourly, and an enema of concentrated beef tea and brandy every two hours. At 7.45 the nurse entered the following record on the chart:—"Patient seems very weak and complains of pain in the region of the wound by spells, but rests quietly greater part of the time." After this her condition gradually and steadily improved. She had a very good night, slept four hours. At 6 a.m. the 29th, her pulse was 96, temp. 98.8, respirations, 21. Voided since the operation 7½ ounces of urine. An interesting feature of her case was the ease and regularity with which she breathed, notwithstanding the profound shock from which she suffered.

On March the 30th, I removed the packing and irrigated the cavity of the abscess well with warm boracic solution and inserted a large rubber drainage into the kidney and packed the wound all around it with iodoform gauze. There was no bleeding. The profuseness of the discharge, which was largely decomposed urine, made it necessary for the dressing to be changed the first ten or twelve days, every two hours.

From the 30th of March until the 7th of April, her temperature ranged between 100 and 101.4° F., and pulse between 118 and 128; respirations were about 23. Quantity of urine voided on 30th of March was 33½ oz.; on 31st, 33 oz., and between the 1st and the 6th of April from 22½ to 28½ oz. per diem.

From the 6th till the 30th of April, pulse stood between 90 and 100 and temperature between normal and 99.6° F. The minimum and maximum quantity of urine voided during the same period, per diem (24 hours), was 18 oz. and 37 oz.

Result of an analysis of the urine on the 9th of April:—Color, light yellow (turbid); odor normal; reaction faintly acid; sp. gr. 1009; albumen present after filtration; pus cells in abundance; epithelium in abundance; heavy whitish deposit; crystals triple phosphates.

During the month of May and until she was discharged on the 26th

of June, the average amount passed daily would be about 24 oz.—minimum 15½ oz., maximum, 29 oz.

An analysis made on the 15th of May gave the following results:—Color pale; odor urinous; reaction acid; albumen present also heavy whitish deposit; pus cells and crystals present; spr. gr. 1010.

From the first of May her health improved steadily and uninteruptedly. On the 10th she was allowed to sit up in the chair.

June 19th, urine still comes in considerable quantity from the right sinus. On the left side only pus appears on the dressings.

To test the potency of the ureters on June the 20th a few c c of methylene blue, representing about one gr. was injected into the fistula on the right side through a small catheter. In 1½ hours the urine, the first which was passed afterwards, was coloured a deep blue. On the 23rd of June, the methylene blue test was applied to the left side with completely negative results.

The patient left the hospital on the 26th of June feeling well and looking healthy. The two sinuses were still discharging.

On July 20th I received the following report of her condition:—“Saw Mrs. D. and she feels very well.” Results of an analysis of urine voided same date. Color pale; odor urinous; reaction faintly acid; sp. gr. 1005; albumen present after filtration; moderate amount of heavy whitish deposit; pus and epithelial cells a few; no crystals or casts; quantity about 25 oz.

The points of interest in the case are: 1. The entire absence of the most prominent symptoms characteristic of renal calculus; 2. the enormous size of the stone; 3. the small amount of healthy secreting kidney structure which is capable of maintaining life under adverse conditions.

With reference to the first point, I may state that renal calculi may and do exist and give rise to no special subjective symptoms, but this is not usually the case. Mr. Henry Morris records a case in which a calculus had grown quietly to such a size as to be felt by palpating the abdomen without giving rise to any special symptoms. Bruce Clark refers to thirteen cases of quiescent calculi out of twenty-four post-mortems and Mr. Murray, of Cape Town; Noble, of Philadelphia, and Doran of London, have each reported cases of painless renal calculi.

Then again the symptoms caused by renal stones may not be referred to the kidney or ureter. On the contrary they may be transferred to other organs. Cases of renal calculi are often treated for cystitis. A very interesting case is referred to by Mr. Morris in which a vesicovaginal fistula was maintained for nearly ten years, to relieve a supposed case of cystitis, but at length a renal calculus was removed and

then the fistula was closed without any return of the symptoms, and the patient recovered perfect health.

The pelvic pains and cramps (flatulence), from which my patient suffered were no doubt reflex from the kidney affections, for these symptoms have all disappeared since the operation.

As regards the second point—the enormous size of the stone, I may say that the largest renal calculus I find recorded weighed 10 oz. It was removed by Henry Morris, of London. He also mentions having removed from the right kidney of a man a stone which weighed about 2 oz. 6 drs. (1333 grs.), and from the left, one that weighed 1 oz 1 ℥ (513 grs.) Mr. Fostner, of Tunbridge Wells, removed one that tipped the scales at 18 5 dis. (822 grs.), and Mr. Day, of Norwich, at 2 oz 6 drs. 1331 grs.) Dr. Shepherd, of Montreal, reported in the *Philadelphia News*, April 23, 1887, having removed a stone that weighed 4 oz. 7 drs. and measured 3½ inches in length and 9 inches in circumference. It was composed of triple phosphates. The stone which I now show you weighs 13½ oz. (av.) This does not include the 28 small calculi removed at the same time.

What is of interest about the third and last point is, that the left kidney was converted into a unifocal cyst cavity with no secreting substance left, and that all the secreting substance left of the right was a layer apparently half an inch in thickness which encircled the stone. The medullary position seemed all gone—and still even this small amount was not only able to maintain life under ordinary conditions, but was capable to withstand the extra strain incidental to two major operations.

During the past two months the average amount of urine voided daily has been 24 oz., and still the patient feels well and looks healthy.

In reporting this case I do not claim to have anything new to offer to the association, but I do think it possesses sufficient interest to warrant my putting it on record.

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## HYSTERECTOMY FOR CANCER OF THE UTERUS.

BY

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Like most other surgical procedures this operation has undergone a decided evolution and improvement within the last few years, along the line of increased thoroughness. The lesson was learned, in the development of the operation for mammary cancer, that the glands and fat of the axilla must be entirely removed. Moreover it was found that the

raw surfaces of the wound must be protected from inoculation with the cancerous infection and for this reason great care is taken not to cut into the diseased mass, nor even to sever the lymphatics which run from the breast to the axilla, but to remove them and the whole of the diseased or suspected tissues in continuity.

These lessons are evidently applicable to the operation for removal of the cancerous uterus. Although this organ is completely isolated for a large part of its surface, and can be easily removed in toto, with little immediate mortality, yet the final results were disappointing.

Long series of cases were published, showing that nearly all the patients finally died of cancer, recurrent, or rather persistent, and extending in parts which were already affected at the time of operation, although such involvement in disease had escaped observation. This is precisely the condition of things which obtained in regard to mammary cancer before the operation was perfected as mentioned above. The lessons from analogy have been heeded and our procedures have been improved accordingly.

Of the two ways by which the uterus can be removed, through the vagina or through the abdominal wall each has certain decided advantages, so that it is not always easy to determine which method it is better to adopt.

The first procedure to be elaborated and to be described with precision was Freund's total abdominal extirpation of the cancerous uterus (1878), but the immediate mortality of this operation was so great that it did not commend itself to surgeons, and not even the technique of tying off the broad ligaments was adopted for hysterectomy for myoma until some twelve years afterwards.

Czerny in 1878 revived vaginal hysterectomy and was followed by Billroth and A. Martin in 1880. A large number of operations were performed, and the mortality was comparatively so low that vaginal hysterectomy gained great favor and by 1885 it had become the accepted operation for cancer of the uterus, under the enthusiastic advocacy of A. Martin, who visited this country in 1887 and performed the operation here several times. In 1888 the writer published twenty-one consecutive cases with two deaths, using clamps. Other surgeons also published series of cases, with very good results, soon after.

Nevertheless there were drawbacks. Some cases were complicated by adhesions of the appendages, not readily distinguishable from infiltrations of the broad ligaments. In some the vagina was narrow, or the tuberosities of the ischia too near together. In some the body of the uterus was large and friable and foul. In some cases the condition of the patient seemed worse than the state of the uterus would account



for, and it was very important to know whether there was a spread of the disease internally. The clamps which were largely in use were painful, and there was much discharge from the vagina after operation, so that hospitals became infected, from this, and from the discharges from the stumps of abdominal hysterectomies, which then were performed with extraperitoneal ligature and fixation of the cervix. There was great longing for a proper and satisfactory means of removing the whole uterus from above.

Then came 1890 and the Trendelenburg position, which changed everything. By 1892-3, total abdominal hysterectomy for fibroids was firmly established at the great meetings of the American Gynecological Society in those years. Thus the possibility was given of safely removing the cancerous uterus from above, substantially after the method of Freund. This procedure had failed in the beginning for want of the elevated position of the pelvis, for want of thorough asepsis and for want of all the little improvements in preparation, technique and after-treatment, which meanwhile had been reducing the mortality of ordinary supravaginal hysterectomy for myoma from 60% to 5%.

In the reaction which ensued from vaginal in favor of abdominal hysterectomy many surgeons abandoned the former entirely, and removed the uterus, and as much of the vagina as might be necessary always from above. But there were still disadvantages connected with this action. The cancerous cervix was septic; and it was necessary to cleanse, curette and cauterize it before it was safe to lift it out through the abdominal wound. Many cases died, and in fact more than by vaginal hysterectomy. This led to further developments of the preliminary vaginal work, so that it grew into a removal of the diseased cervix and separation of the upper part of the vagina, with closure of the vaginal flaps over the stump of the cervix, before opening the abdominal cavity from above.

When all this vaginal work was done, however, it was hardly worth while to make an abdominal incision, except in a few cases, for ordinarily it was possible to pull down the uterus and tie off the broad ligaments and make a finished vaginal hysterectomy without clamps.

In 1895 the writer went to Paris to study the improvements in vaginal hysterectomy made by the French surgeons, and for the next two years he critically compared the vaginal with the abdominal methods in a great variety of affections of the uterus, with the result that he became convinced that the vaginal procedure, although valuable in a certain limited number of cases is much inferior as a method of election to abdominal hysterectomy. In cancer of the uterus he was led to begin the operation by opening the abdomen in certain cases in which it was

doubtful whether the conditions would warrant a hysterectomy, owing to resistance in the broad ligament, or other symptoms, which might indicate that the disease had extended into the pelvic tissues.

Adopted first in difficult and doubtful cases, this soon became his regular procedure, first examining the pelvis from the inside, and then, if the disease had not proceeded too far, going on to tie off the broad ligaments and sever all the connections of the uterus in the pelvis, and then, after closing the abdominal wound, finishing with a very simple division of the vagina above the limit of disease and extraction of the uterus and closure of the wound in the vaginal roof.

The superiority of this method in difficult cases will be easily appreciated by anyone who has witnessed or performed a vaginal hysterectomy where there were complications or difficulties. Moreover it combines the advantages of opportunity to reject cases unsuitable for operation, and avoidance of septic infection of the abdominal cavity and cancerous inoculation of the wound-surfaces, with the possibility of removing the glands which may be already harboring the advanced guard of the cancer.

Werder of Pittsburgh, has lately published a detailed account of a modification of this method. He carries the dissection down all around the vagina so far that he can push the whole uterus and appendages down into a position of prolapse. Then he unites the peritoneum above it, joining the cut edges so as to close the abdominal cavity completely below. The abdominal incision is next closed, and finally the prolapsed uterus is easily removed by severing the inverted vagina with the thermocautery.

In further attempts to improve the remote results of the operative treatment of cancer of the uterus, in the year 1895 Ries devised and Rumof performed the removal of the tissues at the base of the broad ligament and the glands at the bifurcation of the iliac arteries, thus shutting off one great cause of relapse, and following out the analogy of the axilla. At about the same time Clark of Johns Hopkins was working along the same lines and in the next year he published his work in the bulletin of that university, and thus contributed largely to the use of the new methods in this country.

Unfortunately, however, these methods are still too little used. Too many cases are operated on too late. In too many, diseased glands are left, and far too often the cut surfaces of the vagina and broad ligament are rubbed full of cancer juice, so that the permanent results of the operation are not what they should be, and eventually will become.

On the other hand vaginal hysterectomy has incontestable advantages in certain cases. It can be performed very rapidly, especially by

the use of clamps, involving of course less shock, the whole duration of the operation being 5 to 15 minutes.

It is easiest of performance in very fat elderly women, with capacious vagina; just the cases in which the perfected abdominal operation is inconvenient or unadvisable. Although not the method of election it is therefore indicated in cases.

*a.* Where the strength of the patient will not permit a thorough abdominal operation.

*b.* When the patient is very fat and the disease is quite recent.

*c.* *Provided* in either of these cases the uterus is quite movable, and there is plenty of room in the vagina and between the tuberosities of the ischia, and it is possible to remove all the diseased tissue in the vagina before opening up wound surfaces.

Within these rather restricted limits there is still a field for vaginal hysterectomy for cancer, but as a rule we should look to permanent results, which are best attained by painstaking and thorough operation through the abdominal incision.

Where such procedure is contraindicated or impossible, it is best not to attempt the terrible and difficult vaginal operation in advanced cases, but to fall back on palliative methods such as thorough curettement and careful cauterization, or the use of zinc chloride, etc. The patients will live as long or longer, and surgery will benefit in the end, because every such case will be a warning to patients to apply for operation earlier in the course of the disease, while every radical operation followed by death or quick relapse only discourages patients from submitting to hysterectomy even in suitable cases.

Whether it is best to perform any operation on the diseased cervix, as a preliminary to opening the abdomen, must depend on the nature of the case. The main point to keep in mind is that any incised or raw surface which is made will be likely to become inoculated with the cancer. Therefore the only reason for interfering with the cervix before opening the abdomen is the fact that there is a growth in, or springing from the cervix, so large as to interfere with the abdominal work. If this is the case the diseased tissue should be rapidly scraped away, the hemorrhage checked with the cautery and the parts cleansed and tamponed with a strip of gauze soaked in peroxide of hydrogen. If the patient is weak this may be done several days before the main operation, and it is wonderful to see the improvement in strength and nutrition which will ensue after the removal of the foul mass.

On the other hand, one must not wait too long with the hysterectomy, for the patient feeling relieved is likely to refuse further operation, and all the while the infection of the lymphatics is steadily progress-

ing, all the more rapidly from opening the lymphatics in curettement. Just before the hysterectomy, however, the vagina is well washed out with an antiseptic, so that if it is opened inadvertently from above there will be as little risk as possible of infection.

As soon as the abdomen is opened, the patient being in the full Trendelenburg position, the first thing in order is to make a careful examination of the abdominal viscera and the tissues in the pelvis, in order to find out whether the conditions are such as to warrant the complete operation. After looking at the mesentery and omentum to see whether there are any little cancerous nodules, the broad ligaments are carefully palpated, and if they are infiltrated one must decide whether there is a possibility of removing all the diseased tissue. If the infiltration extends clear to the pelvic wall, forming an immovable mass, further operation is contraindicated.

The region of the bladder and the course of the ureters is likewise carefully examined. If by the skill of the operator, or his assistants, it is possible to have catheters put in the ureters, before opening the abdomen, this part of the examination, as well as the most difficult part of the operation will be greatly facilitated. Nevertheless, with care and discrimination and good anatomical knowledge it is possible to dispense with catheterization of the ureters, and thus the time of anæsthesia is shortened. The ideal procedure is to slip catheters into the ureters, under cocaine, before the ether is given.

The next point to examine with attention is the bifurcation of the iliac arteries on each side, for here lie the glands which are first invaded in cancer of the cervix. If these glands are simply enlarged the operation is warranted, but if they form an immovable packet, involving the iliac veins, it is necessary to abandon the operation. Surgically it is possible to tie the common iliac vessels, but it is not justifiable in such cases. The patient will probably die, and if by chance she live it is morally certain that the disease will recur, for the infection will already have passed so far that the diseased tissues cannot all be removed.

By a careful examination of this kind it will be found inadvisable to perform any radical operation in many cases, in which the uterus might be removed with more or less difficulty per vaginam. The patients will thus be spared unnecessary shock, and the surgeon will avoid dangerous and useless interventions, with unfortunate and distressing sequelæ. On the other hand some cases which seem most unpromising by vaginal examination, where for instance the broad ligaments feel hard, and there are immovable masses in the pelvis, are found on examination through an abdominal incision to be perfectly feasible for hysterectomy.

omy, since they are simply cases of cancer of the cervix complicated with pelvic inflammation, adherent tubes, etc.

In removing the uterus the ovarian artery and the artery of the round ligament should be carefully tied, without gathering together the tissues between them, as is often done in hysterectomy for myoma. It is desirable to open widely the space at the side of the uterus in order to facilitate the subsequent steps of the operation.

After careful and very thorough separation of the bladder in front, and of the connective tissue at the sides, the uterine artery is secured as far from the uterus as possible. It is just here that the skill and anatomical knowledge of the operator is most needed.

The ureter runs just under the uterus, crossing it obliquely, and must on no account be injured. The lateral vaginal arteries come off from the uterine, and the ligature should be placed on the proximate side of the origin, close to the internal iliac, in order that the further steps of the operation may be comparatively bloodless, and to facilitate the clearing out of the gland—containing fat around and below the ureter.

Proyer recommends that ligatures be placed on the main trunks of the internal iliac arteries, thus rendering the whole field of operation bloodless. To make sure against recurrent hæmorrhage from anastomosis he ties the uterine, obturator and superior vesical arteries also. It seems to be proved by his experience that both internal iliacs may be ligatured in continuity without causing any tissues to slough. Nevertheless it can hardly be said that surgical opinion, as yet, favors the ligation of the internal iliacs although if experience shows that shock is not unduly increased and that collateral circulation is always established, there are many advantages in this brilliant procedure. The origin of the internal iliacs must be exposed in the perfected operation in order to remove the glands which lie about it, and it is really easier to tie this artery than to trace the uterin back to its source and to tie it there, deep in the pelvis and close to the ureter.

The uterus being removed the bladder gets sufficient nourishment from anastomosis with branches of the superior hæmorrhoidal artery while the gluteal and perineal region is supplied with blood from anastomosis with branches of the deep epigastric and of the circumflexa femoris in other branches of the femoral artery.

I have never found it necessary to tie the trunk of the internal iliac, although I have sometimes tied the anterior branch, thus suppressing the circulation in the uterine and vesical and vaginal arteries, but not interfering with the gluteal, ilio-lumbar and lateral sacral arteries.

The uterine arteries having been tied and severed the uterus can be

lifted up, carefully sundering the utero-sacral ligaments and the rest of the peritoneal attachments of the uterus. Traction on the uterus lifts the floor of the pelvis, and the ureter is next carefully dissected out and pushed forward. Next the thickened tissues around the cervix and vagina are gently enucleated with the finger, and all fatty tissue, which is presumably gland-bearing, is dissected away from the floor of the pelvis. This procedure is carried on until the uterus is only connected with the body by the vaginal tube, which in turn is to be separated from its surroundings as far as may be deemed necessary.

In very simple and clean cases the upper part of the vagina, including all the cancerous tissues, may be shut off with two clamps on each side, and the vagina divided between the clamps. The stump is now carefully cleaned and pared and united with catgut, and the peritoneum closed over it. If the stump of the vagina is so short that this would leave too much space between the vagina and the peritoneum, the former may be drained with gauze, instead of being sewed together.

If the disease is at all advanced it is better not to open the vagina, but to push the uterus down and afterwards to remove it from below. If the dissection has been carried as far as Werder recommends it is possible to close the peritoneum over the uterus, but this involves a deep and difficult dissection, with considerable danger of cutting into the vagina, and thus risking infection. It also leaves the woman substantially with no vagina, which is often a matter of importance.

I am accustomed to free the uterus and the upper part of the vagina and then to sew a pad to the fundus uteri and pushing the uterus down as far as possible to pack the pad into the bottom of the pelvis. This checks oozing and keeps the intestines out of the way when the uterus is finally removed.

Formerly this dissection was deemed sufficient and the abdomen was closed, but the analogy with the axilla requires us to remove all the glands, in order to extirpate the furthest lurking places of the disease.

To accomplish this the edge of the broad ligament, where the stump of the ovarian artery is held by its ligature, is lifted up and the peritoneum is divided with blunt scissors, or on a director, sufficiently to reach the bifurcation of the iliac artery, or about three inches.

The ovarian vessels follow the flap which is lifted up. The ureter must be found as it comes up from the side of the pelvis, substantially parallel with the *iliaca interna*. The ureter is freed and pushed downward and inward, disclosing the fat and glands at the bifurcation of the vessels. These tissues are carefully removed, just as in the axilla, by the fingers, or by teasing them out with a clamp or with a forceps without sharp teeth. The arteries are not easily injured but the great

veins must be respected, for if they are torn we are in the presence of a surgical accident of some gravity. The internal iliac vein may be tied without bad results, but in the only case reported (by Kelly), in which the common iliac vein was torn, although hæmorrhage was stopped by successfully tying the vein, yet the leg became gangrenous.

All visible glands and all fat which may contain glands having been removed, the cut in the peritoneum on each side is united with catgut as far down toward the bladder as possible. The peritoneum is cleansed, all sponges removed and the ureters laid as far as possible in their proper positions, the omentum is pulled down and the abdomen closed.

Next the patient is placed in the lithotomy position and the uterus is pulled down, the everted vagina is carefully cleansed and disinfected, and the diseased tissues enveloped in a pad wet in bichloride solution. The vagina is then severed well above the disease, when the uteria is pulled out, followed by the pad which has been sewed to the fundus.

The free edges of the pelvic peritoneum are easily found, brought down and united with catgut, although this is by no means essential.

The vagina is tamponed with gauze and for the last twelve years I have always used a convenient adaptation of the Miculicz packing for tamponing the vagina in cases of vaginal hysterectomy. A square of gauze is seized by the middle with a clamp and introduced as far as may be necessary. The gauze is then fitted with the fingers to the pelvic space and into the bag thus formed strips of gauze are introduced sufficiently to stop all oozing. This method has the advantage that the strips may be removed singly on the next day, relieving pressure on the bladder and rectum; but the bag remains for several days until the raw surfaces are completely roofed over by adhesions.

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## THE TREATMENT OF NASAL DEFORMITIES BY SUBCUTANEOUS INJECTION OF HARD PARAFFIN.

BY

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At the meeting of the Canadian Medical Association in September, 1902, I had the privilege of reading a short paper on the subcutaneous injection of paraffin wax, and of exhibiting two patients that I had subjected to that treatment; since that a much wider experience of the method has been gained, the technique improved and some of the results obtained by Eckstein, Paget and others, are I venture to suggest little short of marvellous.

Melted paraffin wax has been used with success to overcome many



TWO DAYS BEFORE TREATMENT.



FOURTEEN DAYS AFTER TREATMENT.



TWO DAYS BEFORE TREATMENT.



FOURTEEN DAYS AFTER TREATMENT.



physical deformities; but it is, with reference to the suitability of this method in the treatment of nasal deformities that I beg to draw your attention today and show photographs taken before and after treatment of four of my cases. Sunken or what are known as saddleback noses of diverse degrees of flatness and ugliness, the result of destruction, wrought by congenital or acquired syphilis, tuberculosis or traumatism, have been built up and made presentable, if not handsome, by this method.

In carrying out the treatment the following are the essential points:—

*The Melting Point of the Paraffin.*

When Gersuny, the father of paraffin prosthesis, published his first results in 1900, he recommended paraffin melting at 104°F. Eckstein, who enthusiastically took up this work, and experimented on animals with paraffins of higher melting points, came to the conclusion that paraffin melting at 132°—140°F., gave better results. In July last, I injected 10 c. c. of paraffin melting at 102°, 107° and 112°F. beneath the subcutaneous tissue of the noses of each three rabbits. The shape of the nose of the rabbit injected with paraffin at 112° has remained unchanged, in the others the result has not proved satisfactory. The nose of one of my first patients built up on the 6th of September last with paraffin melting at 104°F. has remained unchanged in outline and the appearance of it is now better than it was a few weeks after the operation, when I exhibited the case at the Montreal meeting.

In the two cases I have recently treated I used paraffin melting at 112°F. and I believe paraffin at that melting point will prove most satisfactory for the following reasons: 1st. It is easy to work with; 2nd. It can be injected at a temperature (of 118°—120°F.), which does not endanger the vitality of the tissues, by burning. 3rd. It becomes a solid substance at the time of, or a few seconds after injection. and of a permanent hardness in 15 or 20 minutes, and with the exception of slight shrinkage (which is common to all paraffins), retains its original shape, unaffected by fever temperature.

*The Best Syringe*—A 5 c.c. solid metal syringe with a metal piston having both a push and screw action answers the purpose well; the syringe and proximal part of the needle should be covered with rubber tubing to retain the heat. The needles should be  $\frac{3}{4}$  to 1 $\frac{1}{4}$  inches long, curved or straight, and the calibre about that of an antitoxine needle.

*Preparation of the Paraffin Syringe and Needle.*

These must be sterilized and placed in a bath of sterile lotion at 120°F. until required.

*The Operation* can be done without an anæsthetic, under a local

anæsthetic, but by preference under general anæsthesia. Immediately before injecting the paraffin the syringe is filled and tried, and a few drops of hot water drawn into the needle, the point of the needle dipped in boiling water for two or three seconds and inserted at once into the tissues. The needle puncture should be made  $\frac{1}{2}$  inch or more from the depression and carried subcutaneously a little beyond the point of greatest deficiency, making sure that the sides and root of the nose are firmly compressed, to prevent escape of the paraffin into the loose tissue near the inner canthi, and on to the forehead. The piston is then slowly and continuously compressed or screwed in, until sufficient paraffin has been injected, meanwhile the point of the needle can be moved about as desired. After a few seconds the needle is withdrawn. In two or three minutes the paraffin becomes firm and the assistant can remove his fingers, but the operator must continue moulding the nose to the desired shape for fifteen or twenty minutes when the paraffin becomes thoroughy set. Should the needle clog before sufficient has been injected, it must be withdrawn, cleaned and the operation repeated. Usually it is best to insert the needle from near the point of the nose.

*The After Treatment.* Flexile collodion is applied to the needle punctures and a lint dressing placed over the nose. If swelling of the nose or œdema of the eyelids occurs cold compresses should be applied, and the swelling will disappear in three or four days.

*The quantity of paraffin required,* varies with each case, (enough being used to correct the deformity so far as possible), the amount necessary in nose cases is usually between 2 and 8 c.c.’

#### *The Dangers of Paraffin Injection.*

Accidents following the injection of paraffin have been few, only two of a serious nature having been reported in European and American literature, in relation with this operation so far as I have been able to learn; in both the cases mentioned there was loss of sight in one eye shortly following injection. The first of these was reported by Leiser in April, 1902, and the other by Hurd, of New York, on the 11th of this month. In Leiser’s case, thrombosis of the ophthalmic vein followed injection. In Hurd’s case, embolism of the central artery of the retina is said to have followed. This, I think, is an anatomical impossibility unless the patient had a patent foramen ovale. Many cases have now been reported in which no accidents have occurred. Of these 29 are by Paget, and 19 by Eckstein. A suppurating point appeared in one of Bush’s cases, but after the pus escaped, healing occurred, the ultimate result being good.

Congestion of the skin over the paraffin will follow when too much has been injected but this hyperæmia disappears in one or two months. In my first case a small superficial slough, the size of a pea, formed in the skin of the nose, the result of high tension, but it separated, and left no disfigurement. The greatest danger of this treatment is undoubtedly venous embolism which I believe is a preventable accident if sufficient care be taken in performing the operation. The chief facts in favour of this method of dealing with nasal deformities may be reviewed:—1st, that nasal deformities the result of destruction, or non-development of the nasal bones, which have not previously been treated successfully by any other method can be obliterated. 2nd, that after some experience in working with paraffin the operation is easily performed and gives little or no pain. 3, that results are good and the risks few.

I think it can now be justly claimed, that the subcutaneous injection of paraffin has acquired a firmly established reputation for the correction of many nasal deformities and many persons who were rendered conspicuously hideous from flat or sunken noses and were constantly made to feel their misfortune by the remarks and stares of those with whom they came in contact, have at least been rendered unnoticeable by this treatment and to many of these the knowledge that they are no longer oddities but presentable persons, has brought a feeling of self-respect and a cheerful expression denoting much happiness, not previously experienced.

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### WILLIAM ERNEST HENLEY—POET AND PATIENT.

BY

J. G. ADAMI, M.D.

There is a little green backed "Book of Verses," by W. E. Henley which should be—but somehow is not—known and treasured by every medical man who finds occasional solace in literature. For the booklet, published in 1888, opens with some thirty short pieces grouped together under the title "In Hospital," and these portray in language so vivid and intimate, so singularly apt, the episodes of hospital life from the point of view of the patient, that their appeal to us is immediate. They are surely unique. Another and greater poet, Paul Verlaine, in "Mes Hôpitaux," has given us vignettes of a like order but then in prose: there is nothing that approaches Henley's impressions penned from the sick bed in the old Edinburgh Infirmary, that Hospital—

. . . grey, quiet, old,

Where Life and Death like friendly chaffers meet,

in which for eighteen months or more he lay, a patient in Lister's wards.

Why the verses are not better known has been a mystery to me ever since they came to occupy a place on my shelves. I have often thought to bring them to the notice of those who read these pages but desisted, doubting whether an article on such a subject might not come as a "bolt from the blue." Henley's death—a week ago—(on July 11th) seemed to afford the right occasion—and forthwith I found that medical men were not alone in their lack of knowledge of Henley and his work. In a great northern English centre, wealthy, very prosperous, a university city, to boot, I spent hours visiting the chief shops for books, both first and second-hand, and never a copy of the "Book of Verses" could I obtain. At one large and long established departmental store, I was gravely informed at the poetry counter, that they did not know any writer of that name, and certainly had never been asked for his works; at another book shop, the first in the city, Henley was known, it is true, and I was offered his last volume—but neither the "Book of Verses" nor his collected poems were obtainable. They did not keep him because he did not sell; he was a disappointment and more than one of his works had proved a drug and had had to be sacrificed at any price. And this on the very day when every reputable paper in Great Britain from *The Times* downwards devoted two to three columns to an obituary and critique of our author, acknowledging him freely to be one of the masters of the late Victorian era. Verily the poet has fallen upon evil days. His lute is played more subtly, his themes and melodies are more varied than ever, but the children of the market place are heedless of his song. But in this case the song seems worth heeding.

It was in 1874 that Henley entered the wards of the old Royal Infirmary at Edinburgh. He was then at twenty-five, after having graduated with distinction at St. Andrews, a struggling writer of verses and contributor to the "Cornhill," under the editorship of Leslie Stephen. There for close upon two years—a weary time for a man of active mind and Bohemian habits—he remained under treatment by Lister for what I gather must have been tuberculous arthritis, a period so long that the hospital and hospitalism sunk into his being. His impressions written upon the sick bed were only published some twelve years later, and then in a little book of "Voluntaries," edited by Mr. H. B. Donkin, for the benefit of a hospital in the East End of London. Later they were incorporated in the "Book of Verses" published that same year.

To make the work known I shall quote freely.

Here first is Henley's entrance to the hospital he was to know so well:—

A small, strange child—so aged yet so young—  
Her little arm besplinted and beslung,  
Precedes me gravely to the waiting room.  
I limp behind, my confidence all gone.

The grey-haired soldier porter waves me on,  
 A tragic meanness seems so to environ  
 And so on I crawl, and still my spirits fall:  
 These corridors and stairs of stone and iron  
 Cold, naked, clean—half workhouse and half jail.

So to the surgical out-patient room for examination:—

Here, on a bench a skeleton would writhe from . . .  
 Angry and sore I wait to be admitted  
 Wait till my heart is lead upon my stomach  
 While at their ease two dressers do their chores.

One has a probe—it feels to me a crowbar—  
 A small boy sniffs and shudders after blue-stone  
 A poor old tramp explains his poor old ulcers.  
 Life is (I think) a blunder and a shame.

He is admitted and lies first in the main surgical ward, with its  
 “gaunt brown walls” looking “infinite.”

The atmosphere  
 Suggests the trail of a ghostly druggist,  
 Dressings and lint on the long, lean table.  
 Whom are they for?  
 The patients yawn  
 Or lie as in training for shroud and coffin  
 A nurse in the corridor scolds and wrangles  
 It's grim and strange.

Oh, a gruesome world!

The limb has to be operated upon and we have the sonnet—“Before.”

Behold me waiting—waiting for the knife.  
 A little while, and at a leap I storm  
 The thick, sweet mystery of chloroform,  
 The drunken dark, the little death-in-life,  
 The gods are good to me: I have no wife,  
 No innocent child, to think of as I near  
 The fateful minute: nothing all too dear  
 Unmans me for my bout of passive strife.  
 Yet am I tremulous and a trifle sick  
 And face to face with chance, I shrink a little  
 My hopes are strong, my will is something weak . . .

So to the operating table:—

Then they bid you close your eyelids  
 And they mask you with a napkin,  
 And the anæsthetic reaches  
 Hot and subtle through your being.

And you gasp and reel and shudder  
 In a rushing swaying rapture  
 While the voices at your elbow  
 Fade — receding — fainter — fainter

And you wrestle, blind and dizzy  
 In an agony of effort

Till a sudden lull accepts you,  
 And you sound an utter darkness . . .  
 And awaken . . . with a struggle . . .  
 On a hushed, attentive audience.

And later:—

. . . . Then my senses fleet:  
 All were a blank, save for this dull new pain  
 That grinds my leg and foot: and brokenly  
 Time and the place glimpse on to me again;  
 And unsurprised, out of uncertainty,  
 I wake — relapsing — somewhat faint and fain  
 To an immense, complacent dreamery.

Then comes the period of healing; the days can be endured, but the long and weary nights are "hideous, asleep or awake."

Shoulders and loins  
 Ache . . . . !  
 Ache, and the mattress,  
 Runs into boulders and hummocks,  
 Glows like a kiln, while the bedclothes  
 Tumble importunate, daft —  
 Ramble and roll, and the gas  
 Screwed to its lowermost,  
 An inevitable atom of light,  
 Haunts, and a stertorous sleeper  
 Snores me to hate and despair.  
 All the old time  
 Surges malignant before me:  
 \* \* \* \* \*

Far in the stillness a cat  
 Languishes loudly. A cinder  
 Falls, and the shadows  
 Lurch to the leap of the flame. The next man to me  
 Turns with a moan; and the snorer,  
 The drug like a rope at his throat,  
 Gasps, gurgles, snorts himself free, as the night nurse,  
 Noiseless and strange,  
 Her bull's eye half lanterned in apron  
 (Whispering me, "Are ye no sleepin' yet?")  
 Passes, list-slipped and peering,  
 Round . . . and is gone.

Then we have the picture of Lister on his rounds and the old familiar ward classes—as seen by the patient:—

Hist? . . .  
 Through the corridor's echoes,  
 Louder and nearer  
 Comes a great shuffling of feet,  
 Quick, every one of you,  
 Straight your quilts, and be decent!  
 Here's the Professor.

In he comes first  
 With the bright look we know,  
 From the broad white brows the kind eyes  
 Soothing yet nerving you. Here at his elbow  
 White-capped, white-aproned, the Nurse  
 Towel on arm and her inkstand  
 Pretful with quills.  
 Here in the ruck, anyhow,  
 Surging along,  
 Louts, duffers, exquisites, students, and prigs

Whiskers and foreheads, scarf pins and spectacles,  
 Hustles the Class! And they ring themselves  
 Round the first bed, where the Chief  
 (His dressers and clerks at attention),  
 Bends in inspection already  
 . . . . . shoulders .

. . . . . serry and shove;  
 While from within a voice  
 Gravely and weightily fluent  
 Sounds; and then ceases; and suddenly  
 (Look at the stress of the shoulders!)  
 Out of a quiver of silence  
 Over the hiss of the spray,  
 Comes a low cry, and the sound  
 Of breath quick intaken through teeth  
 Clenched in resolve. And the master  
 Breaks from the crowd, and goes,  
 Wiping his hands,  
 To the next bed. . . . .

I would like to quote in full the series of pictures which ensue of hospital characters: the casualty patient; the weak witted ploughman; the suicide—the staff nurse, old style, with her “antique liveliness and ponderous grace” and “thick Scot wit that fells you like a mace”; the staff nurse, new style, “blue eyed and bright of face but waning fast into the sere of virginal decay” who talks Beethoven, disapproves of Baizac, speaks Latin with the right accentuation and gives at need “draught, counsel, diagnosis, exhortation; the scrubber—each picture touched in so surely that the character stands clear and incisive as in an antique cameo. There are two, however—or three—that I cannot desist from quoting. The one is that of “The Chief”—a noble tribute to, or, rather, a nobly worded delineation of the greatest of surgeons.

His brow spreads large and placid, and his eye  
 Is deep and bright, with steady looks that still.  
 Soft lines of tranquil thought his face fulfill—  
 His face at once benign and proud and shy.

If envy scout, if ignorance deny  
 His faultless patience, his unyielding will,  
 Beautiful gentleness and splendid skill,  
 Innumerable gratitudes reply.  
 His wise, rare smile is sweet with certainties,  
 And seems in all his patients to compel  
 Such love and faith as failure cannot quell.  
 We hold him for another Hercules  
 Battling with custom, prejudice, disease,  
 As once the sons of Zeus with Death and Hell.

This it must be remembered was written when the fight was still raging hot and strong, when Lister and his methods were still on trial. Had ever poet worthier subject to describe, or surgeon finer tribute to his excellence!

Then there is the House Surgeon :—

Frank-faced, frank-eyed, frank-hearted; always bright  
And always punctual—morning, noon and night;  
Bland as a Jesuit, sober as a hymn;  
Humorous and yet without a touch of whim;  
Gentle and amiable, yet full of fight.

Two days ago I was lunching with Mr. Watson Cheyne who incidentally remarked that Henley was in hospital while he was House Surgeon to Lister. Is this I wonder the young Watson Cheyne? It might be.

Last there is the "Visitor," a character sketch which in its perfectness rivals that of the great "Chief."

..... her soft white hair adorns  
Her withered brows in quaint straight curls, like horns;  
And all about her clings an old sweet smell.  
Prim is her gown and quaker-like her shawl,  
\* \* \* \* \*

A wee old maid that sweeps the Bridegroom's way,  
Strong in a cheerful trust that never fails.

I purposely forbear to give the whole of this exquisite sonnet; something must be left for others to find and enjoy for themselves. If this original edition is not obtainable let each buy for himself the "Poems—A Book of Verses: London Voluntaries," of which since 1898 it would seem that there have been several small editions.

At a later period through the influence and care of friends the poet was transferred from the public to a private or semi-private ward. Leslie Stephen interested others in him, among them Robertson Smith and Robert Louis Stevenson. We obtain a glimpse in Stevenson's letters of the beginning of a memorable intimacy which ended bitterly. Stevenson writes to Mrs. Sitwell in January, 1875:—

"Yesterday Leslie Stephen, who was down here to lecture, called on me and took me up to see a poor fellow, a poet who writes for him (in the *Cornhill Magazine*), and has been eighteen months in our infirmary, and may be, for all I know, eighteen months more. It was very sad to see him there in a little room with two beds, and a couple of sick children in the other bed. A girl came in to visit the children, and played dominoes on the counterpane with them; the gas flared and crackled; the fire burned in a dull, economical way; Stephen and I sat on a couple of chairs and the poor fellow sat up in bed with his hair and beard all tangled and talked cheerfully as if he had been in a King's palace or the great King's palace of the blue air."

Thus the acquaintance began which influenced the lives and work of both men, which led to the writing of plays together, of four prose dramas:—"Deacon Brodie," "Beau Austin," "Admiral Guinea;"



"Robert Macaire." The first of these was played in London and, oddly enough, in Montreal (1887). I do not know that it has since been staged. But, returning to the private ward described by Stevenson, it is interesting to have Henley's own impression of the place.

Here in this dim, dull, double-bedded room

I play the father to a brace of boys

Ailing, but apt for every sort of noise.

\* \* \* \* \*

They eat, and laugh and sing and fight all day;

At night they sleep like dormice. See them play

At operations :—Roden, the Professor

Saws, lectures, takes the artery up and ties;

Wille, self chloroformed, with half shut eyes

Holding the limb and moaning—Case and Dresser.

As the needy poet gained in health and strength Stevenson took him for long drives. In the lines entitled "Pastoral," we have his appreciation of the first of these; the delight at leaving behind the bare walls and seeing the good green land in all the freshness of Spring

O, the brilliance of blossoming orchards

O, the savour and thrill of the woods

When their leafage is stirred

By the flight of the Angel of Rain!\*

The series of verses throw light upon the friendship between Henley and Stevenson and upon its quality—on the part, at least, of our poet.

In the Envoy, to Charles Baxter he writes:—

Do you remember

That afternoon—that Sunday afternoon!

When, as the kirks were ringing in,

And the grey city teemed

With Sabbath feelings and aspects,

*Lewis*—our *Lewis* then,

Now the whole world's—and you

. . . . . came

Laden with *Balzacs*

. . . . .  
To that transformed back-kitchen where I lay

Dear *Charles* since then

We have been friends, *Lewis* and you and I

(How good it sounds, "*Lewis* and you and I")

\* \* \* \* \*

But he who could write thus of his friendship, comparing the three of them to the immortal *Musketeers* did not hesitate to print at the same time the following lines under the heading "Apparition," clearly

---

\* Stevenson writes of this first drive : " The whole country is mad with green. To see the cherry blossom bitten out upon the black firs and the black firs bitten out upon the blue sky, was a sight to set before a king. You may imagine what it was to a man who has been eighteen months in an hospital ward. The look of his face was as wine to me."

referring to Stevenson's first visit to the "transformed back kitchen":—

Thin-legged, thin-chested, slight unspeakably,  
 Nea-footed and weak fingered; in his face—  
 Lean, large-boned, curved of beak, and touched with race.  
 Bold-lipped, rich-tinted, mutable as the sea  
 The brown eyes radiant with vivacity—  
 There shines a brilliant and romantic grace,  
 A spirit intense and rare with trace on trace  
 Of passion and impudence and energy.  
 Valiant in velvet, light in ragged luck,  
 Most vain, most generous, sternly critical  
 Buffoon and poet, lover and sensualist;  
 A deal of Ariel, just a streak of Puck,  
 Much Antony, of Hamlet most of all  
 And something of the shorter Catechist.

No true friend could have written those lines and seen them printed. On the part of Henley I do not hesitate to say that it was amusement, interest, community of ideas and of purpose in life that made the intimacy worthy of being preserved by him; loyal friendship never existed. I am by no means a whole-souled admirer of Stevenson; to me the above appreciation of him seems curiously just, but I do protest that Henley was incapable of knowing what friendship meant if he could write thus.

And the denouement bears me out. Later he writes:—

And so it ends  
 With friends.  
 Friends . . . old friends . . .  
 And what if it ends?  
 Shall we dare to shirk  
 What we live to learn  
 It has done its work  
 It has served its turn;

They had drifted apart—and the drifting it is generally admitted, was on the part of Henley. There were, it may be, "some private excuses for resentment," but to the outsider it seemed that, more particularly, Henley was irritated at the vogue Stevenson had gained, whereas he himself had failed to gain more than a "succes d'estime" for his more serious writings; and so it ended after Stevenson's death in Henley's appalling and unforgivable attack on his old friend in the criticism contributed by him in 1901 to the *Pall Mall Magazine* upon Mr. Graham Balfour's "Life of Stevenson." I speak, it may seem with some heat, but I do so with the memory that one now dead, who was a true friend to me, experienced a like treatment from our poet; he had visited him when in hospital in Edinburgh, and had cared for him; himself a man of vast knowledge and wide sympathies he had appre-

ciated Henley's evident talent and had gained work and opportunities for him; and the poet turned and rent him.

But, it may be asked, are we to ascribe this to Henley's natural character or to his infirmity? It is a difficult question to decide. Though of large frame and burly he was left by the disease which took him to the infirmary a permanent cripple and something of a permanent invalid. A jealousy and bitterness, an aptitude to hit viciously below the belt if I may so express it, or indulge in surreptitious kicks, is curiously frequent in those who are crippled, in those who realizing their impotence, and imagining their capacity if only they were as others—see those others winning in the race. There is indeed a historic parallel in the case of Pope. Were we in their place could we restrain ourselves from doing likewise? All that I would say is that under the conditions it was a mockery for Henley to extol his friendship for Stevenson or for any other man; it was intimacy, not friendship proper.

With two exceptions, modestly included under the title of "Echoes"—I refer to the ballad "O gather me the rose,"\* and the lines beginning, "Out of the night that covers me," both it may be noted written when he was in the wards, Henley wrote nothing finer than this "Hospital" series. In the rush of active life he wrote poems, it is true, but they do not appeal. Upon that later life I shall not dwell—upon his fame as editor of the *Scots Observer*, which became later the *National Observer*, on the subsequent editorship of the *New Review* and so on—nor, interesting though it is, shall I discuss the pioneer part played by him in awaking the spirit of Imperialism throughout England and her colonies and the stimulus he afforded to Kipling and other younger writers. I shall have, I hope, done my duty if I lead others to read and appreciate those verses, the only verses of their kind, in which he so vividly paints the life and the impressions of a patient in the wards of the old Edinburgh Infirmary when Lister was there as surgeon.†

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\* This, it is true, is an echo of Herrick, but is more exquisite than its original.

† For data bearing upon Henley's intimacy with Stevenson, I am more particularly indebted to an unsigned article in the literary department of the *Times* of July 17th.

THE

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*A Monthly Record of the Progress of Medical and Surgical Science.*

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## CANADIAN MEDICAL ASSOCIATION.

The thirty-sixth annual meeting of the Canadian Medical Association, which was held in London during the last week of August, was only excelled in point of numbers by the Montreal meeting the previous year, but it has been surpassed by none, in respect of those qualities of harmony and friendship, which are indeed as important as the scientific elements of a meeting. Dr. Moorhouse presided with kindness and tact, and had a friendly word for everybody, even in the midst of his exacting duties. His confreres in London gave him a cordial support in the offices of hospitality, and provided many little diversions, which found no place in the official programme.

The number in attendance the first day was small, but towards the close of the second day there was a sudden exacerbation in membership as if it were set up by the proximity of the entertainments. About these same entertainments, there may be some, who might think it open to discussion whether the Association acted with the highest wisdom in accept-

ing the very elaborate hospitality of a firm of manufacturers of proprietary preparations, no matter how admirable those products may be.

The attendance from provinces other than Ontario was lamentably small. The profession in Montreal has always been noted for its diffidence, but it could not be charged with self-glorification, even if it had sent considerably more than four members to the London meeting. Many members seem to think their whole duty is done, when they signify that they will read a paper and have their names set down upon the official programme. Of forty-six persons, whose names were so brought forward, seventeen failed to put in an appearance, and in the case of several of them it would appear that their shyness is constitutional for the same thing happened in regard to the July meeting in St. John.

There are two methods of preparing a presidential address; to pass in review the events that have transpired in medicine and surgery during the year, and to cast a glance backward upon the progress of those sciences since the time of Hippocrates. Dr. Moorhouse went a step or rather a leap farther back into the dark and commenced his address with a consideration of that pre-Aaronic King-priest, who, with true Semitic shrewdness gave trivial gifts of bread and wine to an important personage, and then exacted a tithe of the booty the patriarch warrior had acquired in his one adventure of plunder. Without entering into the intrinsic difficulties of this isolated narrative of Pentateuchal history, one would like further evidence upon so high a matter as the ultimate origin of the profession.

However, that may be, as the College of Heralds says, when dealing with matters of remote ancestry, Dr. Moorhouse turned aside from his excursion into exegetics to read a homily to the Province of Quebec upon its stiff-neckedness in regard to the Dominion Registration Bill. We might remind him of that procedure enjoined in those same Oriental writings, which have obtained so wide a currency in Ontario, as being a proper preliminary to improving the vision of one's neighbours. Doubtless we in Quebec have our faults, but we do not apprehend the meaning of the very injurious terms which Dr. Moorhouse thought fit to apply to some of his confreres in Ontario. It is quite true we have our differences and difficulties here; in time we will clear them up, but it will not be by the method of joining with our friends in Ontario who are advised to rise in their "might and their right" to set Quebec at defiance.

It is quite true also that a large majority in this province adopt in their entirety the views advanced by Dr. Moorhouse, yet the president of such an association speaks *ex cathedra*, and he should speak for us in Quebec also, who are both English and French, in terms of

reticence and kindness. If we in Quebec, think that a complete course in classics and philosophy be a necessary introduction to the study of medicine; even if we consider that ability to read the dog Latin of the fathers constitutes a classical education, and an understanding of the patristic speculations of the schoolmen be proof of the philosophical mind, it is as well to acknowledge at once that we are within our rights in holding those views, however absurd they may seem. We hasten to add, that there are many in this province, including the editors of this Journal, to whom these things do seem as absurd as they appear to the profession in Ontario.

The meeting was enriched by the presence of many eminent men from the United States, who contributed largely to the interest of the proceedings. The Association will assemble in Vancouver next year, and if the British Medical Association accede to the request to meet in Toronto in 1905, the claims of Halifax will next be considered.

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### THE TORONTO FEDERATION.

The federation of Trinity university with the university of Toronto has led directly to the fusion of what was known as Trinity medical college with the medical faculty of the Provincial University. Trinity medical college was an independent corporation with a special charter, which was in operation till the beginning of this year, when the faculty became the medical faculty of Trinity university, whose corporation now holds the charter of the medical college. As Trinity university by the terms of federation will hold this charter in abeyance and, further, as the Provincial Government has become possessed of the charter of the old Toronto school of medicine, it is extremely unlikely that there will ever again be more than one medical teaching institution in Toronto.

The general basis of the fusion which is now accomplished is the incorporation, so far as possible, of the staff of Trinity in the Provincial university medical faculty; that is, the Trinity teachers in medicine, surgery, obstetrics, gynæcology, medical jurisprudence, and in the special subjects, ophthalmology, otology, laryngology, and rhinology, were given nearly corresponding positions in the new faculty, while the teachers in the primary subjects, anatomy and physiology, were transferred to various final subjects. Exceptions occur in the case of some demonstrators in anatomy, who are given annual appointments as such in the university, and of Prof. W. T. Stuart, who is given rank as associate professor of medical chemistry. Apart from this case the staff in the sciences and of the two primary years of the medical course is practically as it was in the previous university faculty.

In determining the relative rank to be accorded to the new appointments in any one department, length of service in Trinity, as compared with that of colleagues in the university faculty was a factor, but important exceptions obtained. In the university council, which consists of the head professors of all the departments in the university, there will be four former Trinity teachers and eleven of the original university medical faculty. Dr. Reeve will retain his rank as Dean, and Dr. Primrose will remain secretary of the medical faculty. Dr. Geikie had resigned from the Trinity university medical faculty before fusion was accomplished.

The didactic work of the reconstructed faculty will be carried on in the new university buildings recently erected, which will be formally opened on October 1st next. These buildings will provide laboratory accommodation for about seven hundred and fifty students working in the several departments at the same moment. The old buildings near the Hospital may be used for the purposes of the latter. The large staff in the final years will permit of a thorough subdivision of the work and at the same time permit of more individual teaching at the bedside. This division of the clinical work is necessary on account of the large number—over six hundred—of students who will be in attendance.

One of the terms of agreement demanded that the Provincial Government should endow six additional chairs, namely, those of anatomy, pharmacology, pathology, sanitary science, jurisprudence and preventive medicine. At present the chairs of anatomy and pathology are given a fixed annual remuneration out of the faculty income. The Government has not as yet signified its intention of accepting the proposition, but it is considered only a matter of a couple of years or so when Provincial support for all these chairs will be given. This large school is bound to be an important factor in medical education in Canada.

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### THE HYGIENE OF THE SLEEPING CAR.

Upon this last night of August, every sleeping in America is filled to the roof with families returning from the mountain and the sea, to resume their ordinary way of life, the mothers to take their place in the house and in the social order, the fathers to their business or profession and the children to school or college.

Between the seventh and the eighteenth of September, but for the most part on the fourteenth day, the family physician will be called upon to diagnose a case of coryza and a rapidly spreading eruption; in the second week it may be to a case of convulsive cough with a long drawn whooping inspiration, or a case of inflammation of the

parotid gland, or a case of eruption of vesicles on the skin. Unfortunately the case may be one of a diffuse exanthem with an angina of variable intensity. The physician will say at once, that he is dealing with measles, whooping cough, mumps, chickenpox or scarlet fever and that the diseases were probably contracted in the sleeping car.

Those in Montreal, whose memories go back to the year 1885, will call to mind what Osler describes as the most remarkable instance in modern times of the rapid extension of smallpox. The disease was brought by a Pullman car conductor from Chicago on the 28th February and before it exhausted itself 3,164 persons had died.

Railway travelling has come to be one of the ordinary incidents of life; it is not expecting too much that it should be deprived of its most obvious disadvantages. Johnson made the observation that a ship is worse than a jail, because in prison there is no danger of being drowned; but in a railway car there is a chance of being injured by collision, drowned in a river or contracting some contagious disease.

The report of the Interstate Commerce Commission on railroad accidents in the United States for the three months, ending March 31, last, shows that during that quarter 300 persons were killed, and 2,834 injured in train accidents. Other kinds of accidents, including those sustained by employees at work, and by passengers in getting on and off the cars, make the aggregate casualties 827 killed and 11,481 injured. One might endure all this liability, to disaster with calmness, if it were not for the inconveniences that haunt a crowded sleeping car.

In the presence of these real dangers it may appear a trivial affair to mention the lesser matters of cinders and impure air. Each adult requires 1,000 cubic feet of fresh air per hour; in a lower berth he probably does not obtain as much the whole night through. According to the *Lancet* numerous investigations have shown that the air in railway cars is often very impure, 14 parts of carbonic acid per 10,000, instead of the normal four having been observed, and of a train from St. Petersburg to Moscow, it is recorded that carbonic acid amounting to 94 parts per 10,000 was found. As the result of some experiments Wolffhugel concluded that the air of a compartment ought to be renewed 38 times per hour. In England the ventilation is helped by the rickety construction of the windows, and the simple expedient of frequently opening the doors. In France many of the trains are ventilated by tubes through which the air is forced and purified by passing through water, and in Germany the complicated but inefficient Schmidt's apparatus affords some fancied security at least against suffocation. In this country the ventilation depends upon the initiative of the porter,



who is usually an excellent individual but with very rudimentary notions of hygiene.

The law in regard to the carriage of persons affected with contagious diseases upon railways is perfectly clear. The matter is dealt with by the regulations of the Provincial Board of Health who are authorized by the Act, R. S. Q., 3054, et seq., to issue whatever regulations they may deem advisable, the only requirement being that they shall be approved by the Lieutenant-Governor in Council and published in the official gazette. In virtue of this power they have issued such regulations and by Section 7, no person affected with contagious disease shall be removed from one place to another without the special permission of the Board of Health. The owner of the vehicle used for the transfer of such a patient is obliged to disinfect it according to the manner prescribed, and his recourse is against the patient.

The disinfection of a sleeping car is not an impossibility. The public would willingly pay an increased price for transportation, if they had some security that travelling was not necessarily associated with infection.

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### THE OPENING SESSION.

The university which draws its students from the widest fields is the one that succeeds best. A university which raises its fees unduly cuts off that part of its field which is the most fruitful, the part occupied by young men of industry and inventiveness. The history of all large universities is one of increasing fees and enlarged demands upon its students, and no matter how high they be raised, the number of students will not diminish. With the increasing wealth of a new country, more men will be found willing to undergo a university course with all its advantages, but the standard of numbers is a false measure, if the undergraduates are not drawn from all walks of life. If the number of students of ample means be diminished, that would be a calamity against which a university might successfully struggle, but if men of self-reliance are wanting, the institution has already within it an element of weakness. The great American universities are beginning to suffer from this malady. Of the last twelve presidents of the United States, ten have been graduates of the smaller and cheaper colleges, and graduation from Yale, Harvard or Princeton has come to mean rather a social than scholastic distinction.

The main advantage of a college course is that it affords presumptive evidence of a man's capacity, and as Dr. Buller pointed out in his Convocation address, a presumption is far removed from a probability and

still further from a certainty. The degree of probability is so low in any case, that it is coming to be a matter of increasing indifference from what college a man graduates. This is peculiarly true of the faculties which have to do with the practical affairs of life, such as engineering and law; it is not so applicable to those bodies which are more professional and academic in their functions, and have to do with medicine and pure science. The Medical Faculty is a class or caste, and in some sense a hierarchy, and admission must be sought by the broadest way. That is why the schools that are most exclusive in respect of entrance and most difficult by reason of costliness afford to the young man the readiest success. But that state of affairs will not endure forever. The condition is largely artificial and any school that of design makes itself exclusive, will in the end, have no other distinction. The wealth of a nation is in its sons; that is why continued emigration will reduce it to such a condition of poverty as it witnessed in parts of Ireland and the Midland Counties of England. The wealth of a university is in its teachers and in its students, and if any—teachers or students—are allowed to depart, or are driven out, if it is not refreshed with new blood, it will fall into premature decrepitude. The principle of seniority will destroy any institution. These are not cryptic sayings. At the opening of another session it becomes all medical schools to see to it, that they are not content with being exclusive on the one hand, or on the other hand cheap and easy of access and for graduation.

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The examination for admission to the study of medicine before the Provincial Medical Board of the College of Physicians and Surgeons of the Province of Quebec, will begin on Thursday, the 24th of September next at 9 o'clock a.m., in the city of Quebec, at the rooms of the Laval University. The semi-annual meeting of the board will be held on Wednesday, the 30th September next, at 10 o'clock, at Quebec. The credentials committee will meet on Tuesday, the 29th September, at 9 o'clock a.m., and the examination committee for the license will sit on Tuesday, the 29th September next, at 9 o'clock a.m., at Quebec.

## Reviews and Notices of Books.

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ORGANIC NERVOUS DISEASES. By M. ALLEN STARR, M.D., Ph.D., LL.D. Professor of Diseases of the Mind and Nervous System, College of Physicians and Surgeons, The Medical Department of Columbia University, New York. Lea Brothers & Co., New York and Philadelphia, 1903.

So numerous and so important have been the recent additions of knowledge to the various departments of neurology that all text books written even five years ago are already old, much of the knowledge acquired by the investigators of the past ten years is contained in articles published from time to time by clinicians—both physicians and surgeons, pathologists and physiologists.

An experience of twenty years has placed Professor Starr not only in possession of a "mass of pathological and clinical material" well "worthy of analytical study," but has given him the capacity to successfully analyze not only his own experiences but those of others as recorded in the literature of neurology. How admirably the sifting process has been done; how numerous the collated facts; how carefully the various theories have been considered, appear only after a perusal of the work which bears the marks of rich clinical experience—of careful pathological study, and of due appreciation of the work done by others. The author, we think, may be congratulated on having accomplished his object—viz.: "to make clear both to students and to practitioners the principles upon which localization and diagnosis of nervous diseases rest, and to put before them in a definite manner the appropriate medical and surgical treatment and its results." The work, which is comprised in a book of 750 pages, opens with a chapter on the structure of the nervous system amply illustrated.

Chapters II. and IX. inclusive, deal with the various diseased conditions of the nerves. In discussing the pathology of neuralgia it is stated that the more important lesions appear to be in the neurone bodies which lie in the ganglia; after weighing much evidence recently acquired, this part of the subject is dismissed with the statement that "it is therefore probable that neuralgia has, in every *chronic* case, some organic lesion." The strychnine treatment of trigeminal neuralgia is practically condemned; while aconitine, gelsemium and morphine are warmly recommended.

Dr. Starr has nothing to say in favour of fixation of the limb in cases of sciatica. Those chapters dealing with toxic forms of multiple neuritis are interesting from every standpoint, but we desire to

mention that the historical notes are very valuable, if for no other reason than the references afforded.

Spinal Cord diseases are taken up in the next chapters X. to XXIII. inclusive. This section of the book includes a chapter on muscular dystrophies, under which Thomsen's disease is classified and described. The balance of the work is devoted to diseases of the brain and membranes; diseases of the cranial nerves; general diseases of the nervous system, and syphilis of the nervous system.

The introductory chapter in each of these sections is a study of the symptoms occurring in diseases of the spinal cord and in diseases of the brain, with "an attempt to trace each symptom to its anatomical basis so that its significance as an index of the pathological state present may be clear."

The volume is illustrated in an admirable manner with coloured plates, diagrams and photographs—while cases, briefly set forth, illustrating the conditions discussed, add interest to the text.

An extensive bibliography is distributed throughout the book, the author choosing to place the reference at the foot of the page on which the quotation or reference is made.

*W. F. H.*

**THE DIAGNOSIS OF DISEASES OF WOMEN**, a treatise for students and practitioners, by PALMER FINDLEY, B.S., M.D., Instructor in Obstetrics and Gynæcology, Rush Medical College; Assistant Attending Gynæcologist to the Presbyterian Hospital, Chicago. Illustrated with 210 engravings and 45 plates. Lea Brothers & Co., Philadelphia and New York, 1903.

The book, is well printed, as all Messrs. Lea's publications are, and is adorned with a profuseness of illustration which must prove alluring to the student and general practitioner for whom the work is more especially prepared. It is to be regretted that the title, "Diagnosis of Diseases of Women," should be employed as the greater part of the four hundred and seventy-five pages deals with etiology, anatomy, classification and gross and microscopic pathology, all of which are entered into with extreme minuteness and prolixity, while clinical and differential diagnosis are handled briefly and unsatisfactorily.

The work is divided into three parts. Part I. is devoted to general diagnosis and includes history taking physical examination, gynæcological instruments and microscopic examination. This section is divided into numerous short chapters on such subjects as the speculum, the vulsella, percussion; auscultation and menstruation, etc., such chapters consisting of several pages of illustrations and but a few paragraphs of text.

Part II. comprises Special Diagnosis, beginning with the diagnosis of Pregnancy, which the author enters into carefully and at some length; then follow chapters on ectopic pregnancy, hydatiform mole and chorio-epithelioma maligna. The arrangement of the rest of this part is on anatomical and pathological lines as distinguished from clinical, and while not well adapted for diagnostic purposes, conduces to unnecessary and tiresome repetition.

Part III. consists of a brief survey of diseases of the urinary system, and is largely a resumé of Howard Kelly's cystoscopic methods. Having failed to find the work original or well arranged or particularly useful from a clinical standpoint, it would be pleasant to commend it for facility of expression, lucidity or attractiveness of style, and for correct English. On the contrary, making due allowance for mistakes in proper names and other defects, it is regrettable to find in a scientific manual, repeated faults of grammar and composition combined with obscurity of expression and repetition.

INTERNATIONAL CLINICS. A Quarterly of Illustrated Clinical Lectures and Original Articles. Edited by A. O. J. KELLY. Vol. II., thirteenth series, 1903. J. B. Lippincott Company, Philadelphia, 1903.

It is only necessary to enumerate the contents and mention the authors of this volume to convey some idea of its value. The Summer Diarrhœas of Children: Milk bacteria and intestinal disorders, by H. W. Conn; The causation, nature and prevention of the summer diarrhœas of children, by Alfred Hand, Jr.; The symptomatology of the summer diarrhœas of children, by A. C. Cotton; The treatment of the summer diarrhœas of children, by Matthias Nicoll, Jr.; The treatment of cholera infantum, by A. B. Martin; The dietetic treatment of the summer diarrhœas of children, by Thompson S. Westcott. Disease of the pancreas: The symptoms and treatment of disease of the pancreas, by Eugene L. Opie; The diagnosis and surgical treatment of disease of the pancreas, by John B. Deaver and George P. Muller. Treatment: Truncsek's serum in arterio-sclerosis, by Leopold Levi; Practical notes on the prophylactic and curative treatment of influenza, malaria, erysipelas and ozena, by J. McFadden Gaston; A recent advance in therapeutics. Local treatment by Charles Boucharde; The rest treatment when indicated and how conducted, by John Madison Taylor. Medicine: The etiology, prevention and treatment of a common cold, by Alexander Haig; Peripheral causes of heart disease, by Louis Faugeres Bishop; Endocarditis in childhood considered as a symptom of infective diseases, by F. J. Poynton; The etiology and diagnosis valvular affections of the heart, by Thomas E. Satterthwaite. Surgery: The diagnosis and treat-

ment of hæmorrhoids, by George W. Gay; Abdomino-pelvic diagnosis—abdominal swellings, by E. Stanmore Bishop; The surgical relief of traumatic epilepsy, by D. B. Roncali. Pediatrics: Cirrhosis of the liver in children, with notes on three cases, by W. F. Hamilton. Obstetrics and Gynæcology: The causation and treatment of sterility in women, by J. Riddle Goffe; Ectopic gestation, with notes on a case of tubal mole, by Cuthbert Lockyer; The significance and some suggestions regarding the treatment of cervical lacerations, by Chauncey D. Palmer. Ophthalmology: Surgical intervention in paralysis of the ocular muscles, by Professor Edmund Landolt.

**FIRST PRINCIPLES OF OTOLOGY.** A text book for medical students. By ALBERT H. BUCK, M.D., Clinical Professor of the Diseases of the Ear, College of Physicians, Medical Department of Columbia University, New York, Consulting Aural Surgeon New York Eye and Ear Infirmary and The Presbyterian Hospital. Second edition. Revised Octavo, 209 pages, profusely illustrated. New York: William Wood & Co., 1903.

This little work, written primarily for the undergraduates of Columbia University, will, undoubtedly, prove helpful to medical students in general. The various phases of otology are taken up for the most part in the usual sequence, but the author adheres closely to the discussion of the broad facts underlying ear diseases, and leaves the minutiae to the larger text books and clinics.

There is a great deal in the saying that it might be well for the teachers of greatest experience, capable as they are of viewing their work broadly, to instruct men in general principles at the commencement of their study of a subject, leaving the detail work for the senior, who are more burdened with facts than with experience. Dr. Buck has apparently proceeded along these lines. The book in question is the successful effort of a teacher of experience to present to the student the principles rather than the facts of otology, and it can be warmly recommended to beginners in ear work for its comprehensiveness and simplicity.

W. G. M. B.

**A SYSTEM OF PHYSIOLOGIC THERAPEUTICS.** Edited by G. SOLOMON SOLIS COHEN, A.M., M.D.; Vol. VI. Dietotherapy and Food in Health by Nathan S. Davis, Jr., A.M., M.D. Philadelphia, P. Blakiston's Son & Co., 1902.

This system is an exposition of the methods other than the administering of drugs, which are useful in the treatment of disease and the

present volume deals with food in health and in disease. The author has made a practical book upon dietetics; he has considered the chemical and physiological data connected with the various foods and the changes necessary to render them available for the uses of the organism, in so far as these are known. A large mass of literature has grown up in recent years dealing with these and cognate subjects and this has been made good use of, especially the researches of Professor Atwater. There is a large section dealing with the diet for invalids and the digestive and nutritional processes as modified by abnormal conditions. The book is a compendium of all that is known about foods and food values and enters very fully into matters that are yet under discussion. The section dealing with alcohol is moderate and just, as the author does not side with those who regard alcohol as an indispensable food, nor with those who would restrict a man to a diet of acorns and water. The dietary of invalids is based upon all the facts of which we are possessed, and is entirely to be trusted. The book, and the whole series in fact, is necessary for all who apprehend the fact, that the greater part of the treatment of disease lies outside the giving of medicines.

PORTFOLIO OF DERMOCROMES, Parts I. and II. By PROFESSOR JACOBI, of Freiburg. English adaptation of text, by J. J. Pringle, M.B., F.R.C.P. London: Rebman, Limited, 1903. Canadian Agent: C. E. Wingate, Toronto.

The process employed in these illustrations of the diseases of the skin is that designed by Dr. Albert, of Munich. Most of the figures were executed by Herr Kroner in the Breslau Clinic and done under the care of Professor Jacobi. It would be hard to imagine anything more beautiful and at the same time so faithful as these illustrations of the common diseases of the skin. For artistic excellence and illustrative quality they have probably never been surpassed. Taken in conjunction with the letter press the book constitutes an almost infallible guide to the diagnosis of the conditions dealt with. The text contains a clear description of the various diseases, their etiology, the differential diagnosis, prognosis and treatment. The book will delight skin specialists and the general practitioner.

ATLAS OF ILLUSTRATIONS OF CLINICAL MEDICINE, SURGERY AND PATHOLOGY, compiled for the new Sydenham Society. H. R. Lewis, agent, London.

Three more fasciculi of the splendid publication of the New Sydenham Society are at hand. Number XIV. being a double fasciculus, includes a consideration by Jonathan Hutchinson of Framboesial

syphilis, commonly known as Yaws. Number XV. deals with Xanthelasma and Xanthoma, with especial reference to their association with functional and organic diseases of the liver, and is compiled by Mr. Hutchinson. Number XVI. is upon Coxa Vara and miscellaneous conditions somewhat allied with it. The plates are incredibly beautiful and done in the highest style of the art of illustration. The volume on Yaws revives the old contention as to the identity of yaws with syphilis, but whichever view he adopted, the plates are of equal value, in the one case illustrating a disease new to the atlases, and in the other showing the modifications in syphilis which are common chiefly in the coloured races. It is Mr. Hutchinson's view that they are identical, and certainly these plates lend confirmation to it. No description would serve to convey an idea of the beauty of the drawings nor of the fitness with which the letterpress is done. The subscription to this society is only one guinea, and includes amongst other privileges the securing of one set composed of a varied number of volumes.

HIGH FREQUENCY CURRENTS IN THE TREATMENT OF DISEASE, by CHRISTIANS W. WILLIAMS, F.R.C.S., Edin.; London, Rebman, Limited, 1903; Canadian Agent: Charles E. Wingate, Toronto.

The author of this book is evidently an enthusiastic worker with electricity and it is just as evident that he has allowed his enthusiasm to transcend the limits of sound sense. An investigator, who finds the results of electrical treatment "most satisfactory in each case of diabetes," who is "unable to find any reports of failure in gout," who observes the "greatest benefits" in rheumatism, "remarkable results" in obesity, "most excellent results" in colitis, and notes its employment in hysteria, anæmia, phthisis, dyspepsia, and dilatation of the stomach, requires to have his experiments supervised. High frequency currents, he affirms may be used to advantage in fissure of the anus, prolapse of the rectum, warts and hæmorrhoids; but that is a matter, which some will think is open to discussion. The book contains mistakes as to facts and errors in expression; "having to lay on a couch"—. It is worth reproducing the word D'arsonvalization to show how it looks in print.

INDEX. Catalogue of the Library of the Surgeon-General's Office, United States Army. Second Series: Insane to Kysthospitalet, 1903.

This is the eighth volume of the second series of the Index-Catalogue of the Library of the Surgeon-General's Office of the United States Army. It includes 10,704 author-titles, representing 5,330 volumes, 9,897 pamphlets, 5,731 subject titles, and 29,684 titles of articles in



periodicals. Up to date the catalogue contains 258,525 author notes, and 158,663 titles of journal articles. The Index-Catalogue continues to be the most authentic thing of the kind in the English language and indispensable to all who write upon medical subjects.

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### BOOKS RECEIVED.

The Practical Medicine Series of Year Books: Gustavus P. Head, M.D. Vol. VI. General Medicine: Frank Billings, M.S., M.D., and J. H. Salisbury, M.D., May, 1903. Vol. VII., Pediatrics: Isaac Abt, M.D. Orthopedic Surgery: John Ridlon, A.M., M.D., June, 1903. The Year Book Publishers, Chicago.

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## Medical News.

### CANADIAN MEDICAL ASSOCIATION.

The thirty-sixth annual meeting of the Canadian Medical Association was held in London, Ontario, on the 25th, 26th, 27th and 28th August, 1903. The president, Dr. W. H. Moorhouse, of London, presided, and the members, to the number of 271, registered their attendance:—

#### TUESDAY MORNING—25th AUGUST.

The general meeting opened at 10 a.m., with the usual routine business, the reading of minutes, the Secretary's report, the proposal of new members, notices of motion and general business.

Dr. James Newell, of Watford, read a paper upon the surgical treatment of hallux valgus and bunions. He advocated laying open the joint, amputation of the head of the metatarsal bone and excision of the exostosis. A sheet iron splint was to be applied to the foot and toe, with adduction of the great toe, and passive movements begun in from two to three weeks. He claimed permanent relief, but absolute asepsis must be obtained.

Dr. A. Laphorn Smith, of Montreal, who was to have read a paper, did not appear.

Dr. R. Ferguson, of London, read a paper upon inguinal hernia of the undeveloped uterus and appendages, and presented the specimens.

He gave the preliminary history of the case, a woman 32 years old, married 6 years, who suffered from severe pain, referable to the generative apparatus. The hernia had been present since she was 7 years old and on examination a disordered condition of the internal organs of generation was observed. At the operation Dr. Ferguson found in the

sac an adherent ovary, an imperfectly developed uterus and a cystic body. He ligated the mass and excised it leaving a stump to retract into the pelvic cavity. The recovery was without interruption. Dr. Ferguson expressed the opinion that the case was one of congenital inguinal hernia of the left ovary, subsequently involving the remaining structures. In conclusion he discussed the literature of the subject and congenital anomalies in general, calling especial attention to the cessation of the neurological manifestations, when the local condition was remedied.

A paper upon the radical cure of hernia by Dr. A. Groves, of Ferguson, was not read, but the following is an abstract: He claimed that about 20 per cent. of the population was afflicted with hernia, and that the usual treatment was the unsatisfactory one of wearing a truss. He discussed the anatomical conditions which lead to the protrusion laying emphasis upon the fascial rather than upon the muscular tissue. He explained that his own method was to restore the continuity of each layer of the abdominal wall taking special pains with the fascia, suturing muscular tissues which are normally continuous, so that structures are not brought edge to edge which were not intended by nature to be so. He advised opening the canal widely, restoring to the abdominal cavity everything belonging to it; if the sac could not be easily freed, he would ligate cut off and drop it back, and close the wound layer by layer, using only sutures which are absorbable or removable when their work was done. He insisted upon cleanliness, rather than upon antiseptics; he quoted statistics, and considered two per cent. a proper estimate of failure. In conclusion, he enumerated cases to bear out his contentions.

Dr. Perry Goldsmith, of Belleville, read a paper upon the causes and treatment of post nasal discharge. He was induced to present the paper because of the frequency of the complaint, and the somewhat indifferent treatment usually adopted, which was commonly douching the nose with hot water, burning the mucous membrane and spraying with oil.

The paper was divided into three parts, that dealing with the causes situated in the nose, the cause situated in the pharynx and oropharynx, and systemic defects. After enumerating the various causes, he described in detail those that he had found most common, for example septum deviation, hypertrophy of the turbinated bone, and accessory sinus disease.

He condemned the indiscriminate operations on all septum irregularities, and advocated operations on the septum when it either interfered with nasal drainage or where it was the cause of rhinitis or nasal pharyngitis. The indiscriminate use of the galvano-cautery was pro-

ductive of no small amount of harm and was too frequently employed. Chronic acid was preferred and only small amounts carefully applied were allowable.

The cause situated in the naso pharynx, whether in young children or adults, usually was adenoids; with those causes due to an alternation in the glandular activity, apart from any hypertrophy, were usually associated gastro-intestinal disturbance; massage and measures directed to that condition were valuable adjuncts to various applications, such as iodine, silver nitrate and protargol. In purely neurotic cases, topical applications were not advised, since they tended to fix the patient's mind more strongly on the complaint.

#### TUESDAY AFTERNOON.

The address in medicine was given by Dr. H. A. McCallum, of London, who undertook to replace Dr. James Stewart, of Montreal, who was absent on account of his illness.

Dr. McCallum chose for his subject the lymph circulation in modern medicine. He said it might be pointed out that the lymph circulation during the last twelve years, had assumed enormous importance in the physiological world. Twelve years ago, Heidenhein set to work with certain agents to determine their affect on the amount and character of the lymph coming from the thoracic duct and was able by certain of those agents to alter the quantity and concentration of the lymph. Based upon his experimental evidence, he formed the theory that the endothelial cells of the capillary wall acted as a secretory filter. Since that time all physiologists were attempting to confirm or disprove his theory. A considerable number of physiologists from physiological evidence alone have arrived at a separate conclusion, that lymph depends upon the activity of the tissues. As an illustration, a limb in perfect repose gave no lymph from the lymph ducts, but massage, active or passive movement were immediately followed by a free flow. The quiescent animal, it was agreed, gave lymph from the thoracic duct almost wholly obtained from the viscera.

In order to arrive at a clear comprehension, the modern anatomy of the lymphatics should be considered. Ranvier, Sala, McCallum and Sabine had separately agreed that the lymphatic system was a modified portion of the circulatory system, that it grew backward from the subclavian vein by the process of budding, gradually invading the tissues, that the ends of the lymphatics were blind like the lacteal and intestinal glands, that they had no physical connection with the tissue spaces, and that certain tissues, like the cartilage and the cornea of the eye, were not invaded by lymphatic capillaries.

Those anatomical findings at once threw confusion upon all theories of lymph circulation, for, by them lymph was a double circulation composed of the tissue juices and the lymphatic or absorbent circulation. Basing one's opinion upon all sources of biology, including evolution, physiological, pathological and clinical evidence, the lymphatic circulation was a thoroughly independent one. The part of the lymph was to get rid of offensive material and certain secretions, and to obtain in exchange from the blood nutritive material and oxygen.

The two great forces of the lymph circulation were glandular activity and the muscular system. The relation of the voluntary muscular system as a lymph pump was pointed out, placing the limbs so far as the lymph circulation was concerned wholly under the control of the will.

The involuntary muscular system and its universal distribution was then dealt with. The enormous amount of the involuntary muscular tissue due to its wide area was shown to exist in the skin; possibly half the muscular system of the body would be found to be in the skin.

The modern research on the relation of the skin to the internal viscera was pointed out, and the sympathetic pain reflected from the viscus could be palliated by a reflex act from the skin to the viscus. The lung reflex of Abraham was shown to be one of these.

The immense importance of the skin as a great external body connecting with all forms of impression was pointed out. If it had not been for the fact that impressions could waken up all the laboratories of the body they could not have a heat-regulating mechanism. The application of cold and heat, and sunshine and fresh air were the primal forces of the universe, and they all acted on the external body and would continue so to act for all time.

They had staggered accidentally upon the use of those forces in the treatment of phthisis, the cold bath treatment of typhoid fever, and the massage treatment of malnutrition. If the skin could waken up so much activity inside, what could be said of the great master tissue, the central nervous system in its influence over the vital activity in the functions of the body. They had not used that force sufficiently in the treatment of disease, in the way of training the patient to sane courage, to cease complaining, to minimize his sufferings and to alternate periods of alertness with absolute repose.

The importance of this circulation in the solution of the unsolved problems of the medical world was pointed out, its ancient character, and its important relation with the physiology of the cells. It gave a wide therapeutic application without drugs, and was a field of inquiry that would be enriched by future growth.

The meeting then divided into two sections, medical and surgical.

## MEDICAL SECTION.

Dr. George Hodge, of London, presented two cases of disseminated lateral sclerosis, the one in a woman, the other in a man of 22 years of age, who had had the disease for five years; in the latter there was some suggestion of primary lateral sclerosis.

Dr. W. P. Caven, of Toronto, introduced a discussion upon the treatment of typhoid fever. He laid stress upon diet, and assigned to milk the first place, though he would not employ it to the exclusion of broths, extracts and gelatine, when these were indicated. He remarked the possibility of conferring an artificial immunity, after the manner devised by Wright of Netley, and quoted statistics from the experience in South Africa as establishing its value. He considered next the value of hydrotherapy and described in detail Brand's method and the other methods of applying cold which were commonly employed. He laid stress upon intestinal antiseptics and the ingestion of water, but would recommend no specific medication save in the case of hæmorrhage, where he thought favourably of adrenalin, and of turpentine and asafoetida in tympanites.

In continuing the discussion, Dr. J. Herald, of Kingston, insisted upon an appreciation of the facts of pathology in typhoid. They could not remove nor destroy the cause of offence, but they could control its effects upon the system, guiding the case, if not curing it. He placed diet and nursing first in importance, and was inclined to a rather liberal use of suitable foods. He found the best results from the use of cold water, but thought he had observed increased excitement after the ice bath. He advised sponging the patient with alcohol and then dissipating the heat with a fan. The best they could expect from drugs was control of symptoms, but he would avoid alcohol till the tongue had become dry, till the mind wandered and the heart began to fail. For hæmorrhage he advised rest through morphia and cold to the abdomen, though the latter measure he thought of doubtful value.

Dr. W. B. Thistle, of Toronto, who was to continue the discussion, was not present.

Dr. H. A. McCallum, recommended the use of strychnine from the beginning on physiological grounds.

Dr. E. Hornibrook, of Cherokee, Iowa, read a paper upon the toxic element in appendicitis having changed his subject from auto-intoxication. He contrasted the state of knowledge, as it was, before and after the discovery of the specific element of infections, but made a plea that the knowledge which had been accumulating for ages should not be too lightly regarded. He dwelt upon the importance of the elimina-

tory organs, kidneys, liver, skin and intestines, and considered in short that a toxic condition of the intestinal tract was a large factor in the production of appendicitis. He quoted the authority of Treves and Bouchard, in support of his view and gave illustrations to show that the condition followed the ingestion of tainted meat and contact with putrifying bodies. He thought the element of toxæmia accounted for the grave results following a case that was apparently mild, and the recovery of cases which had gone on to abscess. From this he reasoned in favour of the starvation treatment, of opium, and of the eliminatory treatment with salines and a proprietary preparation which he mentioned. In conclusion, he said appendicitis was neither a medical nor a surgical disease, it was sometimes one and sometimes another, and should be treated accordingly.

Dr. Dewitt in discussion of the paper, favoured medical treatment rather than surgical and recited his experience with calomel, and boracic acid injections.

Dr. J. Duncan, of Toronto, presented a paper upon the size of the pupil as an aid to diagnosis. He recorded the conditions in which changes are observed and then proceeded to interpret them. After dealing with the anatomy of the eye he divided the changes into several classes, the evenly contracted, the evenly dilated, the unequal pupils, the uneven and movable, the uneven and fixed. He discussed at length the significance of these departures from the normal with especial reference to locomotor ataxia.

Dr. Jennie Drennan, of St. Thomas, read a paper upon the physiological generative cycle in woman. The subject was closely reasoned, and many of the observations profound, so that the paper does not readily lend itself to abstraction. After tracing the connection between function and environment and the influence of heredity in the process of evolution, Dr. Drennan explained the normal cycle of impregnation, pregnancy and lactation, which she termed the normal cycle, and menstruation as a subsidiary and abnormal cycle brought about by the hyper development of the sexual side of the nature. Incidentally she advanced the view that fecundation occurred most commonly between the twelfth and fifteenth day of the intermenstrual period.

The next paper was to have been upon the subject of the decline and fall of atropine, but the reader, Dr. G. Stirling Ryerson, of Toronto, was not present.

Dr. John Hunter, of Toronto, read a paper upon the medical treatment of diseases of the nose and throat. The functions of that portion of the respiratory tract were referred to, including the respiratory and vocal functions. A general statement was made, referring to the

condition of the body, and maintenance of good health, the influence that any other disease of the body would have upon any disease of the nose and throat, and the local treatment consisting of thorough cleansing of the secretions. Several methods were mentioned; amongst others the nasal douche in which great care must be exercised, that the return current be not obstructed lest infectious material be carried into the middle ear, and violent ear trouble set up. Special reference was made to the irrigation tube which consisted of a hard rubber catheter closed at the end with numerous perforations in the circumference. The tube was introduced into the nostril and attached to a syringe. Reference was made to the spray and the medicated vapor and special reference was made to the patient's returning regularly to the physician's office, that after the cleansing process the vestibule should be dilated with a nasal speculum, and by means of a head mirror the nasal chambers illuminated, and with a probe the tissues might be examined, and a stronger application applied to the diseased portions.

The mucous membrane must be cleansed from crust, and stimulating applications applied. In syphilitic lesions the surfaces were cleansed and brushed with a strong solution of iodine. In tertiary syphilis strict attention must be paid to constitutional treatment, iodine of potassium in doses of twenty to a hundred and twenty grains in a tumbler of water, one hour after each meal until physiological tolerance was reached.

### SURGICAL SECTION.

The surgical section was to have been opened by a discussion upon the diagnosis and treatment of tuberculosis peritonitis, by Dr. A. B. Atherton, of Fredericton; Dr. H. A. Bruce, of Toronto; Dr. A. Groves, of Fergus, and L. C. Prevost, of Ottawa, but for some reason which did not transpire openly, it was removed from the programme.

Dr. Hadley Williams, of London, showed a case of gunshot wound of the upper arm, with non-union of humerus, and destruction of the musculo-spinal nerve, with result of operation six months later, and recovery. The case was much commented upon.

Total ablation by bisecting the uterus, was to have been discussed by Dr. T. Shaw Webster, of Toronto, and orthopædic surgery at the present time by Dr. C. W. Wilson, of Montreal, but neither of these gentlemen put in an appearance.

Dr. F. N. G. Starr, of Toronto, was also down for a paper upon the open method of treating fractures, but he too was not present.

Dr. Henry Howitt gave a report of two cases of hour glass contraction of the stomach.

The paper contained a list of twenty-five operations on the stomach, many of which were done in desperate condition of the patients. Two deaths occurred, one, accidental five days after operation and the other owing to the lateness in operating. Of the hour-glass stomach cases, which were reported in full, one was complicated by an ulcer on the posterior wall of the stomach and the other by cancer. The former had a history of gastric distress of thirteen years duration. After the operation the patient made a complete recovery and gained fifty pounds in weight. The other case, an old man 73 years of age, recovered and lived for nearly a year in comparative comfort, being able to take solid food until a short time before his death. In this case the constriction was such that nothing could pass through it to the pyloric pouch. Both had had a history of gastric ulcer.

Dr. J. Alex. Hutchison, presented a paper upon perforation of the bowel in typhoid fever. Dr. Hutchison gave the important symptoms of five cases of typhoid perforation operated upon during the last seven years, the first four of which resulted fatally, the fifth done within the last nine months being successful. The early cases were only operated upon after well marked symptoms of general peritonitis had developed. In the last case the perforation was recognized promptly and the operation done within two hours, before any important inflammatory change had developed in the peritoneal cavity.

The technique was much the same in the whole series, the early cases being done by the median incision, the latter cases by the right inguinal incision. The latter method permitted the rapid exposure of the field, and the early completion of the operation, thus lessening the degree of shock. In addition, after the abdomen was closed the cavity was filled with saline solution through a drainage tube, the tube then being clamped, so that a large quantity of fluid was retained within the abdomen. Dr. Hutchison referred to the opinion expressed by Dr. Osler and Dr. Cushing, that fifty per cent. of the cases occurring in the hospital should be saved.

#### TUESDAY EVENING.

Dr. R. H. Moorhouse, London, then read his presidential address. He conveyed his appreciation of the honour that had been conferred upon him, and welcomed the members to London. He emphasized the advantages of meeting together as tending towards harmony and an appreciation of duties and mutual obligations, towards a higher state of scientific efficiency and the resisting of aggression from without.

He then traced the ancestry of the profession to that King-priest of Salem referred to in Oriental literature and followed it through the



Hellenic period, drawing examples from the Homeric and other early writings. He described its condition in the early days in Canada and insisted upon a high standard of professional and personal culture to meet the advancing needs of a growing country.

The President took up the matter of Dominion Registration, and recited the facts, how several provinces had accepted its terms, how Ontario had allowed the matter to stand over, an account of the Premier's "unstable tenure of office, and the very grave charges brought against some members of his cabinet," and he urged the other provinces to rise in their "might and their right" to resist the "selfish policy of Quebec," by endorsing an amendment permitting a majority of the provinces to put the Bill into operation.

Dr. Moorhouse then dealt with medical literature and hospital equipment, urging the profession to greater efforts in writing, and a fuller use of hospital facilities.

He discussed at some length the evils attendant upon the use of patent medicines and proprietary preparations, composed as they largely were of alcohol and narcotics. He insisted upon the credulity of the public and the dishonest propagation of laudatory testimonials, and upon the liability to encouraging secret vices by their employment. In conclusion, he considered the duty of the practitioner to himself, the necessity for rest and relaxation, for availing himself of all legitimate amusements, for justice to himself in financial matters, and for keeping himself informed of the best that is being done and said in medicine.

Dr. G. M. Gould, presented a paper upon the role of eye-strain in civilization and medicine, a subject which he has made peculiarly his own. He epitomized the clinical symptoms and lessons of eleven patients, whose cases he has studied,—DeQuincy, Carlyle, Darwin, Huxley, Browning, Mrs. Caryle, Wagner, Herbert Spencer, Whittier, Parkman, and Nietzsche. The common symptoms were in varying degrees, headache, insomnia, sick headache, biliousness, dyspepsia, indescribable suffering; there was inability to do literary work without producing these symptoms, and relief of these symptoms when use of the eyes was desisted from, for a day, or even a few hours. There was relief of all the symptoms at about sixty years of age, i.e., with the full establishment of presbyopia. This is a definite symptom—complex and clinical picture which differentiates the fundamental pathologic condition from that of any other disease. Each one of the patients and their physicians were intensely conscious of the strange mystery of the disease, and all repeatedly showed by letters, etc., the causal relation of near eye work to the symptoms. Each found relief in a great deal of walking and physical exercise. Three fundamental

errors were made by their physicians, as well as themselves. 1. That the organ was diseased in which the symptoms appeared; 2. that intellectual labor caused these symptoms, when it was the optical part of it that did so; 3. that the "change of scene," and exercise gave the relief, when it was only the stopping the use of the eyes in reading and writing. The disease was functional; the loss in time and opportunity enormous; the resultant suffering terrible. The physiology of insomnia was set forth, and the way eye strain causes it; also the influence of it in creating dyspepsia, irritability and nervousness, or, sometimes, apathy and exhaustion. The ocular symptoms were described, when they existed, others direct and indirect, intercurrent diseases, etc. The fallacy of the explanations erroneously given of these patients' disease was set forth, and the method in which eye strain does cause it, explained at length. The influence of their disease upon the character of their literary work was of peculiar interest to literary critics. The professional blunderer in diagnosis and treatment was not spared. The value to nations and to civilization of its great men and their work was strongly emphasized and how the neglect of the eye-strain factor is a most costly one to the world. "Its great men and writers are the most valuable asset of a nation," was Dr. Gould's conclusion.

Dr. J. H. Elliott, of Gravenhurst, gave an extremely interesting lecture, with lantern illustrations; on the open air treatment of tuberculosis and Dr. E. J. Barrick, of Toronto, read a paper upon municipal sanatoria for consumptives.

Dr. R. P. Robinson, of Ottawa, gave a paper upon operation in the hip joint without shortening, and showed skiagrams and photographs of the conditions before and after operation.

### WEDNESDAY MORNING.

At 8.30, Dr. Ferguson, of Chicago, performed a thyroidectomy at the Victoria Hospital. Dr. McGraw, of Chicago, gave a demonstration of gastro-enterostomy, but neither of his two cases were considered suitable for complete operation and the wounds were closed.

### MEDICAL SECTION.

Dr. J. S. Sprague, of Sterling, who was to have read a paper on the Country Doctor, was not present and the paper was presented by proxy. He described the early life and trials of a typical country doctor, his efforts to maintain himself, and the self-reliance he gained thereby. In practice he insisted upon the good relation which should prevail between the doctor and the clergyman, uniting liberality with faithfulness to tradition and sympathy with the spirit of the age.

The writer had words of censure for some consultants on the one hand and for fledgings on the other, and for the medical journals who are in the pay of pharmaceutical companies. He advised the members not to lose sight of the old remedies and ended with a peroration on the ancestry of the profession, in which he made a free use of poetical quotations. Dr. Mitchell discussed the question from the standpoint of a quarter of a century of country practice and enumerated amongst the ills they had to endure, lodge practice.

Dr. Meek, said that in his district the physicians had combined to resist the encroachments of the lodges.

Dr. Hunter, of Toronto, urged the country practitioner to ally himself with a political party, and to be a leader in politics as well as in other fields of activity.

### MEDICAL SECTION.

Dr. Geo. F. Butler read a paper upon the inter-relation of diabetes and other constitutional states.

He referred in the outset to the error of fixing upon one condition as a test of disease rather than upon the general complex symptoms. In diabetes, glycosuria was merely an expression of metabolic instability dependent upon nerve disturbance. He then described the conditions affecting the nervous system, which might produce glycosuria, such as parietic dementia, locomotor ataxia and epilepsy, delirium tremens, the confusional insanities and febrile conditions. He then described in a very vivid manner the symptom complex of true diabetes, and insisted upon its central origin. In conclusion, he affirmed that most cases of diabetes were at first merely expressions of nutritional and assimilative instability; in consequence of the overstrain of the liver, adrenals, pancreas, spleen and kidneys, what were at first biochemic changes became permanent pathological lesions.

Sir James Grant complimented the writer of the paper and insisted upon the necessity of a fuller knowledge of the elaboration of sugar. Dr. Gould warned them against confusing a glycosuria with true diabetes and in strong words condemned the careless employment of advertised, non-farinaceous foods. Dr. Butler felt sure that the so-called health foods were productive of dyspepsia.

Dr. G. E. Armstrong had a paper upon the condition known as idiopathic peritonitis which was transferred to the surgical section. He recited a series of cases occurring in his experience, and others taken from the records of the Montreal General Hospital, in which the initial lesion could not be determined. In some cases the infective agent was the diplococcus of pneumonia, in others the staphylococcus, and he dis-

cussed the possible association of the condition with events occurring in the appendix, the fallopian tubes and uterus, in the lungs, the retro-peritoneal tissue, intestines and in the blood stream. Finally he noted the occurrence of infection of the peritoneum after child-birth and gave the record of cases.

Dr. DeWitt, of Nova Scotia, read a paper upon fresh air versus disease, and claimed that if fresh air, acting through the circulation indirectly, checked and destroyed the bacilli of consumption, it would have the same effect on other disease germs. It was possible that most of the ailments, fevers, rheumatism and other diseases, had been treated too much in an environment where the temperature was kept at seventy or eighty degrees. He spoke of the germs of consumption flourishing in a heated atmosphere and doing their most deadly work in the system of the host, when the temperature was a few degrees above normal.

Dr. DeWitt cited several cases of rheumatism successfully treated in the fresh air. He said they must not lose sight of the fact that there was much difference between undue exposure and a judicious use of fresh air, and when they had lived so as to preserve and use it as nature designed, they would be better equipped to employ the most potent of all remedies.

Dr. Roseburgh, of Toronto, who was to have read a paper upon the treatment of inebriates, failed to appear, but supplied the following abstract :—

At the meeting of the Canadian Medical Association held in 1899, an economical scheme for the scientific treatment of indigent inebriates without the establishment of special public institutions, was, by resolution, endorsed by the Association. This economical plan of treatment was subsequently submitted to the Premier and Provincial Secretary of Ontario, and at their request a bill was drafted embodying the various features of the scheme proposed. The bill as drafted was submitted to the Government during the session of 1901. From whatever cause the bill has not as yet been introduced to the Legislature, notwithstanding that it is understood to have the approval of the Premier. The bill was drafted with a view to combining maximum efficiency with minimum expense. To this end, it is proposed to combine the Massachusetts probation system with medical treatment, either in cottage hospitals, special wards in general hospitals or in the form of home treatment in suitable cases. At the outset, a medical inspector will be required to inaugurate the system. For the purpose of stimulating local benevolence the bill provides that the Government shall contribute 33% of the expense involved both in the equipment for and the maintenance of inebriate cases.

The bill has been endorsed by the Ontario Medical Association, the

Toronto Medical Society, the Medical Press of Toronto, the Associated Charities of Toronto, as well as by a number of other influential public bodies. The Quarterly Journal of Inebriety gives the proposed bill its emphatic endorsement and adds "We are confident that this bill will lead all the world as a new economic movement to diminish the misery and crime which associate and follow alcoholic drinking. . . . its success is simply a question of the men to carry out its provisions."

As the Canadian Medical Association has endorsed the underlying principle of the proposed bill and as the bill itself has been endorsed by the Ontario Medical Association and as the latter body has appointed a representative committee to promote its adoption, we ask that similar action be taken by the Canadian Medical Association and we also ask that every member of the medical profession who is in a position so to do, will kindly give the movement a helping hand.

The matter was referred to the Executive Committee.

Cardiac complications of influenza was Dr. E. G. Wood's subject. The frequency of the formidable and dangerous pulmonary complications in that disease was very marked, but it was not so well recognized that the heart often suffered serious danger from which it might never entirely recover. Only a want of recognition of the cardiac dangers in influenza could account for the common practice of administering such large and frequently repeated doses of the coal tar preparations, drugs which in a man of over forty are probably as dangerous in influenza as in pneumonia. Months after an attack of influenza a man would complain of unusual weakness, he was short winded and would sweat on slight exertion, his pulse rate was easily disturbed, and perhaps irregular. Physical examination revealed no sign of organic disease, yet he was suffering from cardiac weakness, either functional, in which case complete recovery was probable; or due to muscular change with a loss of cardiac power that might be permanent.

Influenza might be associated with organic change, or functional disturbances. Organic changes were attributed to the direct action of the influenza bacilli or their toxine upon the heart. These changes were, pericarditis, endocarditis, simple or malignant, or myocarditis. The two former were comparatively rare; the inflammatory condition might be primary, but was usually secondary to influenza, pneumonia or pleurisy. Hence the cardiac affection was not unfrequently latent even in fatal cases.

Toxic myocardiac degenerations in varying degrees of intensity were common in influenza and were responsible for the prevalent cardiac weakness. Cases in point were cited.

The bacillus of influenza, he said, elaborated a poison, which when

circulated in the blood in sufficient quantities acted as a powerful heart depressant by the constant irritation of the poison upon the tissue. So long as those patients remained in bed they might suffer from their influenza symptoms only, but as soon as the patient arose, the heart muscle, enfeebled by the action of the influenza poison was no longer able under the increased stress to perform its functions without unusual and often conscious effort. Hence though the heart might be attacked during the acute stage, it might not be until a later period that the cardiac complication would become manifest.

In all cases of influenza the heart should be watched with the same care that was exercised in rheumatism or pneumonia. Sternal oppression or pain, palpitation, dyspnoea or sense of faintness would call for careful examination of the heart. A small feeble pulse, unusually slow or rapid, and the short feeble first sound and later accentuation of the second, then increased deep dullness should make them think of the beginning dilation. Functional disturbances in influenza included those observed in the cardiac rhythm so commonly met with after the disease in patients who presented absolutely no signs of organic disease of the heart. Those symptoms must be attributed to the action of the influenza poison on the cardiac nervous mechanism, either on the vagus or on ganglia. Among the functional cardiac disturbances were palpitations, irregularities, bradycardia and tachycardia. Fortunately, functional disturbances usually disappeared in a few weeks, but in some instances he quoted they often lasted for years. To distinguish the functional from the organic cases might be extremely difficult and well marked examples of myocarditis were discovered at autopsy in cases which presented no symptoms or even signs of cardiac disease during life.

Dr. James Sampson, of Windsor, condemned in the strongest terms the employment of the coal tar products, and gave specific examples of their pernicious effects.

Dr. McPhedran, of Toronto, would condemn the misuse of these products, but he contended there was a legitimate field for their employment. In comparison with the large number of cases of influenza, he was struck by the variety of heart complications in comparison with pneumonia and diphtheria. He had seen cases of functional disturbance, but had not observed organic changes following influenza.

Dr. McCallum advised the use of stimulants, not necessarily alcohol, but strychnine.

### SURGICAL SECTION.

There were six papers assigned to this section, but only two were presented, the first by Dr. E. B. Secord, of Brantford, upon thrombosis of the femoral vein following aseptic laparotomy and the second

by Dr. Ingersoll Olmstead, of Hamilton. Dr. Olmstead, reported a case of gastro-enterostomy with report of cases. After reviewing the operations of gastro-enterostomy as done in various clinics of Germany, France, England and America, and speaking of the results of different operators, the posterior method was said in most cases to be more satisfactory, and was the one usually employed by the surgeon. In a series of five cases, Von Hacker's method was employed in three of the cases, two being for a malignant stenosis of the pylorus, and the third for a case of cancer of the liver with stenosis of the stomach outlet. All cases recovered and were very much improved, all symptoms passing away after the operation. The two other cases were for simple ulceration of the pylorus, and in these the operation of Roux was performed. Both of these cases did perfectly well and gained from twenty to thirty pounds in weight after the operation.

Dr. Howitt, of Guelph, and Dr. Carstens, of Detroit, discussed the paper fully.

#### WEDNESDAY AFTERNOON.

The proceedings opened with a general meeting at which, Dr. Ferguson delivered the address in surgery.

The surgery of to-day was his topic and he designated it as being not national but cosmopolitan. The physician and surgeon, so far from being antagonistic, were inseparable and the best results in surgery were obtained, not by competitive struggle between physician and surgeon, but by a graceful co-operation, one with the other for the benefit of the sufferer. Dr. Ferguson then passed in rapid review many of the operations in surgery, for example, the removal of cerebro-spinal fluid by lumbar puncture, the use of the trephine for the relief of traumatic epilepsy, the X-ray diagnosis of fractures of the skull and detection of bullets, and division of the sensory root of the Gasserian ganglion for relief of *doloureux*. Reference was made to the relief afforded to facial palsy and facial contractions by anastomosis of the spinal accessory and the facial nerve. Improved methods for closure of cleft palate, temporary closure of the carotids, and the enigma of the behaviour of the thyroid fluid in health and disease, and the results of operative treatment received attention in the paper.

The following subjects were discussed further from the surgical point of view, mammary carcinoma, wounds of the heart, surgery of the lungs, visceral pleurectomy and joint surgery.

A retrospect of the study of medicine since the writer entered the profession twenty-six years ago was bewildering. He described an amputation witnessed a quarter of a century ago, and said the advance had

been marvellous. The improvement in abdominal surgery had been most marked. He pointed out that any operation for the cure of oblique inguinal hernia which did not take into consideration the various local causes and natural relationship of structures should be discarded. He then described his operation for that condition. Liver surgery and the surgery of the gall-bladder, the pancreas, spleen, kidneys and prostate were then touched upon. The present day surgery of the female pelvic organs, of the appendix, stomach and intestines, were reviewed in graphic terms. In conclusion, he said that a cure for the two monster human destroyers, cancer and tuberculosis, would materially limit the surgery of the future—a consummation devoutly to be wished.

At the general meeting the following nominating committee was appointed: Ontario, Drs. Mitchell, Cameron, Farncombe, Eccles, Gunn, Herald, Powell and Sir James Grant; Quebec, Drs. Armstrong, Hutchison and Macphail; New Brunswick, Dr. Atherton; Nova Scotia, Dr. Dewitt; North-West Territory, Dr. Patrick; British Columbia, Dr. Gibbs. An address on gynæcology was to have been delivered by Mathew D. Mann, of Buffalo, but the secretary had no intimation at the moment as to whether or not he would be present.

### MEDICAL SECTION.

Dr. A. McPhedran read a paper upon amyotrophic lateral sclerosis. He presented a case with photographic illustrations. The patient was a man aged forty-eight and lived an outdoor life. The symptoms began a year before admission to the Toronto General Hospital, with some weakness and stiffness in the legs, and a few months later the left arm and hand became weak, and then the right arm and hand. About the same time he found his speech defective and swallowing difficult. Upon admission to the hospital he was barely able to walk, and was unable to feed himself. The legs were markedly spastic, but showed atrophy. The hands and arms were the seat of marked atrophy and almost helpless. The face showed some atrophy, the speech was almost unintelligible; the swallowing was difficult, fluids could only be swallowed in an erect position. He left the hospital growing worse and showing the mental perturbation that usually accompanies the disease.

Dr. Benedict, of Buffalo, read a paper upon multiple visceral lesions; two other papers, by Drs. Burnham and Wright were not given. Dr. Dixon, of Toronto, exhibited the Finsen light, and Dr. McCallum exhibited a case of adherent pericardium.



## SURGICAL SECTION.

Dr. J. Price-Brown, Toronto, read a paper upon the "relation between the general practitioner and the specialist in regard to the treatment of intra-nasal disease. He defined the position and mutual relation of these two classes, and pointed out the bearing of the triple function of the nose upon general conditions, namely its purifying, heating and saturating the air of respiration. After describing in detail the qualifications of the ideal nose, he urged upon the general practitioner sufficient knowledge and care to detect any departure from that standard, and ability to deal with defects of minor importance. Dr. Price-Brown described his method of treating atrophic rhinitis, sub-acute and chronic catarrh, and pointed out several conditions with which the general practitioner could adequately deal, namely, the removal of spurs and ledges, of nasal polypi, and empyema of the antrum of Highmore. But he warned them against the dangers attendant upon the use of the thermo-cautery on account of the infiltration that may follow its careless employment. Upon the other hand he enumerated the conditions that should be handed over to the specialist, such as turbinectomy and the removal of tumours, even in preference to having them dealt with by the general surgeon. Dr. Price-Brown then referred to the electrical methods of intra-nasal operation, quoting from an unpublished paper of Bryson Delavan, and saying that he himself had employed the method with excellent results, eight years ago, as was proven by published cases.

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The question of municipal sanitarium for the cure of consumption was introduced and a resolution was submitted, urging the Government of the province to make provision. The resolution was supported by Rev. Dr. Moore, of Ottawa, ex-moderator of the Presbyterian General Assembly, and it was carried unanimously.

The association agreed to invite the British Medical Association to hold its 1905 meeting in Toronto.

Another resolution urged the Government to establish a Department of Public Health.

In the afternoon, the London Hunt and Country Club entertained the visitors at tea at the Kennels. In the evening a dinner was given at the Provincial Asylum, and both entertainments were much enjoyed.

On Thursday morning, a large number of members visited Walkerville and Detroit as the guests of Messrs. Parke, Davis & Co., the well known manufacturers of proprietary preparations, and were given a liberal entertainment, including luncheon, dinner, a sail on the river and free transportation both ways.

On Friday morning a general meeting was held for the reception of reports of Committees, and the election of officers:

President, S. I. Tunstall, Vancouver; Vice-Presidents, A. McPhedran, Toronto; F. G. Finley, Montreal; G. E. DeWitt, Nova Scotia; Dr. Blair, New Brunswick; R. L. Fraser, Victoria; T. A. Patrick, Yorktown, Assa.; S. R. Jenkins, Charlottetown; J. A. McArthur, Winnipeg; Local Secretaries, Ingersoll Olmstead, Hamilton; Andrew Macphail, Montreal; C. D. Murray, Halifax; Dr. Crawford, St. John; W. Bryden Jack, Vancouver; D. Low, Regina; A. E. Douglas, Hunter River, P.E.I.; W. Rogers, Winnipeg; General Secretary, George Elliot, Toronto; Treasurer, H. B. Small, Ottawa.

Dr. George Elliot, of Toronto, performed the duties of General Secretary, and Dr. R. P. Robinson, of Ottawa, replaced Dr. H. B. Small, who was unable to be present, as treasurer.

The meeting in 1904 will be held in Vancouver.

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#### MCGILL MEDICAL COLLEGE.

The seventy-second session of the McGill Medical Faculty, will commence on Tuesday, 22nd September, at 3 p.m., by an introductory lecture. The lectures will be resumed the following day and will continue till the 21st May, 1904, when the annual examinations will begin. The matriculation examination has been raised by the introduction of physics and chemistry, and it begins the 9th September, ending the sixteenth. The fee is five dollars, and the annual fees \$125. To judge from the number of enquiries, it is expected that the Freshman class will be very large.

Dr. J. G. McCarthy, has been appointed assistant professor in anatomy; Dr. J. G. Horsey, assistant professor in pharmacology, both formerly on the list of lecturers. To the latter have been added the names of Dr. R. A. Kerry, lecturer in pharmacology; Dr. S. Ridley Mackenzie, lecturer in clinical medicine; Dr. John McCrac, lecturer in pathology; Dr. D. A. Shirres, lecturer in neuro-pathology, and Dr. D. D. McTaggart, lecturer in medico-legal pathology, whilst to the list of demonstrators have been added the following:—Drs. C. K. P. Henry and A. R. Pennoyer, assistant demonstrators in anatomy; Drs. W. L. Barlow and C. B. Keenan, assistant demonstrators of clinical surgery; Drs. G. K. Grimmer and W. H. Jamieson, assistant demonstrators in laryngology; Dr. D. Patrick, assistant demonstrator in gynæcology, and Drs. B. W. D. Gillies and C. A. Peters, assistant demonstrators in clinical medicine. Dr. H. Wolferstan Thomas has resigned his fellowship in pathology to accept an offer from the school of Tropical Medicine in Liverpool.

## BISHOP'S COLLEGE.

The thirty-third annual session of the Faculty of Medicine of the University of Bishop's College will commence on Tuesday, 15th September, by the usual opening lecture. It will continue till the 28th of May, the date of Convocation, with only the Christmas holidays intervening.

The professorial staff has Dr. Hebbert added to it in the department of anatomy, and Dr. Deeks has resigned his lectureship. The schedule of lectures has been entirely remodelled in accordance with the new regulations to give a graded course and to provide for the greatest economy in the students' daily work.

In outline, the course is as follows:—

First year:—anatomy, practical anatomy, physiology, practical physiology, histology, chemistry hospital attendance.

Second year:—anatomy, practical anatomy, physiology, practical physiology, materia medica and general therapeutics, dispensing chemistry, practical chemistry, histology, hospital attendance.

Third year:—medicine, clinical medicine, surgery, clinical surgery, general pathology and bacteriology, obstetrics, clinical obstetrics, gynaecology, clinical gynaecology, pharmacology, and general therapeutics, medical jurisprudence and toxicology, hygiene, autopsies.

Fourth year:—medicine, clinical medicine, surgery, clinical surgery, autopsies, obstetrics, clinical obstetrics, gynaecology, clinical gynaecology, ophthalmology and otology, laryngology and rhinology, dermatology, pediatrics, psychiatry.

The fees remain as heretofore, \$100, with \$30 for graduation.

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### MONTREAL GENERAL HOSPITAL.

The Montreal General Hospital report for August, shows that there were 243 patients admitted into the wards during the month, 217 discharged and 18 deaths. The average number daily in residence was 188. There was a great increase in the number of typhoid fever cases, which severely taxed the capacity of the hospital; at one time 35 cases, as compared with 15 for the same date last year. The ambulance responded to 140 calls. There were 2,904 consultations in the out-door department. The incoming resident medical staff enter upon their duties to-day, 1st September.

In July 280 patients were admitted and there were 21 deaths. The ambulance responded to 127 calls, and in the out-door department there were 2,672 consultations.

## ROYAL VICTORIA HOSPITAL.

Record for the month ending August 31st: Patients in hospital at last report, 185; admitted during month, 223; discharged, 224; died, 9; patients in hospital at this date, 175. Discharges: cured, 134; improved, 79; unimproved, 5; not treated, 6; died, 9; total, 233. Admittances: medical, 81; surgical, 101; ophthalmological, 8; gynæcological, 27; laryngological, 6; total, 223. Out-door department: Medical, 939; surgical, 475; eye and ear, 279; diseases of women, 164; nose and throat, 250; total, 2125. Ambulance calls, 55.

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## WESTERN HOSPITAL.

During the month of August, there were 44 patients admitted to the hospital. In the out-door department there were 665 consultations, divided as follows: medical, 206; surgical, 153; gynæcological, 107; eye and ear, 55; nose and throat, 96; skin, 15; genito-urinary, 33.

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The Ontario Government has voted \$4,000 to the Gravenhurst Sanatorium under the general statute providing for such grants.

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The ratepayers of Winnipeg by abstaining from voting have defeated the by-law to raise \$60,000 to provide improvements for the General Hospital.

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As a result of the public attention that was called to the condition of the St. John Hospital, the management has decided to expend \$20,000 in enlarging and improving the institution.

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Dr. McArton, of Paisley, died on the 10th August, in his 51st year.

Dr. J. B. Lundy, of Preston, died on the 20th August, in his 77th year.

Dr. Lucius S. Olle, of St. Catharines, died on the 15th August, in his 73rd year.

Dr. James McGarry, Niagara Falls South, died on the 13th August, at the age of 69 years.

Dr. Fife Fowler, dean of Queen's Medical College, Kingston, died on the 3rd August, at an advanced age.

Dr. J. W. McLaughlin, Registrar for West Durham, died in Bowmanville, on the 9th August, aged 63 years.

The death is announced at Guelph on the 18th July, of Dr. E. H. Wells. He died after a two day's illness of pneumonia.

Dr. E. C. P. Chevrefils, inspector of prisons, asylums and public offices for the province of Quebec, died in Montreal on the 23rd of August, in his 68th year.

Dr. Charles Mickle, of Buffalo, died in Ashville on the 21st July. His native place was Guelph and he was buried in Toronto. Dr. Mickle was a graduate of Trinity University in 1880.

Dr. W. J. Nelson, of Winnipeg, died on the 16th July, after a long illness and operation. The cause of death was pneumonia following the impaction of a piece of chewing gum in the bronchi. Dr. Neilson was the member for North Winnipeg in the Legislature and a graduate of McGill University.

Dr. Donald Maclean died in Detroit of gastro-enteritis on the 24th July. Dr. Maclean was a Canadian, a graduate of Edinburgh and practised in Kingston, Ont., up to 1870. He was a surgeon in the United States Army, professor of surgery in the University of Michigan, chief surgeon of the Michigan Central Railway, and in 1894 president of the American Medical Association.

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## Retrospect of Current Literature.

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### MEDICINE.

UNDER THE CHARGE OF JAMES STEWART, F. G. FINLEY AND H. A. LAFLEUR.

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#### Stokes-Adams Disease.

WILLIAM OSLER. "On the so-called Stokes-Adams disease. *The Lancet*, August 22, 1903.

The brief notice which many of the rarer yet very important syndromes or symptoms-complex, command in our text-books, can scarcely avail to give the student an adequate idea of the application of such terms as Stokes-Adams disease, Banti's disease, and Von Recklinghausen's disease. One must turn to such comprehensive articles as appear from time to time written by leading clinicians and including quotations from many observers, if one would acquire an up-to-date knowledge of any of these rarer forms of disease. Professor Osler has contributed largely to the knowledge of many of the more obscure conditions with which one is liable at any time to meet. This article now under review is another of those comprehensive yet succinct descriptions of the conditions included under the term "Stokes-Adams dis-

ease," which therein is described as a clinical condition characterized by:—

1. A profound disturbance in the automatic mechanism of the heart—true bradycardia, hemi-systole (false bradycardia), and allorhythmia.

2. Nervous symptoms, vertigo, syncope, pseudo-apoplexy and epileptiform attacks.

3. Secondary symptoms, Cheyne-Stokes breathing, cardiac asthma, angina pectoris, and the vaso-motor accompaniment of profound heart-shock.

"The clinical picture is very variable—there are acute, rapidly fatal cases, chronic cases in which for years the patient has a slow pulse with syncopal or pseudo-apoplectic attacks, and forms in which slight but well characterized attacks occur at intervals in persons apparently well."

There are no constant post-mortem changes, but in a large proportion of cases arterio-sclerosis is present, while in some no lesion is to be found. While patients presenting this symptom-complex were recognized so long ago as 1827, when Adams described his case, yet the number of reported cases, while doubtless increasing, is yet small. The cases are arranged in three groups: (1) the post-febrile group, where bradycardia, vertigo, syncope, or epileptic seizures come on after an attack of typhoid fever, diphtheria, pneumonia, etc.; (2) the neurotic group (a) with coarse lesions of the nervous system especially medullary pressure or vagi lesions, (b) with no lesion distinguishable; (3) the arterio-sclerotic group comprising the greater number of all reported cases.

Dr. Osler analyzes twelve cases, all of which were male patients, three were above 76 years of age, and six were between 50 and 70 years of age. The youngest was 35 years old—the case following a streptococcus infection. Excluding this patient, these cases are grouped as follows: five cases with severe and acute symptoms, four cases—a senile group; two cases—a milder form. Did space permit a complete review of the cases quoted would be made.

What happens to disturb the rhythm of the heart? "Is the essential factor central in the medulla, or in the ganglia of the heart, or in the automatic mechanism of the muscle itself, or in the auriculo-ventricular bundle of His, jun., or in Kronecker's coordination centre?" It is not known. Transient anæmia of the nerve centres explains vertigo and syncope—and this may be of cardiac origin, or it may be due to local changes in the medulla. The prognosis is bad in all cases. The treatment with potassium iodide, nitrites, atropine, regime, posturing with an on-coming attack, and inhalation of oxygen have all been found of service.

**Sciatica.**

WILLIAM BRUCE. "Sciatica—an inquiry as to its real nature and rational treatment, founded on the observation of upwards of 400 cases." *The Lancet*, August 22, 1903.

In this interesting article Dr. Bruce advances, with becoming earnestness, the view that sciatica, is some affection of the hip joint and not neuritis of the sciatic nerve, that it is connected with the gouty or rheumatic diathesis, and also with so-called mono-articular rheumatic arthritis of the hip. He finds support for this view in many quarters—the site of pain in early cases—about the hip, the flattening of the glutei and the obliteration of the folds of the nates, in the absence of positive signs of a neuritis in the unaltered nutrition of the other muscles of the leg, etc. etc., and in the results of the treatment by *rest!*

MACFAYDEN AND MACCONKEY. "An experimental examination of mesenteric glands, tonsils and adenoids with reference to the presence of virulent tubercle bacilli." *The British Medical Journal*, July 18, 1903.

The experiments were primarily undertaken with a view to determine the presence or absence of virulent tubercle bacilli in the mesenteric glands of young children by an examination of suitable post-mortem material,—thus furnishing possibly some additional data with reference to the importance of the digestive tract as a channel for the entrance of tubercle bacilli into the system. Twenty-eight cases were examined, two only being of patients above five years of age. Tuberculosis was found in but eight of these cases—twenty being non-tuberculous. The animal inoculation experiments showed that virulent tubercle bacilli were present in the mesenteric glands in ten of the twenty-eight cases, eighteen were negative, while of the eight cases of tuberculosis, five gave a positive and three a negative result.

Tubercle bacilli from these experiments it would appear are present in the mesenteric glands more frequently than ordinary post-mortem examinations would lead one to suppose.

The adenoids and tonsils presented no signs of tubercle and in not a single case were tubercle bacilli found in the animal experimented on. In the mesenteric glands of a still-born child, tubercle bacilli were detected.

W. F. H.

## SURGERY.

UNDER THE CHARGE OF GEORGE E. ARMSTRONG.

**The Surgery of Simple Diseases of the Stomach.**

B. G. A. MOYNIHAN, F.R.C.S., Eng. The Surgery of the Simple Diseases of the Stomach. *Boston Medical and Surgical Journal*, June 4, 1903.

The great majority of the simple diseases of the stomach which are successfully treated by surgical intervention are caused by ulceration, or its complications, or results. These various conditions are taken up as follows: (1) Perforation of gastric or duodenal ulcers; (2) Hæmorrhage from gastric or duodenal ulcers; (3) Chronic ulcer, its various clinical types.

In the case of perforation of a chronic ulcer medical treatment alone may lead to cure; (the writer mentions two cases in which a diagnosis of perforation had been made, treated medically of necessity, and the subsequent operation revealed undoubted evidence of a peritonitis completely surrounding the stomach) nevertheless, the difficulties of diagnosing the variety of perforation, its location, the uncertainty of spontaneous recovery and of limiting adhesions, are such as to make it imperative to adopt operative treatment at the earliest possible moment. "The risk of operation is definite, the hazard of delay immeasurable."

Some difficulty in the diagnosis may be experienced if morphine has been previously given, or when the acute pain, etc., is associated with menstruation. The writer puts great stress upon the absence of abdominal rigidity in these conditions, while a continual hardness and rigidity is present in cases of perforation. He does not consider excision of the ulcer at all necessary, but first closes the hole by a single catgut suture and reinforces by two continuous sutures of Pagenstecher thread. If operation be performed within 10 to 12 hours after rupture, no irrigation or drainage is necessary, but a gentle wiping over of surrounding area with wet swabs. If drainage be necessary it should be free, as also should be irrigation by enlarging first incision and by a second superpubic incision. The multiplicity of perforating ulcers is emphasized, double perforation being present in no less than 20 per cent., and generally "on the posterior surface at a point exactly opposed to the first."

Hæmorrhage may take place from an acute or from a chronic ulcer, and the clinical picture in the two cases differs widely. The characteristics of hæmorrhage from an acute ulcer are:—"Spontaneity, abruptness of onset, the rapid loss of a large quantity of blood, the marked



tendency to spontaneous cessation, the infrequency of a repetition of the hæmorrhage in anything but trivial quantity, and the transience of the resulting anæmia." Hæmorrhage from a chronic ulcer varies greatly in frequency and quantity.

(1) It may be latent or concealed and recognized only after minute examination of stomach contents and fæces.

(2) It may be intermittent. Here the bleeding is copious but transient and occurs at intervals of two, three, or more months. In this group indigestion is a prominent symptom and anæmia is almost constant.

(3) In this class the hæmorrhages are rapidly repeated, at intervals of 12 to 24 hours, and are always large, a pint to a pint and a half of blood being vomited. These cases all give histories of long standing indigestion, with recent increase in severity of pain, etc., and then suddenly, and without apparent cause a profuse hæmorrhage occurs to be repeated as above. This, if unchecked, will cause the patient's death.

(4) Here the hæmorrhage is enormous, instant, overwhelming and lethal. Fortunately this class is very rare. The hæmorrhage is due to the opening into the aorta, vena cava, splenic, or pancreatic-duodenal vessels. The writer cites one of his cases where the splenic artery was opened into.

Hæmorrhage from an acute ulcer does not frequently call for surgical intervention, but there are some cases in which the hæmorrhage may be both copious and recurrent. Some cases present no single bleeding point, but the whole mucosa appears to be weeping blood, or there is a villous patch, or many irregularly scattered points of oozing. In all these cases the writer regards any attempts directed locally to stop bleeding as futile, and strongly recommends a gastro-enterostomy as proving "more effective than any other procedure, both in checking the hæmorrhage and in preventing its recurrence." Hæmorrhage from a chronic ulcer requiring surgical treatment is limited mainly to class (3) in which the hæmorrhage is frequently repeated and always abundant. Here again local treatment is considered as "unnecessary, undesirable, and in many cases impossible," and gastro-enterostomy is strongly advocated.

The liability of mistaking a chronic ulceration for malignant disease is dwelt upon, and the following contrast given. "A malignant growth is always irregular, knotted, nodular or gritty on the surface; an inflammatory mass is more smoothly rounded off, and there is often a milky opacity on the peritoneum." He regards Hauser's estimate of 6 per cent. for the frequency in which malignant disease develops in chronic ulcer as being in "excess of the truth."

As a result of chronic ulcer, we have the hour-glass stomach produced, or a trifold stomach, or a dilated stomach due to pyloric or duodenal obstruction, and also a warping of the stomach from adhesions to abdominal wall or neighbouring organs and structures, all giving rise to an inveterate dyspepsia; and "inveterate dyspepsia is, in itself, an ample warrant for surgical treatment." The operative treatment is a gastro-enterostomy. "In all cases, therefore, I submit gastro-enterostomy, and gastro-enterostomy alone should be performed. Excision is unnecessary, often impossible, always insufficient (the ulcers rarely being solitary), and is, therefore, not to be commended. Pyloroplasty is an uncertain operation, and its results cannot compare with those seen after the operation of gastro-enterostomy."

The operation is performed by forming the anastomosis on the posterior surface of the stomach (von Hocker's method), he uses no mechanical aids, claiming that the simple suture is a speedy, "applicable to all forms of anastomosis, and is not open to the objection that future troubles are at least possible." The cut surfaces are united by two suture-lines surrounding the anastomotic ring; an inner, hemostatic, including all layers of the gut, and an outer, approximating, taking in only the serous and subserous coats.

Hour-glass Stomach:—The writer doubts the existence of a congenital hour-glass stomach, and states, "there is, indeed, no inherent improbability in the existence of congenital hour-glass stomach, but it lacks proof." Acquired hour-glass stomach may be produced by (1) perigastric adhesions resulting from gastric ulcer, tuberculous peritonitis, inflammations of gall-bladder, etc.; (2) ulcer with local perforation and anchoring to anterior abdominal wall or pancreas; (3) chronic ulcer; (4) malignant disease. The symptoms vary according to the position of the constriction; if near cardiac end they will resemble œsophageal obstruction low down; if near pylorus those of dilated stomach will be found.

The differential diagnosis is between an œsophageal stricture low down and a constriction near cardiac end, this can be cleared up by passing the œsophageal bougie; and between a dilated stomach and a constriction near the pyloric end, this is determined by gastric lavage (Wölfler's two signs).

The operation will depend upon condition found, and attention is called to the existence of a dual stenosis. The following operations may be performed. (1) Gastroplasty or (2) Gastro-gastrostomy in cases of single hour-glass stenosis. (3) Either of the foregoing with gastro-enterostomy from the pyloric pouch, in cases of dual stenosis. (4) Gastro-enterostomy from cardiac pouch, when pyloric pouch is so

small it can be ignored. (5) Gastro-enterostomy from both pouches. (6) Partial gastrectomy—the operation of choice in malignant stricture in the body of the stomach.

The contribution is based upon the following cases:—

Perforating gastric or duodenal ulcer, 12 cases, 6 deaths; gastro-enterostomy for chronic ulcer, 70 cases, 1 death; pyloroplasty, 3 cases, 0 deaths; hour-glass stomach, 15 cases, 3 deaths; gastroplication, 1 case, 0 deaths; excision of ulcer for hematemesis, 1 case, 1 death.

#### **A Criticism of Current Doctrines Concerning Hernia.**

EDWARD DEANESLEY, M.D., F.R.C.S., Eng., Honorary Surgeon Wolverhampton General Hospital. "A Criticism of Current Doctrines Concerning Hernia." *British Medical Journal*, June 27, 1903.

The author's contention, briefly, is that oblique inguinal hernia, ordinarily regarded by surgeons as being in the majority of cases "acquired," is in reality always "congenital"; that is that even in the so-called acquired cases the hernia comes down through an unclosed tunicular process, present since birth.

In the first place, he argues, it is inherently probable. Again the frequently large size, narrow neck, and rapid development of the early inguinal hernia argue for a pre-existing sac as against an intact peritoneal wall. It is further well known that the first appearance of a hernia may be delayed for many years in a person in whom the funicular process is congenitally patent; and, indeed, this condition has been found not infrequently in patients who have never had a hernia. There is, therefore, "no difficulty in believing that a patent funicular process exists from birth in every oblique inguinal hernia, whatever the age at which it first appears." The question is not of merely academic interest; and the author draws the practical deduction, that, if every case is congenital, it can be completely cured by removal of the congenital malformation—that is, the sac—provided the operation is done soon after the first appearance of the hernia, or, at any rate, before the presence of the hernia or the pressure of a truss have produced secondary distension and atrophy of the muscles of the inguinal canal. Operation therefore should be the rule, and the truss the exception.

#### **The Treatment of Gastric Ulcer.**

JOHN C. MUNRO. "The surgical treatment of gastric ulcer." *Boston Medical and Surgical Journal*, 20th August, 1903.

Dr. Munro believes that sixty per cent. of all cases apply for relief too late, from a surgical point of view. He is of opinion that three-fourths of the diagnoses based upon chemical analyses are of no value

though interesting, and quotes the dictum of Mikulicz; the danger to life from gastric ulcer is at least not less, but probably greater, than the danger of a complete modern operation. In conclusion he urges a more intimate co-operation of the physician and surgeon in the observation of patients with ulcer of the stomach. The surgeon, he says, must willingly grant that a majority of simple ulcers are best treated and cured by the internist, but on the other hand, the latter must as willingly consider surgical advice in the obstinate or serious types of cases, and learn in the living a pathology that it is impossible to learn in any other way.

### **Operation for the Radical Cure of Varicocele.**

ROBERT M. THORNBURGH. "The suprapubic operation for the radical cure of varicocele, with a report of eighteen cases." *Medical Record, 29th August, 1903.*

From these cases the writer concludes that the suprapubic route seems to be the better. The field of operation can be more readily rendered aseptic; a dressing once properly applied will remain indefinitely and not be affected by the movements of the patient, and primary union is a practical certainty. It would appear to the writer that there are no advantages whatever that can be urged in favor of the scrotal incision.

### **Extirpation of the Urinary Bladder.**

FRANK HARTLEY. "Extirpation of the urinary bladder." *Medical News, 29th August, 1903.*

This is an elaborate study of 23 cases with 12 recoveries. The different methods of operating are fully discussed; the writer favours in the male cutaneous or urethral implantation of ureters.

### **Mammary Cysts.**

ROBERT ABBE. "Consideration of mammary cysts in the differentiation of breast tumours." *Medical Record, August 15th, 1903.*

Dr. Abbe lays stress upon the prevalence of cysts, which are often erroneously diagnosed for malignant tumours and quotes 41 cases in support of his argument. He concludes that the severe treatment of mammary amputation, at one time widely advised, and still advocated by some, has been much modified by recent discussion.