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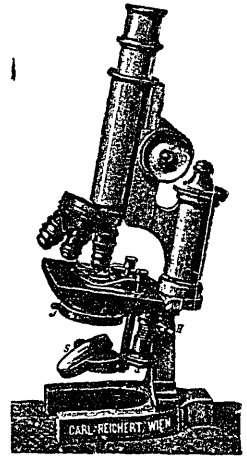
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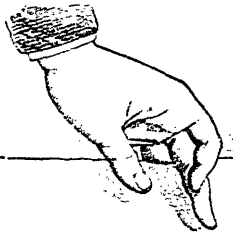
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VOL. X.

HALIFAX, N. S., OCTOBER, 1898.

No. 10.

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Original Communications.

OPERATIVE TREATMENT OF CANCER OF THE TONGUE.\*

By G. E. ARMSTRONG, M. D., Montreal.

The interest in cancer has increased of late years for two reasons. First, hope of securing better results has gradually developed. This increased hopefulness has resulted from two doctrines, the one, agreed to now by all pathologists, that cancer is primarily a local disease, and the other, that there is, in some cases at least, a pre-cancerous stage. Cancer being primarily a local disease, it becomes the duty of the family physician to strive to recognize it in its earliest stage, and the duty of the surgeon to remove it altogether, to completely eradicate it so that not one cancer cell is left behind. Of not less importance is it to prevent the occurrence of any local condition that may under any favourable circumstances take on malignant action. With this object in view, the wise physician advises his patient to consult a dentist at regular intervals, that no carious tooth may cause ulceration of the jaw or projecting point irritate the tongue, and smoking should be prohibited during the secondary stage of syphilis. The accoucher should take a far-seeing interest in the condition of the breast of his patient and thus prevent the occurrence of sore nipples and the train of pathological conditions so frequently resulting from them.

Another stimulus to greater interest in cancer is its increasing frequency of occurrence. Park, in an article in the May number of the

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\*Read at Meeting of Maritime Medical Association, Halifax, July, 1898.

*American Journal of the Medical Sciences*, gives some figures that are startling. I will quote from that article, two or three paragraphs.

"In 1840, in England, the proportion of deaths from cancer, as compared with the total mortality, was 1 in 129; in 1880 this had risen to 1 in 28. Williams estimated a few years ago that at least 40,000 persons were suffering from cancer in England and Wales; this augmented cancer mortality rate became conspicuous notwithstanding great improvement in the general sanitary condition. In 1861 there were in England 376 deaths from cancer to the million of population. Twenty-five years later there were 610, and this at a time when the death rate from phthisis had notably diminished. There can be no doubt that the proportion of this increased death-rate may be in part accounted for by more accurate diagnosis; nevertheless, the death-rate is unquestionably double what it was twenty years ago.

"From the returns of the New York State Board of Health during the ten years from 1885 to 1895, he finds that there have been reported 30,692 deaths from cancer. In the last year of this decade the total number of deaths from cancer was twice that of its first year. Such an increase in the frequency of this most fatal disease should certainly stimulate all of us to greater efforts to master it."

A number of cases of cancer of the tongue having during the past few years been admitted to the wards of the Montreal General Hospital under my care, I have given the subject a good deal of attention and with your kind permission I will very briefly give you the result of my work.

I will not speak of the diagnosis, as it is well considered in many modern text books and I have nothing new to add, unless it be to urge the removal of a piece for microscopic examination in all doubtful cases. On one point I think that we will all agree, viz.: that a positive diagnosis should be made before any treatment is advised or practiced. The irritation of small malignant ulcers of the tongue by caustic does harm, and should never be done. It is a cardinal rule in surgery to remove a cancer altogether or leave it alone.

The principles that should guide us in removing a cancerous tongue are the same that have been adopted in dealing with malignant diseases of the rectum and breast, that is to cut wide of the disease, and to systematically, in all cases, remove the affected lymphatic glands. One other condition must be attained in excision of the tongue, and that is to see that the patient has pure air to breathe during convalescence.

Most of the operations described in the English text-books, and especially what I may style the popular operations, fail in fulfilling one or more of these requirements. The ecraseur has had its day and is no longer much used. The same may be said of Symes' operation. An operation which I have done several times, which is popular because easily and rapidly performed, is Whitehead's, or Whitehead's operation after preliminary ligature of the linguals. Now this method of removing the tongue makes no provision for the removal of affected lymphatic glands or for providing pure air for the patient to breath, and should be discarded, because so often followed by the so-called recurrence in the glands of the neck and by aspiration pneumonia.

The operation which has given me so far the best results is somewhat formidable to contemplate, but is very satisfactory in practice. I refer to the method devised by Kocher of Berne. He first does a preliminary tracheotomy. The patient then breathes during the remainder of the operation, and during convalescence, an atmosphere as pure as the room or ward contains, and the danger of aspiration pneumonia is done away with. The anæsthetic is administered through the tube, and a large sponge is packed into the pharynx over the epiglottis and no blood with contaminated mouth secretion can get into the trachea or be drawn into the lungs. Kocher then makes an incision extending from below the ear to the hyoid bone, and then up to the symphysis of the lower jaw. All the glands in the parotid, submaxillary, submental and carotid regions are removed, including the submaxillary salivary gland. The facial artery is tied, and the loss of blood is reduced to a minimum.

During the past winter I have performed excision of the tongue for cancer six times. In one instance I did not do a preliminary tracheotomy. The man did well for a time, he was up and about the ward, but on the tenth day after operation he developed a septic pneumonia which proved fatal. In the other five cases, a preliminary tracheotomy was done in each instance and they all recovered. In every case, although the operation was a formidable one, the patient was up and about the ward the following and each subsequent day. There is very little loss of blood and consequently very little shock, and these patients begin to gain strength at once.

Kocher does not close the large wound, but packs it with gauze around a drainage tube. I have found it an advantage to close the wound, leaving only sufficient space for the insertion of a large tube.

Within the tube I pack iodoform gauze, after having painted the stump with a solution of iodoform in ether. The wound heals by first intention. Any discharge that occurs passes out through the dependent drain.

Mr. Butlin of St. Bartholomew's hospital, London, in an article published in the *British Medical Journal* for Feb. 26, 1898, advocates a still wider incision. He would make an incision from the mastoid process down along the anterior border of the sterno-mastoid muscle to the level of the lower border of the thyroid cartilage, and another from the middle of the chin joining the first at the level of the upper border of the thyroid. By reflecting the two triangular flaps thus outlined very good access is obtained to each of the regions where infected glands are usually found. He does not mention tracheotomy, which may justify us in assuming that he does not practice it as a rule. Mr. Butlin suggests that it may be advisable to postpone the operation upon the glands of the neck for two or three weeks after the removal of the tongue. In some instances, when the patient is in very poor condition for enduring an operation, this may be a wise plan, but so far I have removed the glands at the same time as the tongue, and the recovery from operation, and the reparative power evidenced during convalescence, has given me no cause to repent having done so. A second operation is generally dreaded by a patient quite as much as a first, and if all can be done at one sitting without undue call upon the patients resisting powers it would seem to be well to do so. Another plan which Mr. Butlin adopted in a few cases was to leave the glands and warn the patient to return as soon as any could be felt. But he found that, when these patients returned, the glands were so extensively involved and so surrounded the great vessels of the neck that they could not be removed.

Another very important question is that of removing the whole or only a part of the tongue. I think that most surgeons are in the habit of removing the whole tongue, on the ground that the danger of the operation is not increased by so doing, that the liability of recurrence is lessened, and that the portion left in partial operation is of very little if any service, Lord Lister and Mr. Jonathan Hutchinson standing almost alone in favour of the partial operation. On this point Mr. Butlin's evidence is of great value. He reports 102 cases of excision of the tongue. He divides them into two classes, the hospital and private. Cases that are alive and well three years after operation or have died

within that period of some other disease without any evidence of recurrence are considered as cured. Estimated in this way, his hospital cases have given him 20% of cures and his private cases 26%. Now in not one of these cases that appear in the group of cures was the whole tongue removed. This is most significant, and I for one shall in the future, in suitable cases, certainly make use of this clinical experience and save to these patients one half of their tongue. It may be of more service to them in masticating and in speaking than we have thought. The division of the lateral half can and should be made well back, an inch and a half or two inches behind the limits of the growth or back to the epiglottis if necessary. These are the lines that we should adopt, partial removal with thorough methodical dissection of the glands.

Another important lesson to be learned from these cases of Mr. Butlin's is the better results obtained in the private cases. In these the operation was done at an earlier period, and the most important work to be done now, in connection with malignant diseases, in any part of the body is to learn to make an early and correct diagnosis. There must be a time in the history of all malignant growths when only a few cells are affected and the lymphatics not involved. Let us strive to recognize cancer in the future at an earlier stage than we have in the past. This can be done by giving careful attention to the first complaint of pain in the breast or a sore on the tongue. A painstaking examination can generally determine the nature of the growth pretty accurately. More errors in diagnosis are committed through carelessness than through ignorance.

One more point I would mention, and that is the necessity of feeding the patients with as much good nourishing food as possible. They are generally past middle life, suffering from a most debilitating disease and they are in great need of good feeding. After the operation for removal of the tongue, the act of swallowing is painful and difficult and mastication can hardly be carried on at all. For these reasons I have adopted the method of feeding, through a tube passed into the stomach, large quantities of milk and eggs artificially digested. The passing of the tube, although not pleasant, is readily submitted to in most cases, and in this way a large quantity of the best food can be given every six or eight hours. This method of feeding possesses the additional advantage of not soiling the mouth and the field of operation. The parts are sooner healed and there is an almost complete absence of septic absorption, as shown by the temperature chart.

I thank you gentlemen for your kind attention and I hope that I have been able to stimulate some increased interest in this terribly fatal disease.



# TUBERCULOSIS AND THE FORECASTLE.\*

## INTRODUCTORY PAPER.

By J. E. MARCH, M. D., St. John, N. B.

In the autumn of 1894 my attention was attracted by two cases of advanced tuberculosis in a crew of 14 men on a Norwegian barque, and beginning Oct. 31st. of that year I have kept a record of such cases of consumption among the sailors inspected by me as were sufficiently marked to permit of a ready diagnosis from the physical signs.

During the past year I observed 26 cases, and, in my annual report, pointed out that this disease is infectious and communicable, expressed the opinion that wherever met with precautionary measures should be taken to prevent its communication to others, quoted the address on medicine delivered by Dr. A. A. Smith before the N. Y. State Med., Assoc., Oct. 15th., '95, in support of this opinion, and closed my reference to this matter with the following paragraph :

“The course to be taken by the inspecting physician (i. e. quarantine officer) when he meets this disease on shipboard either in the crew or among the passengers, has not hitherto, been sharply, or at all, defined, but equally culpable is the physician, either in private or official life, who simply ignores the presence of tuberculosis, and the individual or corporation that leaves unmarked at night a hole in the public street. I venture to express the hope that the department will, during the coming year, and in view of all the facts, formulate for the guidance of quarantine officers, effective and beneficent measures of sanitary surveillance to limit and prevent the spread of tuberculosis by means of sick immigrants and sailors.”

In the next year to Oct. 31st., '96, I observed and reported 22 cases, and to Oct. 31st., '97, 31 additional cases, or a total for the three years of 79 cases.

Enquiring of intelligent steamship masters during 1897 brought out the fact in a general way that the disease was common among sailors.

Among the particular histories elicited were the following: The captain of the S. S. C——, says he has at least one case among his men every year. His crew numbers 33 all told.

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\* Read at meeting of St. John Medical Society, June 1898.

S. S. L—G—, presented two cases in a crew of 25 men. Captain C. who is an old sailor, said "It is common among the poor brutes; its a pity they wouldn't die and be done with it like Christians;" and later, "If you are going to stop every ship that has consumption aboard you will have your hands full."

Captain F., of the S. S. D—, reported to me that he had sent to hospital or discharged 6 consumptive sailors in seven years.

I asked him to accompany me to the forecandle. There it was learned, on questioning the bo'sun, who was an old member of the crew, that four of the cases had occupied the same berth in succession. Of the other cases one had occupied the berth below the infected one, and one had occurred on the other side. All these men had appeared to be healthy when they joined the ship.

S. S. A—H—, Captain L.—The captain, himself tuberculous, had lost two first mates of consumption in a little over four years. The present first mate, Mr. H., is far advanced in the disease. He is very weak, his voice is almost gone, has a distressing cough and exhausting sweats. He only hopes to live long enough to get home. These mates occupied the same room, opening off of the saloon, in succession.

These cases will serve to convey an idea of the general trend of my observations.

Of the 79 observed cases 11 were Norwegians. This is a larger number than they are entitled to proportionately, but I have thought that perhaps this may be accounted for, in part, by the fact that they are usually afloat in old vessels.

The older the ship the greater her chance of having become infected and hence a larger percentage of cases on old ships.

The fact that the bacillus not only lives but multiplies and flourishes on the surface of damp cloth lends strong color to the suggestion which I make namely, that many forecastles are infected with the bacillus tuberculosis. The clothing and bedding in 9 forecastles out of 10 is always damp.

In order to get an idea as to what part of all the time spent in the marine hospitals of Canada by sailors was due to tuberculosis, I wrote to the medical superintendent of seventeen hospitals which were each credited by the Auditor General's Report for 1897 with a total of over two hundred days each.

Here is the result :

St. John General Public, hospital year '97, per cent of time due to tuberculosis .....	3.98
Halifax Victoria General, fiscal year 96-97, per cent. of time due to tuberculosis .....	5.80
Montreal Notre Dame, fiscal year 96-97, per cent. of time due to tuberculosis .....	6.70
Charlottetown General and Marine, fiscal year '96-'97, per cent. due to tuberculosis .....	21.37
St. Catherine's, fiscal year '96-'97, per cent. due to tuberculosis...	21.72
Springhill Cottage Hospital, hospital year '96, per cent. due to tuberculosis .....	32.69
Chicoutimi Hotel Dieu, fiscal year '96-'97, per cent. due to tuberculosis .....	32.89
Miramichi Marine, fiscal year '96-'97, per cent. due to tuberculosis.	33.05
Yarmouth " " " " " "	39.12
Lunenburg " " " " " "	47.75

I have not yet received a report from the Montreal General or either of the two hospitals on the Pacific coast.

The average for the ten hospitals reporting is 24.50 per cent., practically one quarter of all the time. I estimate the cost to the Marine Department of the reported cases at \$10,000 for care alone.

In regard to the three hospitals reporting less than 10 per cent. it will be found that for them the year chosen was not a representative one, or that all the cases of tuberculosis entering them were not recorded as such but were euphemistically diagnosed as atrophy, anæmia, bronchitis, chronic diarrhœa, marasmus, etc., in order, as Dr. Mack of Lunenburg remarks in a letter to me, to give the patient the prop of hope. If, therefore, we eliminate these hospitals from the calculation, as I think we safely may, those remaining give an average of 32.65 per cent., practically one-third of the time spent in hospitals by sailors due to tuberculosis!

I think it a statement hard to refute that of the \$40,000 expended last year by the Dominion Government in the care of sick seamen \$15,000 was on account of consumption, and when we stop to consider that these cases could have been treated as cheaply in special sanatoria, (the cost at Saranac and Muskoka being only six dollars a week) with much better results so far as the patients were concerned, so far as the general hospitals in which they were treated were concerned, so far as the sanitary condition and education of the whole people were concerned, and so far as our self-respect and dignity as physicians were concerned, it seems

to me that it becomes a pressing duty to urge a reconsideration as to the disposal of these cases upon that Department of the Government having them in control.

We know that in many hospitals these cases are treated in the general, and, in some instances, even in the fever wards. I myself have seen five consumptives—three of them sailors—undergoing, shall I say treatment in a ward along with typhoid fever. We know that this is wrong, even intolerable.

During the past eight years 1,023,514 deaths from tuberculosis were reported in the United States. If the disease prevails to an equal extent in Canada there has been a loss of population from this cause, in that time, of 85,293, or 10,662 per annum. If these lives are worth to the country \$100 each the loss on this account is \$1,066,200 a year, and if each case costs the family in which it occurs only \$100 for advice, care, nursing, food, medicine, loss of time and burial, there is another annual payment by our people of \$1,066,200. This annual loss of \$2,134,400 capitalized at 3%, the rate at which the government borrows, is a burden on the people equal to an addition to the national debt of \$71,080,000.

These figures are startling I know, but they are well within the truth for I find it stated by Dr. Bryce, the Secretary of the Ontario Provincial Board of Health, and the foremost authority in Canada on this matter, that in 1895 there was an economic loss in the Province of Ontario alone from tuberculosis of \$2,474,000, a sum which will pay interest at 3% on \$82,466,666.

Now the population of Ontario is to the population of Canada as 1 is to 2768, therefore on the basis of Ontario as stated by Dr. Bryce the annual economic loss for the whole of Canada from tuberculosis is \$6,836,960 and capitalized at 3% represents a national debt of \$227,898,666, or \$45.58 per head on our population of 5,000,000.

Now I do not wish to be understood as stating the accuracy of these figures, for they are, and can be, only approximate. I use them to emphasize two facts; viz.: 1st., that the loss from this cause is *enormous*, and 2nd., that it is *national in its character*.

The right to deal with a national evil is vested in the national authorities and I submit the proposition that where this right is vested there also rests the duty of intervention and relief.

This evil is national and the nation should supply such measures of relief as are possible.

Unfortunately, so far as our practice is concerned, the idea seems to be advanced that there is more security in the administration of health laws by municipal and provincial officers than by federal officers; that a divided control is better than a sole control, and that in the midst of the ravages of infectious disease an army of officers under different jurisdictions and employing different methods, is superior to a compact, disciplined and united corps.

This is not, and cannot be, true. And while municipalities and provinces have power to enact laws to guard against the introduction, and limit the spread of infectious diseases within their own boundaries, these laws are in the nature of police regulations, and must give way at all points where they are inconsistent with any general regulations that may be promulgated by the Dominion authorities. Therefore I say that the right to deal with tuberculosis in a general, summary and effective way is a national right, and that it entails a national responsibility of a very grave and pressing character.

In her quarantine officers Canada already has a corps of trained physicians in her employ, and as a first step towards the recognition of her rights and duties in the premises, these officers, I think, should be instructed to see to it that no more tuberculosis is permitted to come into the country on ships, unless under surveillance or for treatment in special sanatoria.

In my annual report for 1897, now published, I endeavoured to make this clear in the following terms:

“ Medical science has reached a point where it may hopefully grapple with this disease. Its course is known, its methods of propagation are clearly understood. By applying the knowledge we possess a great reduction can undoubtedly be made in the death rate from it.

“ During the past year not only one but several shipmasters have stated to me on enquiry that there has almost always been at least one case of consumption in their forecastles. This can only mean that the forecastles of these ships are infected with the bacillus tuberculosis. The seed is there. The soil in the shape of an anaemic, or underfed sailor is taken to it. The crop grows and the harvest is sure. On many ships this unfortunate and entirely preventable sequence recurs again and again.

“ It seems to me that at our quarantine stations we are able and should do something to improve this condition of affairs, and when we consider the enormous cost of this disease directly and indirectly to the country, we find strong economic reasons—sometimes more potent than humanitarian ones—why we should exclude, so far as we may be able, every case that seeks an entrance.

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“Therefore I respectfully submit that tuberculosis should be scheduled as a quarantine disease; that the regulations shall contemplate the return of tuberculosis steerage passengers to their homes, by the transportation companies bringing them; the removal of consumptive sailors and firemen from the forecastles in which they may be found; the renovation of the quarters which have been occupied by them, and the disinfection by steam at a high temperature of all clothing, bedding &c., that have been exposed to the infection.

“A large percentage of Canada’s carrying trade is done by regular lines of steamships. A notification to the managers of these lines of the intention on the part of the Government to deal as I have indicated with cases of tuberculosis coming to Canadian ports on their ships, would, in itself I think, result in decreasing to a great extent its importation. At all events, the advanced cases, such as I have noted in my reports, would no longer be brought.

“In support of these recommendations which I have respectfully submitted from time to time during the last three years, let me quote but one paragraph from the address on Public Medicine delivered before the British Med. Assoc., at Montreal by Dr. Herman M. Biggs, the Director of the Bacteriological Laboratory of the Health Dept., of the City of N. Y. He said :

“No more striking example of inherited beliefs and prejudices can be found than is afforded by the exhibition of hesitation and reluctance on the part of the proper authorities to assume the sanitary supervision of the tubercular diseases. It is now universally admitted that tuberculosis is infectious and communicable and the most fatal disease to which the human race is subjected; yet, as a rule, no effective measures, or no measures at all have been adopted by sanitary authorities with relation to it. Nevertheless we believe it may be more easily controlled than any other of the principal infectious diseases with which we have to deal, and that it is of as great importance, judged by the deaths it causes as well as all the others together.”

The passive method of dealing with tuberculosis has failed utterly, and the desirability of minimizing its ravages being granted, it remains for us to adapt and put into continuous operation the simple but potent forces of isolation and disinfection.

Experience teaches that where these forces have been brought to bear as a result of accurate knowledge of the causes and methods of propagation of infectious diseases they have been effective, and have amply justified their employment.

Who shall say that this knowledge is not sufficiently complete in regard to tuberculosis ?



## NOTES FROM MIDWIFERY PRACTICE.\*

W. S. MUIR, M. D., Truro, N. S.

When I tell you that I can hardly recollect when I attended my first case of midwifery, you will wonder at my statement. I was, as many of you know, born and reared in a medical hothouse, and forced upon the public at an early age. To those of you who have sons who intend following their father's profession, let me say that this has always been, and shall always be my only regret, that my father was born before me. True, some families mature early, still I care not who the young man is, he is better by far to be fully matured and to have a good collegiate education before he begins the study of medicine.

Since beginning the practice of medicine, I have attended upwards of sixteen hundred cases of confinement, and during that time a man, I care not who he is, must pick up something not found in books or taught in medical schools, and it is upon these ideas, facts, fancies, or whatever name you will be pleased to call them that I wish to draw your attention today.

The science of midwifery is as old as mankind, and upon the safe delivery of the mother depends the life and existence of at least two persons. That labor which was intended by God to be a natural and easy performance is by many of our medical men of the day seemingly forgotten. True modern life, ease, luxury, with its surroundings, has to a great degree been responsible for many a hard labor. Still this was understood by Pharaoh, King of Egypt, long ago, for did he not consult the midwives when he wanted to diminish the power of the Israelites?—and these chosen people of God pointed out to him that they had rapid and easy labors, whilst the luxurious Egyptians had not. We need not go to Egypt or to the Old Testament for a coexisting state of affairs. Look today at our own Mic-Mac Indians. Two years ago at Sydney we were told by Dr. Hart of Baddeck that over seventy-five per cent of the Mic-Mac tribe in Cape Breton were tuberculous, still, how many die during, after, or from their confinements, and how often is a medical man called to deliver a squaw with forceps? I have yet to learn of

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\* Read at meeting of Maritime Medical Association, Halifax, July, 1898.

such a circumstance. Puerperal convulsions and puerperal diseases of all kinds are very rare with the Mic-Mac Indian. This is true also all over the world with the aborigines, and why is it so? Pardon me, gentlemen, if I say chiefly because they are severely let alone. The man that first said, "Meddlesome midwifery is dangerous," should for the sake of suffering humanity, have been knighted upon the spot—many a man has had that honor conferred for less. Dr. Japp Sinclair in that wonderfully honest and common-sense paper read before the British Medical Association at Montreal last year, speaking upon the frequent use of forceps in practice, says: "I have endeavored to trace the course of change in obstetric practice in England, and to indicate the causes; that practice is now, in my estimation, vastly too meddlesome and mischievous, and some reform is urgently required." Dr. Sinclair gives a number of instances showing the per cent in which forceps are used, the lowest being 17 per cent, the highest 57 per cent. What inferences do we draw from this? First, that the patients must belong to a class of society where the medical attendant can hurry things up, and secondly, that they do so, simply that and nothing more. During the last ten years, my percentage of forceps cases has been five per cent of all. When I was younger and thought that I was not doing enough for my patient and could not afford so much time, my percentage of forceps cases was over fifteen of all. Year by year as I grew older in the art, I find that my time and patience are both elongated, so to speak, and the patient and child both benefit from my experience. How does the patient benefit? Simply because I let nature do all she can, and I handle my patient as little as possible. I am not at this time of life looking for patients, but results. An old physician of much experience in my own native town once asked me this question: Did you ever know a woman who had been left to her own resources die of post-partum hæmorrhage? Or did you ever know a woman die after an abortion who had been left to herself. I said that I could not recollect. He quietly said, "I do not think that you ever will." There is a whole sermon, text and all, in that question. Within forty years, a specialty in medicine known as gynæcology has sprung up, a science so called by many, not in any way related to pure obstetrics, which is regulated to be a mere mechanical procedure. The gynæcologist is generally a smart chap from all points of the term, slick at most things, and five times out of eight a money-maker. I have during my career known several general practitioners who have become gynæcologists after a four or six weeks' post-graduate course. It's to be hoped

that they knew the anatomy of the parts before they started. But why was there ever such a specialty needed? Wherever there is a need the want will be supplied, hence the gynæcologist. Seventy-five per cent of the gynæcologists, so called, live from errors or accidents occurring during the parturient state. May I ask how many are due to the too frequent use of forceps? This I will say, that seven-eighths of the women coming under my own observation for treatment have been delivered with forceps. Did any of you ever think that with the use of chloroform in obstetrics came the gynæcologist? It is so. In this world we find that it is not whose ox is gored, so much as who does the goring. Many a first-class, honest, careful physician is turned to one side because he gives his patients time to be delivered naturally, and another employed simply because he has the reputation of not allowing his patients to suffer, but uses chloroform and instruments early. The latter is the man who gives the gynæcologist his inning. How many children are left maimed for life from the use of forceps? I know of several. I know of two epileptic children who were brought into this world with forceps. We have convulsions more often in boy babies than in girls. Get the history of any cases of epilepsy in your practice and find out how the child was delivered, it's worth the trouble. I will venture to say that in a certain class, fifty per cent of all male first-born children delivered within ten miles of a physician in Nova Scotia are delivered by forceps. There are many reasons for this. The physician's time, the irritability of the patient's friends, and sometimes of the patient herself. I have yet to learn of a case of post-partum hæmorrhage occurring where the physician has been called in to deliver, or rather remove a retained placenta at any distance from his own home. This in itself is ominous, but it means a great deal. The following little incident will illustrate what often takes place. I was called to assist a young man who had just returned from college armed with a curette and well up in Crédé's method. The delivery of the child was natural, but as soon as he had tied the cord I adjourned to another room when I heard, "Oh doctor! doctor! what are you doing?" I at once returned to the bedside, found my young friend giggling with his right hand at the cord, with his left squeezing for all that he was worth at the womb. In reply to what he was doing, Crédé, Crédé. I asked him to give the played-out organ a chance, and in two or three minutes a natural contraction and a slight expulsive movement on the part of the patient expelled the placenta complete. My rule is never to remove the placenta until I can feel the insertion of the cord

quite easily. Ergot I never give without I know my patient's habits, and it is indicated. Ergot is not a reliable drug in my hands; still, I think that it has been of service in some cases of inertia of the uterus. Now I generally use it hypodermically. Another thing I have learned by experience, and that is, never to underrate the idea of the patient that things are not right. Time after time I have been told this, but thinking it only some hallucination on my patient's part, afterwards I have learned to my surprise, if not regret, that she was correct. Let me say to the younger men present, never underrate this. In breech presentations often you will find the head to the right of the median line, just near the free edge of the liver. This gives the abdomen a peculiar shape which the woman may have noticed for some time. One patient who has had three breech presentations in succession, told me as early as the seventh month on each occasion that "things were not right." Then again, in breech or foot presentations, the pains, rather pain, is continuous. In four cases I have had from the first to keep my patient slightly under chloroform, owing to the severity of the continuous pain. In one case the pain was so severe, continuous and localized, that I thought it a case of peritonitis. In some of my breech cases the pain was entirely abdominal, and the abdomen was painful to touch. I have never noticed an excessive quantity of liquor amnii in breech or foot presentations. This is not my experience with club-foot. In two cases of club-foot, one was associated with any excessive quantity of liquor amnii; the other is interesting as being a foot presentation, and seeing and knowing that club-foot was often associated with hydrocephalus, the child being dead, and delivered as far as the shoulders some two hours before my arrival by a local midwife, I, after some difficulty, punched a hole through the occipital bone, and drained off nearly a quart of fluid, and delivered the head without further difficulty. It has been my experience that whenever I have found an excessive quantity of amniotic fluid, the pains from the first have been continuous, excessive and unnatural, the patient expressing her opinion, especially if she is a multipara, that she is not right. It has been my good fortune to attend five acephalic cases—one child was born before my arrival and it was impossible for me to get a history of the case. The other four were interesting from the fact that two of them kept me dancing in attendance for nearly two days. The pains were unnatural and the women were excessively nervous. Both cases were associated with an excessive quantity of amniotic fluid which overflowed the bed, and both

were boys, which sex is most common in these cases. The pains, as I said before, were of a spasmodic character and varied little in intensity during the whole course of the labor. In each case the shoulder presented, and in one the convulsive movements of the foetus were almost unbearable shortly after the rupture of the membranes. In both of these cases labor came on at the eighth month, and curiously enough, both patients expressed their belief for some time before that they were not right. Another case occurring during the early part of the present year: the patient was the mother of five children, all healthy, but from the first she expressed herself "that things were not right." After the fifth month of her pregnancy she was sleepless and uneasy, and the movements of the foetus were very painful. The patient from her size and shape thought herself pregnant with twins. There was an excessive quantity of liquor amnii, and it was an arm presentation, a female child, the first acephalic female child I have seen. My fourth acephalic case was also accompanied by an excessive quantity of liquor amnii, and was only interesting as the patient was far advanced with, and died shortly after from phthisis. What I want to draw your attention to is the fact that in three out of the five cases the patient knew that "things were not right." The following case is interesting from another standpoint, viz., the family history—a neurotic history one might say. In August last I delivered Mrs. D., aged 40, mother of eight children; the labor was easy and natural. The nurse called my attention to the child, saying it had no eyes! I found the lids and lachrymal apparatus complete, but the orbital fossa empty; there was a complete absence of the orbits. The child lived for five or six weeks and finally died from inanition. Two of the older children are cross-eyed. The mother has a conical cornea (Rerato-Globus). The mother's sister died from exhaustion after her fourth confinement, being far advanced towards her end from exophthalmic goitre. The grandmother, who is still living, has been under treatment for years for some disease of her eyes, and has, I believe, had a double iridectomy performed. The whole family on the mother's side are neurotic, but not tuberculous. At this point please allow me to draw you attention to the fact that in cases of Graves' disease, the patients, if married, should sleep alone, and if possible, avoid all sexual excitement. Some writers have said that during pregnancy an exophthalmic goitre case will improve, and one actually said got well. This has not been my experience, and it is an appalling fact that during the past ten years I have seen more cases of

exophthalmic goitre than cystic. I have never seen goitre of any description develop during pregnancy. The history of one case goes to prove what I have said about sexual excitement. The husband of one of my fatal cases was a commercial man, who only came home at intervals. Then my patient would become much worse and my treatment of the previous one or two months, or for whatsoever time he was absent, was destroyed. After his departure she would get well again. Finally she became pregnant, and during the first few months she did improve wonderfully, but after the fifth month she gradually became worse, and during her confinement we had great difficulty to save her. Four weeks after her confinement she died from exhaustion. This was a lesson to me. In March, 1897, I read Dr. Atthill's paper upon the use of ergot and strychnine during pregnancy as a preventive of the alarming accident, post-partum hæmorrhage, where a history of this trouble was known to exist. At that time I had a patient pregnant for the fourth time with a history for this unpleasant accident that would make most men quake. She was entering upon her thirty-fourth work of uteroquake. She was entering upon her thirty-fourth week of utero-gestation. I immediately put her upon Dr. Atthill's prescription, and all that I have to report is that the result was wonderful. She had a perfectly easy and natural labor, devoid of any untoward symptoms or accident whatever. I call post-partum hæmorrhage an accident; it may be, and perhaps it is just as well that it is called so, but is it not a fact some men rarely or ever meet with it in their practice, whilst others are continually running into it? May it not be with the latter the old story, too much hurry? In conclusion, let me say that I deplore that fact that soon the use of forceps in practice will become the rule and not the exception if some means are not obtained to bring practitioners to their sober senses, that these men who are continually using forceps cannot stop to think of the results therefrom, and that the army of mushroom specialists who are springing up all over our country are in many cases men completely devoid of even a fair medical education, and even if they had that amount of education necessary to make a successful specialist, would at once retire into private life. I would most respectfully suggest that hereafter medical specialists be compelled to pass a special examination in their own particular work and then the public will be protected, especially from the six weeks' post-graduate specialist.

## SOME LEADING EUROPEAN GYNÆCOLOGISTS AND THEIR WORK.

By A. LAPHORN SMITH, B. A., M. D., M. R. C. S., (Eng.), Montreal.

*(Concluded from last issue.)*

DUHRSEN of Berlin seems by consent to be acknowledged as the ablest among younger men of note. He is not much over forty, but his large private hospital at 25 Schiffbauerdämm, filled with important cases and maintained at his own expense, testifies to his ability and energy. He received us most courteously and patiently answered my very numerous questions. He showed me a patient from whom he had removed the uterus by the vagina, for hæmorrhage due to hæmophilia, which interested us, particularly because three years before she had come to him for the same thing and he had employed Sneguiroffs' steam cure which cooked the mucous membrane so well that she did not menstruate at all for three years. He kindly set it going for us. It is a little boiler fitted with a thermometer so as not to let it get hotter than 120° Cent., and the steam is conveyed into the uterus by means of a double catheter during a quarter to four minutes. The cervix must first be thoroughly dilated and there must be a rubber tube over the steam pipe so as not to burn the cervix, which would cause a stricture. He is an enthusiast for vaginal laparotomy and claims to be the inventor of vaginal fixation for retroversion, he having published his first fifteen cases before anyone else published one. I was very much opposed to the operation before coming here, but since I have seen Duhrrsen doing three in an hour, as well as several other operators doing it very quickly, and after hearing its manifest advantages, I have been most favorably impressed with what I have seen of it. He opens into the peritoneal cavity, in two minutes or less hooks out the ovaries, tubes and uterus, destroys all cysts by ignipuncture, replaces them, passes a silk worm gut ligature through vagina, peritoneum, uterus and out again on other side through peritoneum and vagina. This is left untied until he has sewed up the opening in the peritoneum with a running catgut and the vagina with another row of catgut, after which the fixation ligature is tied. I made many enquiries about Alexander's operation, but nobody here does it. When I told Olshausen that I could generally find the round muscle with my eyes shut he invited me to do the operation on a case, but on examination

her uterus was found to be fixed, and therefore unsuitable. Next day I saw Duhrrsen remove the vermiform appendix and double pus tubes by the abdomen, which he does in about 25 per cent. and by the vagina in 75 per cent. Next day he removed a pair of very angry gonorrhœal pus tubes by the vagina. There was recent peritonitis. As she was a young woman he left the uterus and one ovary. This was a very nice case as he did it very quickly and all outside of the vagina.

MACKENRODT of Berlin, is one of the coming great men, if not already one. He appears to be under 40 years of age and is a fine operator. I saw him doing a Cæsarean section and subsequent total extirpation of the uterus for cancer. The child, about 8 months, was taken out alive and did well. There was hardly any bleeding. As soon as the child was removed through the opening in the uterus he put on 2 ligatures on each side and a few temporary ones on the uterine side, and cut between them until he came to the uterine arteries which he tied. He then separated the bladder and freed the uterus until he had it and the vagina like one tube, free almost to the vulva. He felt for the large cervix and cut the vagina below it, not with a knife but with a large cherry red electrical cautery, his object being to prevent it from infecting the peritoneum. The current measured 17 amperes and was obtained from the street. The asepsis of himself and assistants was most thorough, spending 20 minutes by the clock in disinfecting their hands. He and most of the patients here stand on the patients left so as to use their right hands.

KOBLANOK of Berlin, is Olshausen's first assistant, whom I saw removing a large fibroid by the abdomen. The case was an easy one but he did it beautifully.

Gusseruv, whom I was anxious to see, did not operate while I was in Berlin. Neither did Nagel, his assistant.

In closing my letter from Berlin, I must truly say that I have seen more here in one day than I have ever seen in any other city and I cannot speak too highly of the kindness with which I was received by one and all. Nearly every day I was up before six a. m. in order to get to Olshausen's by seven, and from there I went to Landau's, and from there to Marten's, where I remained till nearly two, by which time I felt that I had seen enough for one day. As all these places are within a few minutes of each other, Berlin offers especial advantages for a post-graduate course. My next letter will speak of Sanger, Zweifel and Jacobs.



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Editorial.

RECIPROCAL REGISTRATION.

The annual meeting of the Canadian Medical Association which was held at Quebec last August, was well attended and greatly enjoyed by those who took part in the proceedings. The profession of the "ancient city" of both nationalities left no stone unturned to make the convention a success, consequently the social features of the meeting proved quite attractive. The scientific proceedings were up to the average. The programme while not lengthy afforded time for profitable discussions. A number of prominent physicians and surgeons from the United States were present as guests, and took part in the proceedings. The attendance from the maritime provinces was far below the average.

The most gratifying feature of the meeting was the prominence accorded to Interprovincial Registration. A report of the proceedings in reference to this subject was published in our last issue, and the conclusions arrived at justify the hope that this vexed problem has at last been solved. The refusal of the representative of the Ontario Council to concur in the report adopted at the previous meeting was discouraging to those who had taken an interest in the matter, and many thought that the solution of the problem was indefinitely postponed. Happily wiser councils have prevailed, and the willingness of the representatives of the Quebec Medical Council to adopt in toto the principle of a central examining board, has removed the only serious obstacle to the completion of a scheme of reciprocity for the whole of Canada based upon uniform requirement in respect to matriculation, period of study, course of study and methods of examination.

The steps taken by the Canadian Medical Association should be followed by vigorous action on the part of the various Medical Boards of Canada. The details of reciprocity can only be finally settled through a conference embracing representatives of the various boards. Such a conference might be brought about either by the authorities of Ontario or Quebec taking the initiative steps. The Medical Board of Nova Scotia has not yet received authority from the legislature to adopt the principle of a central examining board, a vital feature of the proposed scheme. We understand that steps are being taken to approach the legislature next session to obtain such changes of the Act as may be necessary to carry out reciprocity, and it is to be hoped that no serious opposition will be encountered.

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### PAMPHLETS RECEIVED.

THE ASEPTIC ANIMAL SUTURE, ITS PLACE IN SURGERY.—By Henry O. Marcy, A. M., M. D., L. L. D., Boston. Reprinted from *Journal of American Medical Association*.

GLAUCOMA WITH DETACHMENT OF RETINA.—By William Cheatham, M. D., Louisville, Ky. Reprinted from *Annals of Ophthalmology*.

ORTHOFORM AND EXTRACT SUPRARENAL GLANDS.—By William Cheatham, M. D., Louisville, Ky. Reprinted from *American Practitioner and News*.

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### BOOKS OF THE MONTH.

PATHOLOGY AND MORBID ANATOMY.—By T. Henry Green, M. D., Lecturer on Pathology and Morbid Anatomy at Charing-Cross Hospital Medical School, London. New (3th) American from the eighth and revised English edition. In one very handsome royal octavo volume of 600 pages, with 215 engravings, many being new, and a colored plate. Cloth, \$2.50 *net*. Published by Lea Brothers & Co., Philadelphia.

THE AMERICAN POCKET DICTIONARY.—By W. A. Newman Dorland, A. M., M. D. New and complete, containing over 25,000 words, with the pronunciation indicated with the utmost precision. Price, \$1.25 *net*. Published by W. B. Saunders, Philadelphia.

## Matters Personal and Impersonal.

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Dr. George L. Sinclair, on the 30th of September, resigned his position as superintendent of the Nova Scotia Hospital for the Insane. For over twenty years he discharged his duties in that institution with credit to himself, first as assistant, and for the past six years as superintendent. His attention to the wants of the patients was well known and greatly appreciated by the large number under his care. No officer could serve an institution more faithfully. The vacancy caused by the resignation of Dr. Sinclair has been filled by the appointment of Dr. W. H. Hattie, who spent four years as assistant in that institution, and is therefore considerably acquainted with the duties he has just undertaken.

Dr. A. C. Page, of Truro, has resigned his position as Inspector of Provincial Institutions of this province, a position he filled faithfully and capably. Advanced years and declining health necessitated this step. Dr. Sinclair has been appointed his successor and is now discharging the duties entrusted to him.

Dr. F. W. Goodwin and family have just returned from London, where they have resided for nearly six months. The doctor has been taking post-graduate work in the great centre of learning and is well pleased with the clinical advantages to be obtained in that large city. He took a part of the examination of the Royal College of Physicians passing in medicine, gynaecology and obstetrics. He will resume practice at once.

Dr. W. G. Putman, one of Yarmouth's prominent physicians, is now doing post-graduate work in New York. He will remain there about six months before resuming active practice.

*Langsdale Lunnet* published in Kansas City for the past three years, is about to change its name and will in future be known as the *Kansas City Lunnet*. Dr. Langsdale who edited this journal so ably since its beginning, has retired from the position of editor, and in future Dr. Panton will assume the editorship.

Dr. Hugh L. Diekey, of Canning, who lately took his degree in medicine from Dalhousie University sailed for London last week, it being his intention to confine his studies mostly to the eye, ear and throat.

We are not fond of adjectives in the superlative form, but we cannot deny that the highest praise is merited by the last edition of Parke, Davis & Co.'s Priced Catalogue. It was prepared in Canada, printed in Canada, and embodies an array of nearly five thousand preparations, every one of which is manufactured at the Walkerville Laboratory of this great House. Not alone does this list set fourth formulæ and prices of each item in the twenty-nine extensive lines manufactured by P., D. & Co., but it also contains in convenient form a vast fund of information which makes it permanently valuable for purposes of references. Thirty-five pages are devoted to a most useful "property and dose list" of drugs from which Parke, Davis & Co. manufacture a fluid, solid or powdered extract or concentration. Every paragraph in the eighteen pages of "Notes of Reference" is a valuable nugget of information.

The list is compactly and handsomely printed and is sent without charge to every physician who asks for a copy. Do not fail to write for one of these catalogues, and when you get it, keep it within easy reach for it will answer a thousand queries relating to drugs, their uses, doses, prices and pharmaceutical preparations.

A marvellous growth has been the happy and merited lot of this famous house, and it is pleasant to feel and know that the wonderful increase of its trade in the Dominion, in the States and in every other civilized country is due, not to printer's ink, but wholly to the honorable character of its management, to its scientific activity, to the transparently conscientious spirit which prevails in every department of its immense laboratories, to its generous treatment of every patron, and to its urbane and courteous correspondence. Parke, Davis & Co. has done vastly more than win success—they have richly deserved it, and no one need grudge them a single one of the triumphs which the future holds yet in store for them.

The Walkerville Branch of Parke, Davis & Co. is keeping even pace with the growth of the parent-house, and deserves warm commendation for the scientific work on which this catalogue throws such a significant light.

## Correspondence.

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*To the Editor :*

A concern in Chicago claiming to teach the alleged science misnamed osteopathy, makes the following remarkable statement relative to its so-called courses, in circulars which are sent broadcast over the country :

“ Terms of study are so graded and the courses of study so broad and complete, that they comply with all the requirements of the Illinois State Medical Board and allow our students two years' credit on a regular medical education. These credits are recognized in any medical college in this country and will be equivalent to two years' work done there.”

If by the “ Illinois State Medical Board ” is meant the Illinois State Board of Health, the assertion made in reference to that body is a lie in the fullest acceptation of the term. It is not true furthermore, that the “ credits ” named are recognized in any medical college in this country. On the contrary is it exceedingly doubtful if a single reputable medical institution will grant any advanced standing whatever to applicants from this and other “ colleges ” of similar character. Should however, this be done, it is needless to say that the institution or institutions concerned will receive no further recognition from this Board, and it will be remarkably strange if the various State Boards of Medical Examiners throughout the Union, will view such irregular proceedings with complacency.

As the circulars are calculated to deceive the unwary, and to cause prospective graduates in medicine to waste two years of time, I will ask you to give this letter a prominent place in your journal, so he who runs may read.

J. A. EGAN, M. D.,  
*Secretary Illinois State Board of Health.*

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contains all the nutritive virtues of the best malt liquors in a much higher degree than any other product with which it can be compared, and the least amount of alcohol (3 per cent.) of any like preparation which avoids the distressing consequences experienced from the use of spirituous liquors, or malt extracts containing a large amount of alcohol.

## WYETH'S MALT EXTRACT

is agreeable to take, and is a valuable nutrient, tonic and digestive agent, containing a large amount of extractive matter. Those of the medical profession who have given the subject of malt extracts careful study are unanimous in endorsing all the claims that are made for it.

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is a purely pharmaceutical preparation, and we would caution physicians when ordering to specify "Wyeth's," as it is well known that there are a great many so-called malt extracts in the drug stores which contain such an amount of alcohol that it is not safe to leave the choice to the discretion of the patient, who might be prevailed upon to purchase an inferior article on account of its being a little cheaper.

*Free sample bottles of Wyeth's Liquid Malt Extract will be sent to any practicing physician in Canada upon application.*

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Physicians will find very useful in the following diseases: *Scrofula, Anaemia, Chlorosis, Amenorrhoea, Debility* from various causes, *Convalescence* from acute fevers and surgical operations, *Nervous Maladies*, such as *Graves's Disease, Neurasthenia, Epilepsy, Cretinism*, and any other *Nervous Condition* requiring a *Tonic Strengthening Medicine*, in *Rickets, Pyloric Stenosis, Phthisis, Diabetes, etc.*, etc.

This remedy is of pleasant, neutral taste. It can readily be taken in a little water, milk or sweet wines, free of tannin, as may be preferred. Is non-astringent, and does not injure the teeth or constipate the bowels.

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Will be found peculiarly efficacious in those derangements attended with flatulence, acid fermentation, eructation superinduced by eating rich food, pastry, starchy vegetables, excess in drinking spirituous liquors, and excessive smoking. It will prove equally valuable in almost every condition of weak and impaired or imperfect digestive powers, either due to catarrh of the mucous coat of the stomach or in those symptoms characterized by sensations of distress and uneasiness during digestion, usually termed Nervous Dyspepsia.

Each dessertspoonful contains: Pepsin 1 gr., Pancreatin 2 grs., Cascara Sagrada 1 gr., Ipecac 1-5 gr., Strychnine 1-60 gr., with the active constituents of 30 minims Antiseptic Solution.

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## Matters Medical.

SOME OBSERVATIONS OF BRAIN ANATOMY AND BRAIN TUMORS.—  
Dr. William C. Krauss, of Buffalo, read a paper at the 92nd annual meeting of the Medical Society of the State of New York, Albany, Jan. 25th, 1898, with the above title.

He called attention (1) to the difficulty in remembering the gross anatomy of the brain, and (2) to the almost universal presence of optic neuritis in cases of brain tumor.

He attempted to overcome the difficulty in regard to the anatomy of the brain by formulating the following rules, which are somewhat unique and original, and at the same time easily remembered.

Rule of Two.—1. The nerve centers are divided into two great divisions, (1) encephalon, (2) myelon. 2. The encephalon is divided into two subdivisions, (1) cerebrum, (2) cerebellum. 3. The cerebrum, cerebellum and myelon are divided into two hemispheres each, (1) right, (2) left. 4. The encephalon is indented by two great fissures, (1) longitudinal, (2) transverse. 5. Into these two great fissures there dip two folds of the dura, (1) falx cerebri, (2) tentorium cerebelli. 6. There are two varieties of brain matter, (1) white, (2) gray.

Rule of THREE.—1. There are three layers of membranes surrounding the brain, (1) dura, (2) arachnoid, (3) pia. 2. Each hemisphere is indented by three major fissures, (1) sylvian, (2) rolandic or central, (3) parieto-occipital. 3. Three lobes, frontal, temporal and occipital, on their convex surface are divided into three convolutions each,—superior, middle and inferior, or 1st, 2nd, and 3rd. 4. There are three pairs of basal ganglia, (1) striata, (2) thalami, (3) quadrigemina. 5. The hemispheres of the brain are connected by three commissures, (1) anterior, (2) medi, (3) post-commissure. 6. The cerebellum consists of three portions, (1) right, (2) left hemisphere, (3) vermes. 7. There are three pairs of cerebellar peduncles, (1) superior, (2) middle, (3) inferior. 8. The number of pairs of cranial nerves, in the classifications of Willis and Sommering, can be determined by adding 3 to the number of letters in each name: that of Willis making 9, and that of Sommering making 12, (or the name containing the more letters has the larger number of pairs of nerves, and vice versa). 9. The cortex of the cerebellum is



divided into three layers of cells, (1) granular, (2) Purkinje's cells, (3) a molecular layer.

Rule of FIVE.—1. Each hemisphere is divided externally into five lobes of which four are visible, (1) frontal, (2) parietal, (3) temporal, (4) occipital; and one invisible, (5) insula (isle of Reil). Roughly speaking, the visible lobes correspond to the bones of the cranium: that is, the frontal lobe is underneath the frontal bone, the parietal lobe beneath the parietal bone, etc. 2. The brain contains five ventricles, of which four are visible—the right and left, or 1st and 2nd, the 3rd and the 4th: and one invisible, the 5th or pseudo-ventricle. 3. The cortex of the brain contains 5 distinct layers of ganglion cells.

Studying carefully 100 cases of brain tumor in which an ophthalmoscopic examination had been made for the presence or absence of choked disc (optic neuritis) Dr. Krauss announced the following conclusions:

1. Optic neuritis is present in about 90% of all the cases of brain tumor.
2. It is more often present in cerebral than in cerebellar cases.
3. The location of the tumor exerts little influence over the appearance of the papillitis.
4. The size and nature of the tumor exerts but little influence over the production of the papillitis.
5. Tumors of slow growth are less inclined to be accompanied with optic neuritis than those of rapid growth.
6. It is probable that unilateral choked disc is indicative of disease in the hemisphere corresponding to the eye involved.
7. It is doubtful whether increased intracranial pressure is solely and alone responsible for the production of an optic neuritis in cases of brain tumor.—*Philadelphia Medical Journal*.

FRACTURES OF PATELLA BY THE PURSE-STRING SUTURE.—Haynes (*N. Y. Medical Journal*, vol. 68, No. 10) submits a mode of suturing fractured patellæ in the following succinct description:

As a rule patients are not operated upon until about a week has elapsed, during which time the knee is bandaged, lead and opium and an ice bag applied, and the limb fixed to posterior splint.

The leg is prepared the night preceding the operation. An aseptic operation is performed—no antiseptics being used except in the preliminary scrubbing of the patient, operator and assistants. Sterilized deci-

normal salt solution is the only fluid used without and within the knee during the operation. A vertical incision is used by preference, as it is not open to the objection that belongs to the transverse one—viz., that if a refracture occur with a transverse incision the fracture is apt to be compound. As the scar is adherent to the deeper tissues, the incision varies in length from three to five inches, depending upon the conditions present. The superficial tissues are cut through, the fragments and the quadriceps extensor tendon and the ligamentum patellæ exposed and dissected up at the sides to lay bare the entire extent of the tear in the lateral fibrous tissues. All blood clots are carefully and thoroughly removed by irrigation; all frayed edges and damaged tissues trimmed away, especially along the torn edges of the capsule.

Attention is now directed to the patella. The fibro-periosteal cap covering the upper fragment is cut away, the surfaces of the fracture lightly but thoroughly curetted until they bleed freely. Oozing is checked by hot irrigation and pressure. The rents in the fibrous tissues at the side of the patella are sutured with catgut or silk. The purse-string suture is now inserted. The suture is of strong braided silk, usually No. 10, capable of standing a heavy strain, so as not to break in tying. This silk has been freshly sterilized preceding the operation. Two pieces of silk are used, each about eighteen inches long, threaded into long half-curved surgical needles. The surgical needle is used in preference to the Hagedorn, as it passes through the dense fibrous tissues with greater ease. Before using the sutures the operator should wash his hands and irrigate the joint. The upper fragment is first semi-encircled. The needle is entered in the midst of the tissues close to the fractured edge of the patella, carried upward, with its point closely hugging the bone, and brought out at the lateral and superior angle; it is reinserted close to the hole of emergence and carried through the tendon of the quadriceps extensor, always close to the bone, then brought out at the other lateral and superior angle; again it is pushed through the tissues and made to emerge at the side of the fractured edge opposite to that of entrance. The lower fragment is similarly semi-encircled by the other strand of silk which hugs the bone and transfixes transversely the ligamentum patellæ. The joint is washed out for the last time, the two sutures tied with a square knot simultaneously, as much force being used as the silk will stand, so as to firmly crowd together the fragments. The knot and cut ends of the silk lie between the torn capsule, and are out of the way. The skin is closed with cat or silkworm gut, sealed with

an aristo-collodion dressing, and a plaster-of-Paris splint applied over a lint bandage. In seven to ten days the splint should be opened and the sutures, if non-absorbable, removed. A second light splint is applied and worn for two weeks more. This is now taken off daily, and passive and voluntary motion instituted, combined with hot and cold water douches and massage. Usually there will be ten degree of motion obtained when the joint is first tested.

DIAGNOSIS OF RENAL PERMEABILITY BY METHYLENE BLUE.—Castaigne (*Gaz. des hopitaux.*), one of the pioneers in the study of this subject, sums up all that is known about it to date. He says that the possibilities in this direction have long been apparent, because of the impermeability of diseased kidneys to many medicinal substances. The difficulty has always been in the choice of a drug adapted to practical needs. In methylene blue we have an ideal substance. Its subcutaneous injection is not attended with pain or danger: in its passage through the body it is not subjected to any essential decomposition: its color is readily appreciable and cannot be mistaken for anything else: and, finally, its use is not incompatible with the administration of other drugs for medicinal purposes. The practical worth of the test has been proved by the numerous articles which continue to appear upon the subject. Surgeons resort to its use before giving chloroform, and even use it in conjunction with catheterism of the ureters to determine the permeability of either kidney. Obstetricians use it to determine the likelihood of eclampsia. It is frequently resorted to in the hope of determining the presence of hepatic insufficiency.

The technique is very simple. One c.c. of a five per cent. solution is injected under the skin, and the urine is voided. All subsequent urinations are performed methodically, at regular intervals, in separate vessels, and each specimen is at once examined, the first appearance and persistence of the blue being carefully noted. In healthy subjects the blue begins to appear within a half hour. The maximum is attained by the third or fourth hour, and all traces vanish in from thirty to forty hours.

In acute and chronic nephritis the permeability is sometimes normal, or even increased. In other cases the blue goes through the kidney in the form of chromogene, which is colorless, but readily found by the beautiful green color which forms after boiling the urine with acetic acid. In atrophic nephritis the blue does not appear until the third or

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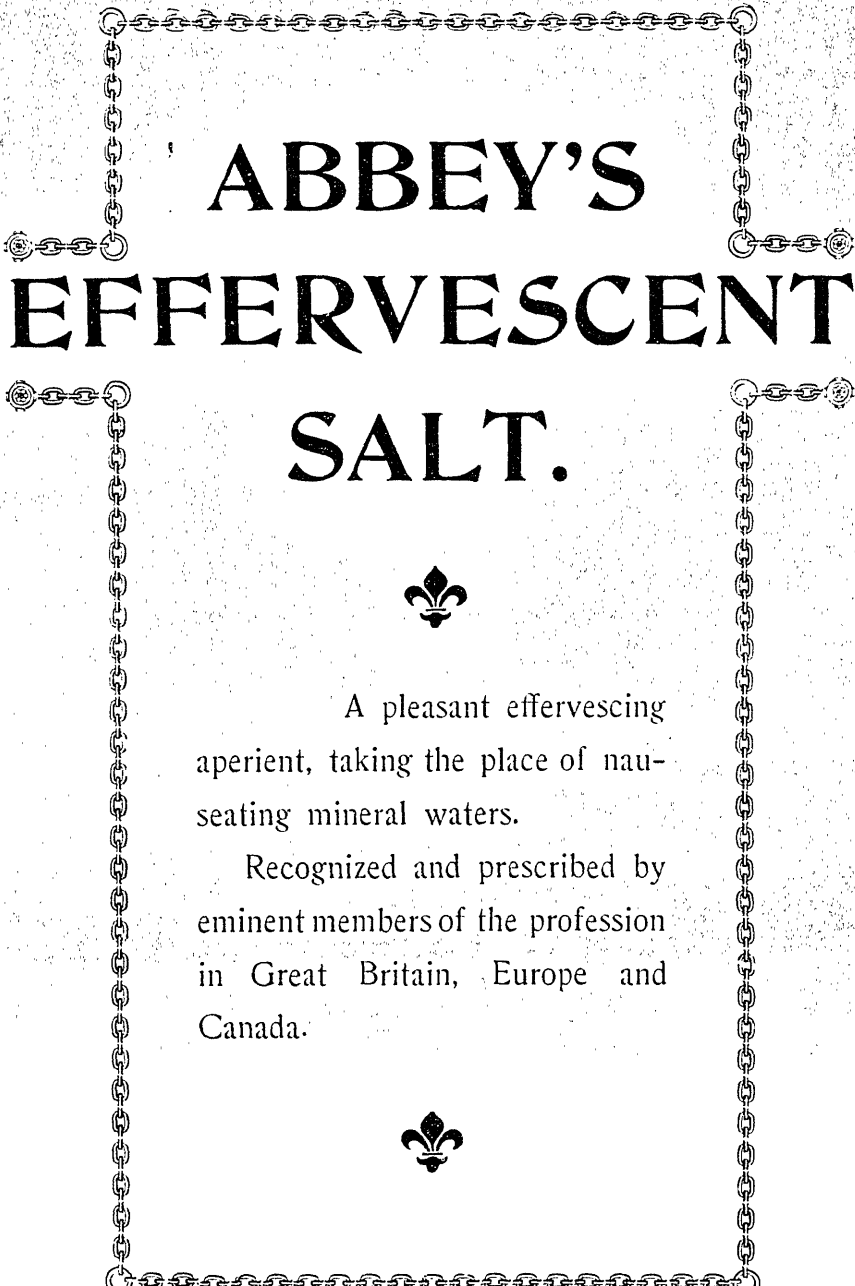
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fourth hour, and may persist for a week. In the cardiac kidney permeability is normal as long as mere congestion is present, but after degenerative changes occur the appearance of the blue is delayed to two or three hours. In intermittent albuminuria the blue appears at normal time, but is eliminated in a peculiar intermittent manner. In diabetes elimination is either normal or delayed. In hepatic subjects there is an intermittent rhythmic elimination, a fact of great physiological interest. In the various forms of surgical kidney, if the blue appears by the end of first hour, one kidney is believed to be sound. By catheterizing the ureters much may be learned at times. Permeability is normal in pregnancy, and even during eclampsia.

Castaigne gives a brief summary of the four types of results :

1. Intermittence, as in hepatic diseases.
2. Dissociation—the presence of chromogenæ means impermeability.
3. Prolonged elimination means organic disease.
4. Delayed appearance means impermeability.—*Medical Review of*

*Reviews.*

PRIMARY TUBERCULOSIS OF THE SPLEEN. EXOSPLENOPEXY.—Quenin and Baudet (*Revue de Gynecol.*, 1898, 2), have studied six or seven cases of this rare affection. The symptoms, which are tolerably constant, are enlargement (spleno-megaly), severe stabbing pain, pronounced anæmia, feebleness and emaciation. Less common are ascites, grave digestive troubles and hæmorrhages.

If upon laparotomy the spleen is found covered with granulations and nodules of tuberculosis, splenectomy should be performed. In certain cases partial splenectomy might suffice, the procedure known as exosplenopexy having been successful in at least one case. This operation is patterned upon Poncet's exothyreopexy for goitre. The spleen is drawn forward into the clefts of the abdominal wound, and retained therein until later on when a partial resection is made, or sloughing is allowed to occur.—*Medical Review of Reviews.*

WHAT PRODUCES ANKYLOSIS OF JOINTS.—Dr. O. W. Phelps, Britt, Iowa, in a paper appearing in the *Railway Surgeon*, July 26th, cites a number of interesting experiments made by him in order to determine this question, after a review of which he says :

"The conclusion in my mind is clear—1. That motion is not necessary to preserve the normal functions of a joint. 2. A normal joint will not become ankylosed by simply immobilizing it for three or four

months. 3. Atrophy of the muscles of the limb will follow prolonged immobilization of a joint. 4. These experiments have demonstrated to me conclusively that prolonged fixation will not produce ankylosis of a normal joint, and that motion is not essential for the preservation of normal functions.

"Then the cause of ankylosis must depend upon pathological conditions, and not upon fixation."

"The question of ankylosis, in my mind, is determined by the severity of the inflammation, the duration of intra-articular pressure, and destruction of periosteum. I believe that the motion of an inflamed joint interferes with the process of repair and hastens ankylosis, and to prevent this calamity it is the duty of the surgeon to put the limb at absolute rest and relieve intra-articular pressure by extension and immobilization. Inflamed joints treated by absolute rest will furnish far fewer cases of ankylosis, better motion and less deformity."—*Medical Review of Reviews*.

THE PREVENTION OF TUBERCULOSIS.—We are glad to see that the *Daily Telegraph* is lending its powerful support to the movement recently started by Sir Wm. Broadbent, Mr. Malcolm Morris, and a considerable number of leading members of the medical profession in London to take steps to check the continued prevalence of tuberculous disease in this country. The question is eminently one upon which an enlightened public opinion ought to be formed. The public mind must be aroused to the fact that consumption and other forms of tubercle are preventable diseases. "If preventable, why not prevented?" as the Prince of Wales said on a memorable occasion. We understand that His Royal Highness has already shown a warm interest in the movement, and has promised to preside over a public meeting which will be held after the autumn holidays, probably early in October. At this meeting the formation of an Association for the Prevention of Tuberculosis on lines similar to those of the associations which are doing such good work in France and Belgium will be proposed, and other means will be concerted for placing sufferers from pulmonary consumption in its early stages under the most favorable conditions for recovery.—*British Medical Journal*.

## Therapeutic Suggestions.

THE TREATMENT OF CHRONIC RHEUMATIC ARTHRITIS WITH HOT AIR AND CONGESTIVE HYPERÆMIA.—Lately heated air has been widely commended in chronic diseases of the joints. Dr. August Bier, the author, has used this treatment for tubercular joints for several years without any promising results. His experience with this treatment has been more favorable in chronic rheumatic arthritis. Marked improvements were noticed in stiff and painful joints. The men who have used this method credit the heat itself, the diaphoresis, the hyperæmia, and the destruction of bacteria from heat. There is no doubt that painful and stiff joints are more comfortable in a warm condition and a warm surrounding than in a cold one. The author credits the hyperæmia with the beneficial effects obtained, and gives the following reasons :

1. A limb which has been subjected to heat for a number of hours is reddened and swollen.

2. With congestive hyperæmia the same results are obtained as with heat.

3. If hot air be used for a number of hours daily, the hyperæmia does not disappear during the intermissions, but the limb remains congested and œdematous.

Therefore the author recommends the use of congestive hyperæmia, as its application is more practical and the results are the same, namely, relief from stiffness and pain. If the following method is used correctly, beneficial results are sure to follow: Take an affection of the knee-joint for an example. Bandage the leg snugly from the toes to about six inches below the joint with a cotton bandage, so that the healthy parts will not be involved by the hyperæmia. Above the joint apply a rubber bandage, first using some cotton or lint so that the bandage does not lie next to the skin. This bandage should not overlap each different layer, but should cover each layer exactly, so that the space occupied is just the width of the bandage. Draw it firmly until the parts are of a dark, bluish-red color. If any part of the limb gets cold the bandage must be loosened. Try and get the greatest congestion without shutting off circulation entirely. In some cases it is possible to get a high degree of congestion with the first application; in others the bandage must be gradually tightened. The first bandage may remain several days with-



out removing it. Then it should be worn at night or day only. Usually an hour after the application the joint is painless, and after several days the stiffness disappears.—*Manchener Medicinische Wochenschrift*, No. 31, 1898.

STYPTICIN IN UTERINE HÆMORRHAGES.—(*Muench Med. Woch.*, 1898, p. 419). While most cases of uterine hæmorrhage demand operative interference, yet there are cases in which it is unsuitable and the hæmorrhage may be influenced by drugs. For this purpose stypticin or cotarninum hydrochloricum was introduced by Freund. It is a derivative of narcotine and is chemically related to hydrastin. It comes as a sulphur yellow amorphous powder, which is readily soluble in water and can be administered in doses of from 0.025 to 0.05 several times daily, either as a powder or in solution, and may be even used subcutaneously. Suitable formulæ are as follows:

R. Stypticin . . . . .	0.05.
Sacchar. alb . . . . .	0.5.
M. f. pulv.	
D. tal. dos. no. xv.	
S.—4 to 5 times daily.	
or R Stypticin . . . . .	1.5.
Pulv. et succ. liquir. q.s. ut. ft. pilul. no. xxx.	
S.—4 to 5 times a day.	

If it is going to prove efficacious eight to fifteen pills of 0.05 each is sufficient, but it is suitable for continued use. Of five cases of virginal menstrual hæmorrhages in three was it efficacious, the remaining two were very anæmic girls in which hydrastis had been unsuccessfully used. While in nine cases of menorrhagia due to inflammatory disease of the pelvic connective tissues, or of the adnexa, or of malposition of the uterus associated with inflammation of the surrounding tissues, was it efficient in every case, and in twelve cases of metrorrhagia due to the same causes it acted well in eight, in one the hæmorrhage was lessened but not stopped by twenty pills, and in the remaining three it was without success. In two cases of acute gonorrhœa of the uterine mucous membrane it yielded good results. In endometritis hæmorrhagica the result was favorable in five, in one doubtful and in the remaining two without effect. Fungous endometritis he believes best treated by curettement, and in one case of myoma the hæmorrhage promptly ceased only to return in the intervals. One woman pregnant four or five months was successfully treated for hæmorrhage without exciting pains. At times patients

complain of nausea and diarrhœa, and Falk has shown that in dogs and rabbits even subcutaneous use causes intestinal peristalsis. While a sedative action would be expected from its chemical composition, yet the author failed to notice any. In his forty-five cases in which operation was not immediately indicated, stypticin failed in ten cases and in four was it of doubtful use, so that the author considers it useful, especially in secondary hæmorrhages.—*Dominion Medical Monthly*.

THE PREVENTION OF SORE NIPPLES.—Mabbott, in the *The New York Medical Journal* of September 10th, 1898, recommends the use of lanolin for the prevention of sore nipples. He instructs the patient to begin its use from four to six weeks before the expected date of confinement, and continue until delivery. Every night at bedtime a small portion of lanolin is thoroughly worked into each nipple with the thumb and fingers, special pains being taken to rub it well into any folds or crevices, especially in the case of depressed and sunken nipples. This kneading process has the effect of forming the nipple—partly by pulling it out and partly by causing erection—and this in itself develops the nipple and promotes facility of nursing. Lanolin is superior to other substances which might be used for this purpose by reason of its combined adhesive and penetrative qualities, promoting the nutrition of the epidermis. However, perhaps the most useful purpose of the lanolin is associated with its moral effect in furnishing a substance to remove in the morning. Lanolin resists saponification and requires considerable time for its removal.—*Medical Age*.

CHRONIC ULCERS OF THE LEG.—A confrere (Paris *Cor. Med. Press & Cir.*, vol. 66, no. 3088) reports having treated over 200 cases of chronic ulcers of the leg by the following method, and each time with success. The treatment is based on a thorough disinfection of the sores. The limb is first well washed with black soap and dried, and then the ulcers are powdered with calomel and triturated by means of a plug of cotton attached to a piece of wood (penholder), and steeped in water, so as to form with the calomel a thick paste. On this paste is sprinkled some fine table salt; a dressing of gauze and cotton terminates the operation. The sublimate resulting from the combination of the chloride of sodium and the calomel is very active in its effects, and for three hours the patient suffers from an intense burning sensation in the wound, although never so unbearable as to require an injection of morphine. At the end of twenty-four hours the ulcers are washed again, and this time the surfaces are of a bright red color—all the granulations having been destroyed. The pain derived from the injection and the inflammation of the surrounding tissue has generally disappeared at this stage. The wound heals now rapidly, but, to hasten the cicatrization, the author generally applies an ointment of turpentine.—*Memphis Med. Monthly*.

THE TREATMENT OF WHOOPING COUGH BY RESORCIN.—Roskam (*Annales de la Societe Med. Chirurg. de Liege. 1897, xxxvi, 71*). Since 1890 Roskam has treated 290 cases according to the method recommended by Moncorvo and modified by himself. His method has been to make immediate application to the glottis by means of a very fine sponge of a 2 to 3 per cent. solution of resorcin, but without the previous use, as recommended by Moncorvo, of a 16 per cent. solution of cocaine, which latter frequently induces violent spasm. As a rule the treatment was begun during the first two weeks of the disease, although a number of the children had already reached the convulsive stage. Not a single child died, although severe symptoms of adynamia were present in three of the children; two cases recovered in fourteen days, seventy cases were cured before the end of twenty-five days, counting from the beginning of treatment, eighteen recovered within a month. As a rule children under one year of age recovered more rapidly, generally within eight days. In children under one year of age a 2 per cent. solution was used; in those between one and two years of age, a 2 per cent. solution was used during the first few days and later a 3 per cent. solution; in still older children, the 3 per cent. solution was at once employed. The application was made every four hours and, where possible, once or twice during the night. After two or three days, and occasionally still earlier, a marked improvement of the digestion occurred, the children took their food with relish, and after four to five days the cough had lost its characteristic sound, the paroxysms became shorter and less severe, vomiting ceased, and the general condition improved notably. After ten to twelve days the treatment was discontinued, and when necessary was resumed after five to six days.—*Pediatrics*.

THE TREATMENT OF PNEUMONIA.—De Renzi advises the frequent use of a mouth wash of sublimate solution (1 in 5000) or ac. salicylic (1 in 500) both as a prophylactic and as a germicide, killing the pneumococcus which is frequently found in the mouth. He dwells on the importance of fresh and pure air and on the necessity of feeding, relying chiefly on milk and eggs, broths having certain disadvantages. As to drugs, the only one recognized by him is alcohol (ethylic), which he is in the habit of giving to all his cases. Since the introduction of the anti-pneumonic serum (prepared by Pane) he has used it with very gratifying results. During the last three years he has used the serum in 32 cases (and in the earlier years only the severest cases were selected; in the last year all the cases (14) were treated with serum), with a mortality of 9 per cent., whereas in the previous years, with the ordinary treatment in vogue, the mortality was 24 per cent. No bad results have followed injection, and in one case as much as 200 c. cm. was injected in the course of 24 hours. The most marked effect was the lowering of the temperature. Of the three fatal cases two were admitted almost moribund, and the third had serious concomitant disease.—*Gaz., degli Osped. e delle Clin.*

**ACUTE INFLAMMATION OF THE PROSTATE GLAND.**—*The Journal of the American Medical Association*, for August 20th, contains a report on inflammation of the prostate gland, which was presented to the Section on Surgery and Anatomy at the forty-ninth annual meeting of the American Medical Association, held at Denver, Colo., June 7-10, 1898, by Liston Homer Montgomery, M. D., of Chicago, Ills. His plan of treatment in acute inflammation of the prostate gland is to wash out the abscess cavity with hydrogen peroxid, give copious hot water enema and hot hip baths frequently, avoid morphine internally and advise care lest the patient strain at stool or during micturition. On the theory that toxins are retained in the circulation and within the gland, and to prevent degeneration in the gland substance, he administers triticum repens or fluid extract tritipalm freely, combined with gum arabic or flaxseed infusion. Along with these remedies the mineral waters, particularly vichy with citrate of potash, go well together. Hydrate of chloral or this salt combined with antikamnia are the very best anodyne remedies to control pain and spasms of the neck of the bladder. These pharmacologic or medicinal remedies are the most logical to use in his judgment, while externally, applications of an inunction of 10 or 20 per cent. iodoform, lanoline, as well as mercury, are also of value.

**SANMETTO IN URETHRAL AND BLADDER DISEASES. IN PRE-SENILITY AND ENLARGED PROSTATE.**—In nearly thirty years practice I have never written to the proprietors of any medicine extolling its virtues, but after some years constant use of sanmetto I can but say it is my sheet anchor in all urethral and bladder diseases. In pre-senility it has no equal. Have recently used it in two cases of enlarged prostate with marked benefit in both cases.

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one in twenty, and it appears to be a very important associate and aid to iron in the human economy.

We have described in the Pharmacopœia an almost endless number and variety of preparations of iron, and yet the physician rarely employs more than two or three of these. The few that are of practical importance are often objectionable on account of their astringency and tendency to irritate the stomach, constipate the bowels, or injure the teeth.

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Gude's pepto-mangan is an unusually happy combination of iron and manganese in such a way as to be easy of absorption and free from the objectionable effects of other preparations of iron. In its preparation a large amount of egg albumen is used to convert the iron and manganese into a form easy of absorption; there is also sufficient pepsin employed to make the preparation an aid to the digestion, whereas many of the other preparations interfere with this all-important function. The tr. chloride of iron, which is the most generally used of all preparations in the Pharmacopœia, is very astringent; it can rarely be tolerated by a weak stomach; it discolors and injures the teeth, and always constipates the bowels.

Gude's pepto-mangan is free of all these objectionable features, and has the advantage of containing manganese in combination with the iron, which is decidedly synergistic to the action of the latter. The preparation is useful in all forms of anæmia and chlorosis, and is especially indicated in anæmic and chlorotic girls who suffer with dysmenorrhœa and amenorrhœa, and is the most useful of all preparations in cases where iron and manganese are indicated.

In nervous conditions associated with anæmia no preparation can be found of more service than this in combination with strychnia sulphate. It is given in dessert to tablespoonful doses, with or immediately after meals, and may be given in water, sweet milk, or preferably, in most cases, sherry wine. This preparation, as in case with all general tonics, should be given from four to six weeks before any marked improvement is expected.—*Alabama Med. and Surg. Age.*

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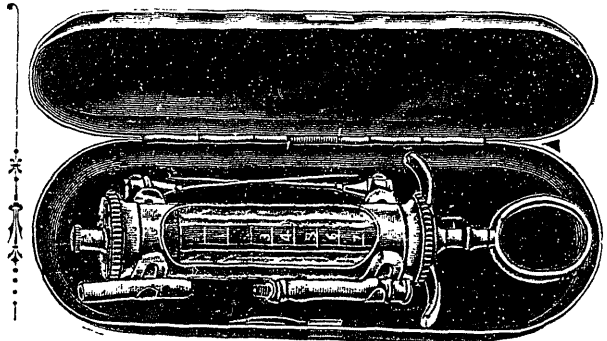
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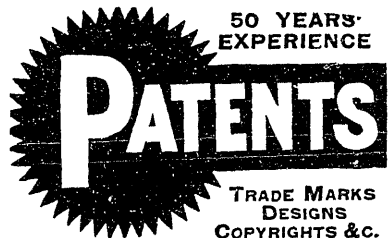
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