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THE MARITIME MEDICAL NEWS

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WORLD OF MEDICINE.

Puerperal Insanity.

Of all attacks of mental diseases that occur, those are fraught with possibly the most danger to the patient which commence during the puerperal period or soon after it. The special dangers lie in the facts that the onset is, as a rule, insidious, and that among the earliest symptoms are a growing dislike for those for whom most affection should be felt and a suicidal tendency. These early symptoms are generally carefully concealed by the patient, and often the first indication of anything wrong is some marked attack on a relative, or a determined attempt at suicide. Of all those that harm may be done to, the one that runs the gravest risk is, naturally, the baby. Reports of trials for murder of the child, committed under these circumstances, are not uncommon, but the cases in which the catastrophe was barely averted would, were they all reported, surprise and shock most people. The medical man is, of course, frequently blamed for not having warned the friends of the impending danger; but as a rule he is not only in no way to blame, but is less likely to notice small mental changes in his patient than the near relatives who are with her, and who know her better than he does. Besides this, one is always naturally loth to attribute small mental changes in an individual to anything else than normal variation, or to mention the fact if one does, since to the lay mind insanity is not a disease but an unfortunate stigma. This being so in ordinary circumstances, one is still more careful when observing anyone who is undergoing a normal reaction after a period of abnormal mental stress, as after a confinement. The blame, therefore, for not having called attention to minor mental changes which were not noticed by the friends, cannot be with justice thrown on the doctor.

Puerperal insanity is commoner after the first than after subsequent confinements; and is said to occur frequently after illegitimate pregnancies. The reason for this appears to be that the mental stress is greater during the first pregnancy than during later ones. The normal symptoms of pregnancy, besides being wearing, are new to the patient; there is an emotional state which is very strong, and which lasts for some months, becoming stronger as confinement approaches; and finally a period of much physical pain followed by a change of emotional state. Of this emotional state, the principal components appear to be fear, expectation, and joy; and of these, the two former disappear on delivery. Thus the normal mental stress is great, and it is sometimes further increased by croakings of ignorant friends, or the reading of books of the "Advice to Young Mothers" type which abound nowadays. In many cases is found an extra source of trouble in the pres-

sure of family or financial worries. In illegitimate pregnancies there is, of course, further emotional burden. The factors just enumerated can generally be found sufficient to ascribe as a cause; but in many cases none of them seem to have been of sufficient strength to have had anything to do with the breakdown, and in these one is often quite unable to account for it at all. Sometimes shock at the child been born dead or physically abnormal is the determining cause. Cases, it may be noted, following puerperal sepsis are not classed as puerperal, but as toxic insanity.

The symptoms may take the form of either mania or melancholia, but in the excited cases there is generally a very marked reactionary depression. Whichever form they take, the dislike for friends and relatives appears, and a suicidal impulse, except in the mildest cases. Some very mild cases display neither excitement nor depression, but simply appear to be of the confusional type. Hallucinations and delusions of all kinds occur, also insomnia and refusal of food. Constipation, as would be expected, is present, and often dirty tongue and foul breath. In the depression following maniacal symptoms, the suicidal tendency is very dangerous, and must be very carefully guarded against.

The majority of cases make good recoveries, and the greater number do not have any recurrence at subsequent confinements. Some few do not recover, but drift into a chronic state and finally into dementia. In these will usually be found a history of former attacks or a bad family history. Many of the patients who finally recover hang fire at some period of the illness, and remain without sign of improvement for a long time. The liability to this renders any prophecy as to the probable length of the attack both difficult and dangerous.

The indications for prevention are plain. As much freedom from all sources of worry as possible, attention to the general health, occupation enough to interest and to prevent too much thought being given to her own condition and feelings, and advice and help, when needed, from a sensible woman whom she can trust. Books of advice should not be allowed, as not only are they useless if there is someone to appeal to in case of need, but one so often hears from patients and friends of the baneful influence they have had on those who have studied them. The engagement of a capable nurse, and the knowledge that she will be at hand when required, will remove a good deal of anxiety at a time when it is least desirable.

At the first sign of the presence of mental symptoms the baby should be removed, and should not be left with the mother again until after complete recovery. It is generally best not to allow her to see it at all, but in mild cases, if she is anxious to do so, she may be allowed to, though she should not be permitted to nurse it. She should be left alone as little as possible on account of the frequent tendency to suicidal impulse, and all poisonous substances and objects with which she could do herself bodily harm should be removed. If food is refused, forcible feeding may become necessary, and should not be delayed. In the case of there being much secretion of milk, steps must be taken at once to stop it, and a close watch kept for signs of mammary inflammation. Lochia cease with the onset of the mental symptoms, but nothing need be done for this unless there is some indication for a douche, which very

rarely happens. At first patients are best kept in bed, unless there is any contra-indication; after a week or so they should be got up and given exercise in the open air. The case will be best nursed by those who have had training in nursing mental patients and who are strangers to her. If possible to manage at home, and if progress is made, certification is, of course, best avoided; but if improvement does not appear, a change from home, either in an institution or not, ought to be tried. It is best to insist on a long period of convalescence and change of air before allowing return to home duties.—*Hospital.*

* * *

The Centenary of Oliver Wendell Holmes. The centenary of Oliver Wendell Holmes was celebrated by the Medical Society of the County of New York on October 9th, 1909. Dr. Jacobi, who was in the chair, said Holmes was a rare combination of science and poetry. He was destined to be a follower of Apollo, the only Greek god who combined medicine and art and music and poetry. Dr. Maurice H. Richardson gave some personal reminiscences of the "Autocrat." They related to the last years of Holmes's teaching, when he was at the height of his fame and Dr. Richardson was his youngest assistant. He made even the dry bones intensely interesting. His lectures were full of wit, bright and sparkling. Many of his sayings had been handed down from student to student to this day. Dr. Richardson recalled Holmes's description of the greatest possible rewards of the physician and surgeon: "He is always one of the most respected of men; his highest political reward is to be on the school committee; he lives well but dies poor." He said that his highest possible ambition was to have some loathsome disease named after him—Bright's disease, Ménière's disease, etc. The surgeon's highest reward would be to have some bloody operation named after him. Holmes had to lecture on a subject repulsive to some, difficult for all, and at an hour—one o'clock—when the class was jaded and hungry. The wooden seats were hard, the backs were straight, and the air was bad. In alluding to the air, he said: "So when "the class was sitting in an atmosphere once breathed already, after I "had seen head after head gently declining and one pair of eyes after "another emptying themselves of intelligence, I have said inaudibly, "with the considerate self-restraint of "Musidora's rural lover, 'Sleep on, "'dear youth, this does not mean that "'you are indolent or that I am dull. "'It is the partial coma of commenc-"'ing asphyxia.'" To make head against these odds he gave his imagination full play in comparisons often charming and quaint. None but Holmes could have compared the microscopic coiled tube of a sweat gland to a fairy's intestine. Medical readers would appreciate the aptness of comparing the mesentery to the shirt ruffles of a preceding generation, which from a short line of attachment expanded into yards of complicated folds. In seeking some illustration of his way of teaching anatomy, he mentioned the book of Spigelius, "in "which lovely ladies display their "viscera with a coquettish grace, im-"plying that it is rather a pleasure "than otherwise to show the lacelike "omentum, and hold up their appen-"dices epiploïcae, as if they were say-"ing 'these are our jewels.'" Great pains were taken in getting the subject ready for the anatomical room to make the dissection as beautiful in

itself as it could be made, and to make the setting appropriate. The dissections were really works of art. Holmes's plan was to arouse his audience to keen receptiveness, and then to plunge at once into his subject. One simply could not help listening, absorbing and storing away the driest of facts. By the association of ideas, especially by the aid of humour, he suggested, through easily remembered anecdotes, jokes, puns, or mnemonics, the really dry facts of anatomy. One method he usedwas to bring out the applications of anatomy, and to-day the applications of anatomy offer a more attractive field than they did then. He believed in iteration and reiteration. He said: "My advice to "every teacher less experienced than "myself would be, therefore, 'Do not "'fret over details you have to omit; "'you probably teach altogether too "'many as it is. The only way of "'teaching a whole class is by enor-"'mous repetition, representation, and "'illustration in all possible forms.'" A curious thing was his unwillingness to allow any one to lecture for him. He said: "If I allow any one to take "my place he may give a better lec-"ture than I could." Dr. Edward O. Otis, of Boston, spoke of Holmes's medical work, and traced the influence of his professional knowledge on his literary productions. He believed that Holmes felt—at least for the greater part of his life—that, while literature was his avocation, medicine and the teaching of his branch of medicine was his vocation. He might well have been an original investigator if he had been less of a literary man, but he was in some respects an incomparable medical interpreter and critic. Dr. William Hanna Thompson spoke of Holmes as author, poet, and man, and the proceedings were brought to a close by the reading of a poem by Mr. Richard Watson Gilder, who described Holmes as

The poet who first to science sought,
And to the Merry Muses after,
Who learned what in no school is taught—
The secret of men's tears and laughter. B. M. J.

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The School-Child's Breakfast. W. C. Hollopeter (*Journal A. M. A.*, November 20), commenting on the startling statements of sociologic writers which have been made so much of lately, says the published statements are based on insufficient grounds. His views correspond very closely with those editorially expressed in the *Journal*, Nov. 7, 1908, p. 1604, that poverty was only exceptionally the cause. The capricious appetites of children due to bad hygiene and suroundings are much more influential in bringing about the state of affairs complained of. For several years he has been investigating the subject and he finds that a large proportion of the children, if asked why they did not have breakfast, would say that they didn't want it; or, if in the younger children, the answer would be that their mothers could not make them taken any. It is not among the poorer classes alone that we find capricious appetites. With the object of corroborating or disproving the correctness of the statements made by sociological writers he found that only six claimed to eat no breakfast out of 2,169 children interrogated, but a large number reported insufficient time devoted to that function. While he considers the figures insufficient to give definite conclusions he thinks we may infer that the child has a chance though a very poor one indeed, for a breakfast, and the reason he has so

poor a one is not because he has no food, but because he has unfortunate surroundings to prepare him for his day's work. The sensational statements therefore are misleading, the real remedy will be in the more general reform of the habits and hygiene of the people, and not in providing free meals for school children.

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Placenta Praevia in Private Practice. Professor Fritsch stated recently that the clinical teaching of midwifery has necessarily become divorced from midwifery of general practice, and contended that the general practitioner is not capable of keeping up with the modern requirements of science owing to want of constant operative practice, want of the necessary instruments and apparatus, and to the absence of adequate care and nursing in private. This pessimistic doctrine has been vigorously combated by Bokelmann, who, taking as an illustration the treatment of placenta praevia, contends that as good results are obtained by general practitioners as by specialist professors. He states that Kronig and Sellheim have gone so far as to assert that it is necessary to admit every case of placenta prævia into hospital, and to deliver by means of vaginal Cæsarean section, while they do not hesitate to recommend supravaginal amputation of the uterus if hæmorrhage occurs later. In reply to these assertions Bokelmann relates how, in a long experience, he has had to deal with some 16 cases of placenta prævia in private practice, but that, if the cases he treated as obstetric house-physician is added, the number is raised to 50. Several of these cases were severe, and were treated in earlier days by combined version, but more recently by the dilator. He had no death from hæmorrhage—in fact, all the mothers recovered. What claim, he asks, have the specialists to introduce a modern form of treatment, which involves a considerable risk to the mother's life even when performed by the most skilled operator, when a general practitioner can obtain results such as these? He admits that the number of his cases is small; nevertheless he claims that they suffice to show that placent prævia, when properly treated, is not a complication the treatment of which the general practitioner need fear to undertake. He states that he lost more infants when he turned than since he has employed the dilator, but he has never met with a single case of hæmorrhage after delivery. More than this, he states that in his whole experience he has only plugged a uterus once, and then not for placenta prævia. Provided that the cervix and uterus are not torn, he maintains that hæmorrhage after delivery need not occur. He asks general practitioners to publish the results of their cases of placenta prævia, in order to demonstrate that the results in private practice are better than those obained in modern clinics, where heroic procedures are employed for conditions which may terminate spontaneously. In his opinion, before the professors advocate wholesale operations, they should show that the results obtainable with care and skill by the older methods are such as to warrant these drastic measures.—*B. M. J.*

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Interstice and Crevice. It is not difficult to present cases which prove that the interstice and the crevice can be enemies of health. The man who allows particles of white lead to accumulate and to stay be-

neath his finger-nails sooner or later suffers from lead poisoning. To him the frequent application of the scrubbing brush may make all the difference between health and disease. The neglect, again, to remove particles of decaying food lodged between the teeth may well give rise to a septic process. Once more the brush must be brought into hygiene service. As is well known, a factor of no little importance in infant feeding is the use of a bottle which can be easily and scrupulously cleaned and which contains, therefore, no crevices which make the cleaning process difficult and which harbor pabulum and provide a breeding ground for disease-producing organisms. The interstices of the common dining fork are similarly hygienically objectionable and require careful attention when the fork is cleaned. The moustache cup is an abomination, the inside surface of the guard being almost inaccessible for cleaning purposes, and the hollow stemmed wine glass presents a similar objection. Hygienic practice suggests in fact, that all articles in domestic use which are difficult to clean because of interstice and crevice should be banished. This tenet, however, may more reasonably be supported in the case of articles, as ,for example, clothes. It would be difficult, for example to abolish interstices and crevices of our boots, and yet we have it on scientific authority that the boots of the Members of the House Commons may be a contributory factor to the seasonal prevalence of influenza in that place. It would appear ridiculous to suggest that the boots he left outside the portal of our homes and offices, although that would clearly be a real remedy which no amount of amount of cleaning on a mat can ever be. The interstices of the outdoor garment obviously afford excellent lodgement for micro-organisms and dust, which the application of the clothes-brush proves day by day, but clothes should be brushed out of doors. There are cases in which the dangers of interstice and crevice can be avoided, and where they cannot they can be minimised by a regard for cleanly practices.—*Lancet.*

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Clinical Varieties of Periodic. Drinking. Pearce Baily, of New York, urges a careful psychological analysis of alcoholism in order that measures may be formulated. Chronic alcoholism has some right to be called a disease; dipsomania is not so much a disease as a disorder of personality. The defects of personality must be laid bare and proper treatment shaped out, which must be individualistic. The periodic character of a certain type of inebriety has caused it to be compared to epilepsy. Many dipsomaniacs have had convulsions and there are many neuropathic tendencies in heir antecedents. In both epilepsy and alcoholism the patient is excited and restless before the attack, and premonitory depression is constant. True dipsomania has the same prognosis and treatment as epilepsy. Periodic drinking from other causes offers more hope of cure. Alcoholism is not prominent in dementia precox or melancholia. In general paresis alcoholic attacks are frequent. In manic-depressive insanity alcoholism often obscures the clinical picture and is habitually present. Many of the psychic states are both causes and effects of alcoholism. Sexual desires, wrong moral attitudes, idleness and jealousy are both causes and effects. Periodic drinking is met with in cases that are mildly paranoid, usually of the jealous type. Hysteria and psychasthenia

form a large field for future investigation as to the genesis of periodic drinking.—*Medical Record*, October 30th, 1909.

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Typhoid Fever. Abdullah K. Sallom, of Philadelphia, Pa. (*Medical Record*, November 20, 1909), gives tables obtained from the statistical reports of the Bureau of Health of Philadelphia, from 1898 to 1909, including 68,943 cases of typhoid fever. The greatest number of cases has occurred in February and the next greatest in September, the lowest being in July. The number of cases yearly is seen in another table. The largest number corresponds to the year in which our soldiers returned from the Spanish war, 1,346 being soldiers brought from the Southern camps. Since February, 1907, the disease has been decreasing. The filtration of the water supply has had a marked effect on the number of yearly cases.

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Guiacol Carbonate in Arthritis. Symes - Thompson says that the drug which has been followed by most benefit in rheumatoid arthritis is guiacol carbonate. It should be given in full doses for six months, and the improvement which follows may be explained on the assumption that it inhibits the growth of certain micro-organisms in the digestive tract, with a constant diminution of the infection of the blood-stream from the intestine.—*Clinical Journal.*

EDITORIAL.

Recent Contributions to the Study of Cancer.

IN the *Pennsylvania Medical Journal* for November, we find a series of interesting and practical papers on the subject of cancer. These were read in the Section on Surgery of the Medical Society of the State of Pennsylvania, at Philadelphia, in September. We shall attempt a brief resume of some of them.

The Present Status of Cancer Research.

By Leo Loeb, M. D., Philadelphia.

In the present state of our knowledge, the parasitic hypothesis of the origin of cancer can be neither affirmed nor denied, and the researches of the last few years have not supported that theory. All attempts to demonstrate the presence of a micro-organism have failed so far. And yet there is a large body of indirect, evidence, such as well authenticated, instances of so-called "cancer houses" and "cancer districts," in which the relative incidence of cancer is much increased. Then there is the endemic occurrence of cancer in animals.

Whatever may be the primary cause, there can be no doubt that various non-specific physical and chemical stimuli are among the best established factors in the pathogenesis of cancer and the result of recent study have shown the importance of the study of cancerous processes in the lower animals.

While no positive results have been attained in the attempt to elaborate a curative serum, unless perhaps, in the recent work of Walker, of Liverpool, positive results have been attain-

ed in producing active immunity against tumour growth in mice and other animals. The fact remains that the principal weapon in the struggle against cancer lies in thorough extirpation of the growth, and all knowledge points to the advisability of avoiding as far as possible long continued irritation of any kind.

The Prevalence of Cancer.

By Samuel G. Dixon, M. D., LL. D.

One of the difficulties in securing reliable statistics of cancer is the vagueness with which mortality returns are often made up. "In the "Bureau of Vital Statistics in the "Pennsylvania State Department of "Health, it is necessary to ask each "month not less than twenty-five "physicians throughout the State for "a more definite statement, even as to "the location of cancers and malig-"nant growths."

"The value of all mortality statis-"tics must depend upon the honesty "and accuracy of physicians who sup-"ply the information upon which "these statistics are based."

The mortality from cancer is steadily increasing throughout the civilized world. There are good reasons for believing that over 50,000 deaths occurred from cancer in the United States in the year 1907. Of all countries from which reliable statistics come, Hungary appears to have the lowest and Switzerland the highest mortality from cancer.

The death rate from cancer per 100,000 of population increased between 1890 and 1907, from 27 to 42 in Hungary, from 41 to 73 in Prussia, from 48 to 73 in the United States, from 63 to 91 in England and Wales, from 70 to 102 in the Netherlands, and from 114 to 132 in Switzerland. In the State of Pennsylvania the rate in 1890 was 41.5 and in 1907, 62.8.

Nearly 40 per cent. of the deaths from cancer are due to cancer of the stomach and liver, next comes cancer of the uterus and aduexa, over 14 per cent., third in frequency is cancer of the intestines and peritoneum, nearly 12 per cent., and cancer of the breast is accountable for 8.5 per cent.

Of all deaths from cancer, 90 per cent. occur after 35 years of age, but it occurs in young children, and it is more frequent during the first five years of life than between five and fifteen. The most frequent seat of cancer in children is the kidney and suprarenal body, and next, the eye or the orbit. With the single exception of cancer of the breast, rare in men, cancer is more frequent in males than in females. There is no evidence that any occupation predisposes to cancer.

The Differential Diagnosis of Gall-stones, Ulcer and Cancer of the Stomach.

By Christopher Graham, B. S., M. D., Rochester, Minn.

This is an unusually good paper; clear, simple, definite, practical, a good illustration of the teaching of what we call the Mayo school of Surgery. In summarizing the paper the following points are considered in reference to those three definite diseases. 1. The General Health. In gall stones this is good until complications arise, such as obstruction, jaundice or pancreatitis. The course of ulcer is prolonged, with intervals of pain and distress, followed by apparently perfect health, and the patient is hopeful and active, though often emaciated. In cancer the progress of the disease is rapid and steadily downward and the patient is depressed, languid, and often cachectic.

2. Pain. In gallstone disease, or cholelithiasis the pain may be slight, rather a feeling of distress, but an attack of gallstone colic is an exceedingly severe pain, sudden, usually short, and often ceasing abruptly: it is independent of food.

In ulcer the pain is definite, coming in spells with some regularity, often relieved by food, and reappearing in two or three hours. (Pain, relieved by food, and recurring in two or three hours is almost pathognomonic of duodenal ulcer and ulcers near the cardiac end do not give such distinct symptoms.) In cancer the pain is continuous, dull, depressing, and is immediately aggravated by food.

3. Vomiting is not important in the diagnosis of gall stones. It is generally of sour, bitter bile, and small in amount. In ulcer, vomiting is as regular as pain, generally of sour material, often abundant in liquid, and it brings immediate relief. In cancer vomiting is irregular, large in quantity, of ill-digested food, generally foul, often bloody, and it gives marked though rarely complete ease.

4. Blood in vomit, or in fœces is rare in gall-stones, rare also in ulcer (about 25 per cent. of the cases), but is common in cancer.

The clinical history of cancer of the stomach indicate three groups of cases. First, those succeeded by a clear and prolonged typical history of ulcer; second, those in which there is an old history of "indigestion," with a long period of freedom from symptoms (latent ulcer); and third, those in which symptoms of malignant disease burst suddenly out. "Ulcer is the great soil upon which cancer is engrafted." In cancer nutrition fails early, wasting follows rapidly, paleness follows and anæmia. It is in the early stage, the stage of ulcer that operative measures are most hopeful. When vomiting has existed for some time, when cachexia has set in, when an epigastric tumour can be felt, it is probably too late to hope for benefit from operation.

The Early Diagnosis of Cancer of the Breast and the Best Operative Technique.

By William L. Rodman, M. D., Philadelphia.

In this short paper the author points out that cancer, while it may affect any part of the breast is more generally found in its axillary than in its sternal half and in the upper, rather than in the lower part. Sarcoma and benign tumours are more frequently found in the sternal half. He notes that the fact of greatest diagnostic importance is the mobility of the tumour. "A growth which is not adherent to the skin and is freely moveable is almost certainly not cancerous." Retraction of the nipple is a valuable sign, but present in barely over fifty per cent. of cases. He thinks that heridity cannot even be inferred in more than twenty-five per cent. of cases. In aoout ten per cent. of cases cancer of the breast, in its early stage, cannot be recognized clinically, and the only method of certainty is microscopic examination. Arrangements should be made for the complete removal, and a microscopic examination can be made at the time of operation, and the course then decided.

Dr. Rodman is much influenced by the work of Mr. Sampson Handley, of the Middlesex Hospital, and always clears the fascia in the epigastric triangle. He also recommends the operator to begin by clearing out the axilla, and then removing the breast.

The Early Diagnosis and Best Treatment of Cancer of the Rectum.

Robert W. Stewart, M. D., Pittsburg.

The onset of cancer of the rectum is often insidious. An early symptom being a sense of discomfort that is relieved by an evacuation of the bowels.

(No case with this symptom, or complaining of piles, should be treated without a careful examination of the rectum.)

Pathological investigation shows that cancer of the rectum spreads with marked slowness: therefore in this region an early operation is promising.

One of the most painful features of this disease is the tardiness shown by patients in consulting a doctor. In barely thirty per cent. of cases does the patient come early enough for a radical operation. If the prostate or bladder is involved radical operation is contra-indicated. Dr. Stewart does not think well of Kraske's operation. The plan is ideal, but the results are not good. The best operation in hopeful cases of disease which cannot be dealt with from the perineum is the combined abdominal and perineal method. "The rectal specialist who undertakes this work without previous experience in abdominal surgery should for his own peace of mind, be born with an easy conscience."

Early Diagnosis of Cancer of the Uterus: Operative Technique.

Thomas S. Cullen, M. D., Baltimore.

In this admirable paper by our distinguished fellow-countryman, emphasis is laid on the supreme importance of early diagnosis. While the usual age-period for this disease is from thirty-five to fifty, it may occur much earlier.

"Any bloody or watery vaginal discharge that cannot be definitely accounted for demands an immediate and careful local examination. The cervix may appear perfectly normal: then the curette should be used and the tissue removed, sent to a pathologist for examination. If the cervix is rough or ulcerated a small piece should be excised for examination. Bleeding from amyoma is as a rule at the menstrual period and not fœtid. Bleeding during extra uterine fœtation is frequently inter-menstrual, but the history helps us as well as the bimanual examination.

Pelvic inflammations accompanied by hæmorrhage are usually characterized by a rise in temperature, in early cancer there is no fever.

In all uncertain cases examination must be made, and if necessary an anæsthetic must be given. The bimanual, the speculum, the curette, or the scissors to remove a piece of cervix, and the microscope, all must be used. "We, as general practitioners and surgeons. have absolutely no excuse for failing to diagnose cancer of the uterus within one week after the first time the patient comes under our observation."

As to operation, Dr. Cullen recommends Wertheim's method, and in pointing out that the greatest dangers of the radical operation are due to shock, urges two considerations on the operation: Rapidity in operating. 2. Provision for keeping the patient's body heat up while the on the operating table.

THE CANADIAN MEDICAL PROTECTIVE ASSOCIATION.

WE have before us the Eighth Annual Report of the Association, which was presented by the President, R. W. Powell, of Ottawa, to the Canadian Medical Association at Winnipeg last August.

In the year 1901 and at a meeting of the Canadian Medical Association held in Winnipeg in August, our lamented friend, Dr. W. S. Muir presented the report of the Committee on Medical Defence, which was in favour of the formation of a protective association, and it was then decided, on motion of Dr. Muir, seconded by Dr. F. N. G. Starr, to form such an association. Dr. Muir's report states the object of the Association "is to protect its members from prosecution where such action appears to our counsel and solicitor, as well as the committee in charge, to be unjust, harrassing, or frivolous." At that meeting R. W. Powell was elected president and he has ever since in the most faithful and energetic way guided the work of the Association and endeavoured to widen its circle of membership. The annual fee was fixed at $2.50 per member, but at the fourth annual meeting, in 1905, in Halifax, this was raised to $5.00. At the Vancouver meeting, in 1904, it was decided to form a small executive for each province to act in the interests of the Association and to pass on nominations for membership in their respective provinces. At the Halifax meeting above referred to, it was also decided that the membership fee should be collected through the banks. This plan was adopted as being really the simplest and easiest way of collecting the membership fee, which, it had been found, was often forgotten, and remained forgotten until some correspondence aroused the slumbering memory.

At the Montreal meeting of 1907 it was moved by Dr. R. A. Reeve, of Toronto, seconded by Dr. T. G. Roddick, and carried, that in future "all "new members applying for admiss- "ion to this Association will require "to be nominated and seconded by "two practitioners who are already "members of the Association, and "that the qualifications essential for "membership in the Canadian Medi- "cal Association be made the basis "for admission to the Canadian Me- "dical Protective Association."

Dr. Powell, in his report this year, is able to say that the membership is growing, and that of all the cases defended by the Association since it began work in 1902, every case has been won, and not one appealed. We think he has made good his aim, to establish a reputation for "successful and lawful defence," and that already there is evidence that the Association is protecting its members from "unreli- "able suitors who only seek financial "satisfaction at the expense of a phy- "sician's good name and reputation, "his only capital in this world."

In looking over the list of members we find, as might be expected, that Ontario leads, but it is evident there is more appreciation of the benefits of the Association in that province than elsewhere, for the membership of Ontario is considerably more than that of all the other provinces together, the total membership being 622, and that of Ontario 386. The membership of Quebec is only 60, of New Brunswick 36, of Nova Scotia 24, and of P. E. I. 2.

The Executive for New Brunswick consists of Drs. T. D. Walker and Murray MacLaren in St. John, Dr.

Atherton of Fredericton and Dr. W. D. Rankin of Woodstock.

For Nova Scotia: Dr. John Stewart, Halifax; Dr. J. W. T. Patton, Truro; Dr. H. E. Kendall, Sydney, and Dr. J. G. McDougal, Amherst.

The sole executive for P. E. I. is Dr. S. R. Jenkins.

We commend this Association to our readers: no one knows when the spectres of ignorance, suspicion and envy may take shape and strike at him, and even if he win his case in a court of law, his reputation may be unjustly damaged, and he is almost sure to find he will have to pay heavily for his defence, with small hope of damages.

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DOMINION REGISTRATION AND THE NEW JOURNAL.

IN our last number we reviewed the question of Dominion Registration and indicated some of the difficulties in the attainment of this object.

At the last meeting of the Canadian Medical Association there was an overwhelming majority in favour of another attempt to secure the working of the Roddick Act, and a committee was formed to consider means for removing difficulties. This committee met in Montreal on November 6th, under the chairmanship of Dr. Roddick. Almost every member of the large committee was present, representing British Columbia, Manitoba, Ontario, Quebec and the Maritime Provinces. Prince Edward Island was represented by Dr. S. R. Jenkins, New Brunswick by Dr. Murray MacLaren and Dr. J. W. Daniel, M. P., and Nova Scotia by Drs. G. M. Campbell and Stewart, and Dr. G. L. Sinclair was present as the delegate of the Provincial Medical Board of Nova Scotia. The Act was discussed with great earnestness, each member of the committee was asked to express his views, and it seemed at one time that no common platform could be reached. Finally, at a "round table" conference the Act was reviewed clause by clause, certain modifications were suggested and unanimously accepted. Copies of the Act thus amended are being sent to the various Boards and Councils, and Dr. Roddick will make another attempt to secure the passage of the Act on the next meeting of the legislature, and we may say that the prospects of success are brighter than ever before.

Another matter on which we commented in our last number was the proposed journal of the Canadian Medical Association. Arrangements have now been made for launching this journal and the Association may be congratulated on having secured the services of Dr. Andrew MacPhail, of Montreal, as editor. It is largely due to the able way in which Dr. MacPhail has directed the course of the *Montreal Medical Journal* that it has become the leading medical periodical in the Dominion. It has, however, been found impossible to issue the first number with the New Year, as was at one time hoped. Indeed we may not see the first nmber until June, or possibly in May. The general arrangement as to the price of the journal and its bearing on the membership of the Association is much as was indicated in the NEWS in November. The subscription price of the Journal is five dollars, and any one paying this can have the Journal, but any subscriber who is not a member of the Association must apply for admission in the usual way, through the Committee on Credentials.

For full particulars we refer our readers to he circulars of the Finance Committee which we print on another page.

ABOUT OURSELVES.

WE take the opportunity presented by the last issue of the year to bring to the notice of our readers in these Maritime Provinces certain facts connected with the publication of the MARITIME MEDICAL NEWS.

The NEWS has now attained its majority, having been first issued in November, 1888. The editorship has all along been gratuitous, no financial return of any kind has accrued to those whose names figure on the title page. The income of the NEWS is derived from its subscription list, and its advertisements, and these are barely sufficient to pay the cost of issuing the paper. In fact the half dozen men who have managed the NEWS find a gradually increasing deficit, and have had to consider the question of ceasing publication. We would like to continue the NEWS. We believe it has been a useful medium of communication for the profession of the Maritime Provinces, a repository of papers read at the provincial and county societies, and an advocate of all measures tending to the improvement of the standing of the profession. But the profession does not respond very enthusiastically. Many of the leading physicians have been subscribers and contributors since the NEWS was started, but a large number do not take the paper, and unless our subscription list is enlarged we cannot continue it. We have no ambition to go hat in hand to our colleagues and beg them to subscribe, and to pay when they have subscribed. We believe the NEWS is worth at least one dollar a year to every practitioner who reads it, but we are not sufficiently altruistic to continue publishing it at a loss.

The Journal of the Canadian Medical Association, which will commence publication by midsummer, and which its publishers hope will be largely subscribed for all over Canada, introduces a new feature into the prospects of the NEWS. If it should be taken by a majority of the practitioners of the Maritime Provinces the chief source of income of the NEWS will vanish, for the advertisers, who really pay our bills, cannot be expected to carry advertisements in two journals serving the same constituency. And a journal of the Association circulating throughout the Dominion must be a better medium than one with a restricted circulation.

We have decided to attempt another year; whether the NEWS will be continued after that must be decided during the coming year.

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THE ANTI-TUBERCULOSIS CAMPAIGN IN NEWFOUNDLAND.

THE "Ancient Colony" is wide awake in its dealing with matters of public health. At the last session of the legislature a committee was appointed to enquire into matters of Public Health in general, and Tuberculosis in particular. This committee found it impossible, in the absence of a good system of vital statisics, to estimate with any certainty the prevalence of tuberculosis, which is admittedly common in Newfoundland. They made certain recommendations to the government in reference to tuberculosis, and His Excellency the Governor-in-Council has approved of these. As a consequence it is now compulsory on medical men to report within twenty-four hours to the Medical Health Officer at St. John's, every case of tuberculosis coming to his knowledge. Neglect to do so involves a penalty of not less than ten or more than forty dollars. A fee of thirty cents is paid for each case

of notification. These reports are to be entered in a register provided for the purpose, and not open to public inspection.

Doctors must also notify the death, or removal from any house of any tuberculous person, in order that the premises may be disinfected.

Burials are not permitted unless a certificate of the cause of death is handed in.

Forms are supplied on which reports are to be made, and these are exempt from postage, as O. H. M. service.

TO THE MEDICAL PROFESSION IN CANADA.

MEMORANDUM FROM THE FINANCE COMMITTEE, CANADIAN MEDICAL ASSOCIATION.

Toronto, Nov. 15, 1909.

DEAR DOCTOR,—It has been thought desirable to request the attention of the Canadian Profession at large to the proposals of the Association with regard to the publishing of an official Journal of the Association, and the following statement is submitted for your information, with the hope that it will be found not too long for careful perusal and favourable consideration.

At the Montreal meeting in 1907 the Association adopted a set of By-laws and a Constitution, and decided that after the model of the British Medical Association, the American Medical Association, and other such bodies in other countries, we should as a united profession have a Journal as a mouthpiece for the profession of the Dominion.

The Constitution lays upon the Finance Committee this duty and the entire responsibility for the conducting of the proposed Journal.

Under the authority vested in it by the Constitution, the Finance Committee took steps to have an Act of Incorporation passed by the Dominion Parliament early this year, giving the Association, among other powers, the right to publish a Journal. This seemed the least expensive and most efficient means to the end desired. The plan adopted by the Finance Committee therefore is:

(*a*) To raise the annual fee to $5.00.

(*b*) To make membership permanent, and collect the annual fee from all members, whether they attend the Annual Meeting or not, as is now the practice of all considerable medical societies.

(*c*) In return for this fee to give to all the members the following three things:

(1) A monthly Journal.

(2) Membership in the Canadian Medical Association.

(3) Membership in the Provincial Association of the Province in which the members reside.

It should be explained that the latter proposal came from the Ontario Medical Association, which returns to each of its branches 2 shillings for every member of the branch, out of its annual fee of 24 shillings.

The action of the Ontario Medical Association has been followed, or will shortly be, by several of the other

Provincial Associations, Alberta, British Columbia, Manitoba, as they believe that their annual expenses can met by the payment of 50c. per member to the Provincial Association by the Canadian Medical Association.

It is expected that the Credentials Committee of the Canadian Medical Association will accept the findings of the similar committee of each local association.

In view of the action taken this year by the four western provinces looking to the establishment of a common Licensing Board, and in view of the overwhelming majority in favor of the Roddick Act of 1902 at the Winnipeg meeting, the time seems to be opportune, and professional opinion all over Canada seems to be ripe, for the establishment of an official Journal of the Association. The profession of this country does not lag behind the rest of the people in the desire to foster the awakening sentiment of nationhood in this portion of the Empire, and the Canadian Association, while establishing the new Journal, will take all care to avoid interference with the interests of the other Journals already so long in existence with so creditable a history.

The annual fee is for the calendar year and is accordingly due at the beginning of each year. During January, 1910, your committee hopes to have the first issue in the hands of all the medical men of the country, and, as is the custom of the British Medical Association, will venture to draw upon you for the annual fee during February, 1910, unless notified by you to the contrary by the blank form which will be inserted in the Journal, January issue. If you do not favour the plan your failure to honor the draft will be accepted by the Finance Committee as an intimation that you do not desire to become or to remain a member of the Association. The object of this method is to save you the trouble of correspondence in the matter.

The Finance Committee respectfully remind you that no efforts of theirs can make a success of the Journal without the loyal support of the profession to whom it belongs.

J. T. Fotheringham, Toronto, (Chairman).
F. N. G. Starr, Toronto,
S. J. Tunstall, Vancouver, B. C.,
R. J. Blanchard, Winnipeg, Man.,
James Bell, Montreal,
Murray MacLaren, St. John, N.B.,
Finance Committee.

CANADIAN MEDICAL ASSOCIATION.

MEMORANDUM FROM FINANCE COMMITTEE.

Toronto, Nov. 25th, 1909.

AS a result of a meeting of the Finance Committee in Montreal on Tuesday, the 16th of Nov., and the arrangements which it has been able to make with Dr. Macphail to undertake the editorship of the journal, the following information should be added to that contained in the circular of Nov. 15th:

The Committee considers itself fortunate in securing the services of Dr. Macphail, but learns from him that his other engagements will prevent the issuing of the Journal at the date expected. Your Committee feels bound

to defer to the opinions of the editor, who has had a wide experience in journalism and whose ideals as to the character of the proposed journal are high, consequently it will not be possible to publish the first issue shortly after the New Year as proposed; but the Commitee can venture to promise this before the next annual meeting in June, 1910.

In the meantime the annual fee will not be asked for as indicated in the circular of Nov. 15th, and under the circumstances it is not proposed to exact the whole fee for the ensuing year.

J. T. FOTHERINGHAM. Chairman.

AFFILIATION WITH C. M. A.

THE following is the text of the report presented at the Annual Meeting of the Medical Society of Nova Scotia, held in Sydney in July last, wih respect to the affiliation of the Society with the Canadian Medical Association:

To the Members of the Medical Society of Nova Scotia:

Your Committee appointed to consider the question of affiliation of the Medical Society of Nova Scotia with the Canadian Medical Association, beg to report as follows:

Your Committee find that by Article IV of the Constitution of the Canadian Medical Association, membership in the Association, when provincial or interprovincial medical associations are formed, can be "continued only through such local organization."

Your Committee also find that by Article I sub. sec. 3 of the Executive Council, "Every affiliated Branch, Society or Association shall be entitled to elect in addition to its President, who becomes an *ex officio* member, one delegate to serve on the Executive Council for its membership from fifteen to fifty; two delegates for its membership from fifty and to one hundred and fifty," etc.

Your Committee would therefore recommend (1) that the Medical Society of Nova Scotia affiliate with the Canadian Medical Association as the Medical Society of Nova Scotia in affiliation with the Canadian Medical Association, provided equitable fees can be arranged; (2) that two representatives be appointed on the Executive Council of the Canadian Medical Association, in accordance with the membership of sixty for the present session of the Society required by the Constitution of the Canadian Medical Association.

Your Committee would further recommend that the two members appointed to the Executive be a committee to arrange for an equitable per capita tax or fee to be paid each year to the Canadian Medical Association after each annual session of the Medical Society of Nova Scotia and to report back to the meeting of this Society next year for confirmation.

The above conclusions have been reached for the following reasons:

By affiliation we become eligible for

1. Membership in the Canadian Medical Association.

2. We continue our provincial association and do not lose our identity as such.

3. We become participants in the benefits accruing from belonging to the national association.

4. We believe that the best results for the profession generally are to be obtained by a national organization rather than through isolated local organizations; looking particularly to unification of medical education in the provinces and interprovincial registraion.

5. The results of national organization, as in the British Medical Association and American Medical Association, are such as to encourage our assistance in bringing about such an organization for Canada.

Signed. J. G. McDOUGAL,
M. A. B. SMITH,
EVAN KENNEDY,
Committee.

EXPLORATORY LAPAROTOMY.

A EUROPEAN physician writing of his impressions of American hospital methods made the criticism (which was reprinted in at least one of our newspapers), that in this country surgeons too often indulge in abdominal exploration. If it be true that we have fallen into the way of making abdominal diagnosis with the knife, of seeking visual demonstration before exhausting all the reasonable (and for the individual case, expedient) means of clinical diagnosis, then the criticism is a just one. Intelligent and patient study of signs and symptoms will usually direct the experienced surgeon to a correct diagnosis. On the other hand, exploratory laparotomy is often a justifiable means of diagnosis, deserving of proper consideration. Just as in cases of suspected gastric carcinoma, so in other abdominal diseases it is unfair to the patient to wait for positive signs or to rely on complicated and sometimes misleading laboratory tests.

In the acute cases diagnosis presents fewer difficulties, but of chronic abdominal diseases and especially of tumours, the diagnosis, in spite of every test, is often possible only on the operating table. Even when the diagnosis is not clear, the indication for operation may be; and an autopsy *in vivo* may prevent an autopsy *post-mortem!*

Visual demonstration is the most reliable of all diagnostic determination —hence the value of cystoscopy, of skiagraphy, of exploratory laparotomy. But he who rushes at once to these demonstrations before atempting to establish a conclusion by bedside examination, appropriate analyses and deductive reasoning will soon blunt the edge of his diagnostic discernment. Exploration as a means of diagnosis, usually immediately precendent to surgical treatment, has an appropriate place in the armamentarium of those whose clinical training has not been spoiled, and such a place it will continue to occupy as long as abdominal diagnosis presents elements of doubt.—W. M. B., in *American Journal of Surgery.*

PYELONEPHRITIS OF PREGNANCY.

By H. K. MACDONALD, M. D.,
Halifax, N. S.

(Read before the Maritime Medieal Association, Charlottetown, July, 1909)

THIS is a condition which of late years has been recognized with increasing frequency in pregnant women, and the following case occurring in my own practice, has prompted me to report it and afterward consider some of the more important points.

The patient, aged 24 years, primipara, consulted me on April 24th, 1908. She complained of pains in abdomen, intermittent in character. On inquiry she stated that she was six months pregnant and was in perfect health up until twenty-four hours ago. During past 24 hours had some bloody discharge. Anticipating an abortion I ordered her to bed, absolute rest, etc., and gave Fluid Extract Black Haw, thirty minims every four hours.

For a few days patient rapidly improved, until morning of 29th, when she was awakened with pain in left loin, constant and sevére in character. She remained in bed during that day, and I saw her at 7 p. m. Tenderness was then very marked in lumbar region, front and back; maximum point of tenderness was posi teriorly, just below edge of twelfth rib (costo-vertebral angle). Pain extended, however, anteriorly and down into left iliac fœsa. She also had severe headache, some nausea, but no vomiting. There had been marked constipation for some months previously. Temperature 99.8° F., pulse 84, respiration 24. Examination of urine resulted as follows: Color some what smoky, Sp. Gr., 1026; albumen present, sugar negative; amount 40 ounces in past 24 hours. Microscopic examination: Pus cells, flakes of pus, coci, bacilli, squamous and columnar epithelium. Did not have a bacteriologic examination at this date.

The following day (April 30th) patient seemed much better, but about 6 p. m. was seized with a very severe chill, lasting fully an hour. Pain in lumbar region had become very severe and tended to radiate up and down left side. She had great difficulty in breathing, severe headache and nausea; no vomiting. Temperature 102 3-5° F., pulse 116. It was difficult to examine her on account of the severe pain and the enlargement of the abdomen due to pregnancy. Neither kidney was palpable.

The following morning patient was again better, but marked tenderness in loin, same position, continued. On the evening of this day (May 1st), a decided fullness could be made out in left loin. During the next week reference to chart and bedside notes gives a fair picture of her condition: temperature was around normal line in morning; but there was always a rise of two or three degrees in the evening. Patient suffered intermittently. She usually felt fair in the morning but had bad nights, with severe pain, sweats and sometimes slight rigors, Pain often simulated "labour pains," but always commenced above in region of loin and radiated.

Urine was segregated and pus was found coming from left ureter; also some blood cells, casts, etc. Examination of blood at this time showed a leucocytosis of 21,000.

The question of opening and draining the kidney was considered, but

apart from any professional opinion which might have been given, the patient and friends objected to operative interference.

On the twelfth day of disease, patient's temperature remained normal all day. Her symptoms were all improved, and the tenderness in loin had markedly lessened. We thought she was doing well, but on the evening of the 13th day she had another chill and severe attack of pain in right loin and lumbar region. The maximum point of tenderness was just below the twelfth rib. This attack was followed by marked hæmaturia which persisted for the next five days, the amount of blood gradually diminishing. From the thirteenth to the seventeenth day the patient was very ill and suffered almost constantly from pain in both loins, headache, chills, etc. Bacteriological examination of urine gave pure culture of bacilli coli. She was very languid and had attacks of gaping and sighing similar to condition seen in severe hæmorrhage. On the twenty-second day of the attack the temperature became normal, the pulse rate was 72, and the condition of urine was improved. Pus cells although still present were markedly lessened until the thirty-second day of disease, when patient had another slight chill and temperature rose to 100° F., and pulse to 100. This continued for a couple of days, when normal condition was again reached. After thirty-ninth day of disease, which was June 6th, patient's condition remained good, although pus cells were constantly present in urine and tenderness was always present in both loins though not so marked.

On July 25th she was delivered of a full term male child, weighing 8 pounds 9 ounces, after a very difficult, protracted labor and a bad perineal tear. The first week of the puerperal state was rather a stormy one. The patient had to be catheterized, and on evening of fourth day she had a severe chill, but she made a good recovery. After four weeks pus cells had entirely disappeared from the urine and since that time patient has enjoyed good health.

Treatment consisted of Urotropin qrs. v., q. 4 h., and meeting other indications as they arose: Veronal for sleeplessness, alcohol sponge when restless, absolute rest in bed, bland diet and free purgation. When hæmaturia was severe, I discontinued the Urotropin and hæmaturia improved. I was forced to believe that the drug was partly the cause of hæmaturia.

Before entering into the discussion of the pathology, bacteriology and other phases of the disease, let me state that owing to fact that this is the only case which ever occurred in my own practice, my remarks are largely culled from the experience of men, who have had similar, but many more cases during the past few years, and an article which appeared in the May number of *British Medical Journal*, not only supplies most of the material for these remarks, but was of the greatest benefit to me clinically, because at that time, although diagnosis of my case was clearly established, I was looking for light upon the subject and found the reports of two very similar cases in that journal.

As to the pathology of the condition, it is probable that the gravid uterus is a responsible factor in the production of the mischief and the condition is not secondary to cystitis, for there is an absence of all evidence of renal or bladder trouble previous to commencement of the pregnancy.

This applies in my case. It has been demonstrated at post-mortem examination that there is a dilatation of the ureter on affected side, commencing at about level of pelvic brim, and that the inflammation is not confined to the pelvis of the kidney, but extends right up into the cortex. (Case II as reported in *British Medical Journal* demonstrated this at operation.)

Partial stenosis of the ureter by the pregnant uterus is generally regarded as the essential predisposing factor to this kind of pyelonephritis, this compression causes difficulty in the ejection of the urine by that ureter. This is followed by infection of urine retained in the partially obstructed ureter and renal pelvis, and subsquent spread to the kidney substance itself. According to authorities the right kidney is very much more often affected than the left and in the two cases reported in *British Medical Journal* the infection commenced in right kidney. Several explanations of this peculiarity have been offered. The uterus develops more to the right and undergoes a rotation on its vertical axis, and turns in the direction of its greatest development, i. e., to the right, and hence there is greater liability to compression on right side. This was not the condition of affairs in my case, for left kidney was first invovled.

The condition may arise during any pregnancy. According to authorities it makes little difference whether patient is a primipara or multipara. Obstruction to ureter being an essential factor, the complication is not to be expected until the later months of pregnancy. This is borne out by cases reported and likewise by my own case.

The bacteriology of the condition is fairly constant. The bacillus coli communis is by far the commonest cause of the condition. One observer found it in seventeen consecutive cases. Other organisms have, however, been found and the steptococcus, staphylococcus, aureus, pneumococcus and typhoid bacillus have been known to produce the condition.

A controversy exists as to how the invading organism reaches the kidney. The three paths by which the organism may reach the kidneys are: (1) from the bladder, (2) from the blood, (3) by the lymphatic vessels. Those in favor of infection from the bladder claim that cystitis is a very common condition in pregnancy, and if ureter is dilated, it is an easy matter for infection to spread upwards.

But in this class of cases we are supposed to be dealing with patients in which no previous cystitis existed and hence this is used as a strong argument against infection via the bladder. Again one of the clinical features of the condition in cases reported is the absence of cystitis, as demonstrated by the cystoscope, and in my own case there was no existence of cystitis before or during the whole course of disease. There was no frequency, and no pain in urinating, and segregated urine was normal on right side, although later both urines contained pus, etc.

Infection by the blood stream, is possible, and in many cases probable, and is the more likely view. It has been shown that the healthy kidney sometimes excretes micro-organisms, as the tubercle bacilli in cases where a localized tuberculosis is known to have existed, and the typhoid bacillus in cases of typhoid fever. If the colon bacillus, as is often the case (as has been demonstrated by its presence in organs apart from the intestines at post-mortems) is circulating in the blood, the existence of a steno-

sis of the ureter, might cause a sufficient stagnation of the urine containing bacilcus coli to allow of infection of the walls of the urinary tubules and passages, and a pyclonephritis would be established. Constipation is claimed by some to be an important factor, the constipation allowing of the entrance of a number of color bacilli into the blood stream, and the pregnancy and stenosis of ureter playing their part. Constipation was a marked feature in case just reported.

A word or two as to prognosis. It would seem that if diagnosed early, and there should be little difficulty in this, and patient be confined to bed and antipyuric measures adopted, the condition usually tends towards resolution, notwithstanding the continuance of the pregnancy. These were the only measures adopted in the case under my care and pregnancy went on to full term and patient made an excellent recovery.

There is no special reason why the child should die in utero, and the mother is not likely to develop uræmic convulsions at time of labour. I made repeated estimates of amount of urea excreted in my own case, and it was always fairly normal in amount.

My patient did not suffer from constant but intermittent headache and there were no eye symptoms nor dyspeptic symptoms at any time, except nausea.

The question of interference and the emptying of the uterus has always to be considered, and of course action will depend upon the severity of the case. Where symptoms had set in early and persisted for weeks without abatement it might be indicated, but such cases are the exception, and interference is not indicated in the great majority of cases. Treatment upon purely medical lines, absolute rest in bed, light nourishing diet, laxatives, and such drugs as are known to be beneficial in pyuria are indicated, and usually have the effect of relieving the patient. Treatment should be kept up some time after prominent symptoms have subsided, as relapses are known to have occurred.

The question of vaccine treatment is important. A vaccine prepared from the cultures from patient's urine would be indicated and a good result would be expected.

Opening and draining the kidney through a loin incision would be another procedure to be considered. In case No. 4, reported in *British Medical Journal* this procedure was adopted. About the same date a vaccine was used, and improvement promptly followed. The important point, however, was that even after opening kidney through the loin and inserting a drain, no pus or urine escaped for about fourteen days, still improvement followed. The fact that a vaccine was used at this same date would lead me to suppose that result was more likely due to this procedure than to surgical procedure. I think a vaccine should always be tried before any surgical procedure.

A CASE OF SUDDEN DEATH.

By JOHN STEWART, M. B.

(Paper prepared for Annual Meeting of the N. S. Medical Society at Sydney, 1909.)

FOUR or five years ago a man about fifty years of age consulted me on account of stricture of the urethra. Some years before he had a stone removed from his bladder by perineal lithotomy and the stricture appeared to be due to cicatricial contraction.

I was able to pass a No. 3 bougie and dilated to No. 9, using Lister's graduated bougies, and advised him to return for further dilatation. I did not see him again until a year later, when he returned with his urethra again contracted so that it was with some difficulty a No. 3 bougie was passed. I again dilated the stricture, and provided him with a flexible olivary bougie, with instructions to pass this instrument at regular intervals, I also advised him in case of further difficulty to have an operation done.

I did not see him again until May of this year, when he returned with the stricture worse than ever. He told me he had managed to pass the bougie very well for some time, but had gradually neglected to use it as often as he had been directed, and that as time went on it did not pass quite through the stricture, but that he had for various reasons postponed coming to have anything done. For a considerable time he had been passing urine with difficulty and in a dribbling stream, but there had been no retention. His attempts at passing the bougie were also sometimes followed by bleeding.

After a prolonged trial I was unable to pass an instrument of any kind, and there was some oozing of blood and small clots. I then injected into the urethra a drachm or two of a solution of eucaine and adrenalin prepared by dissolving three grains of eucaine in three and one-half ounces of normal saline (boiling) and adding about 18 drops of adrenalin solution, and again tried to pass a bougie, but in vain. He was able after this to pass water, which, after the first few drops, was clear. I advised him to come into the Infirmary and have an operation done and I found he had come prepared to do so

I saw him the following morning at the Infirmary. He had slept well, felt comfortable and was cheerful. He had passed water as usual. It seemed too bad that he should have to lie up just as the busy farming season was coming on, and I decided to make another attempt to get an instrument into the bladder. I injected, as before, the solution of eucaine and adrenalin, and, intending it should remain in the urethra for a few minutes, I was about to leave the room to see another case, when my patient, who had been conversing quietly, remarked, "It didn't act this way before," at the same time raising his hand to his forehead. I asked him if it caused pain. He replied, "No, but it seems going to my head." I was quickly at his side and felt his pulse: it was extremely rapid. I asked if he felt sick. There was no reply. His head and eyes turned to the right, there was a single, slight convulsive movement and the pulse suddenly stopped. At the same moment his face, which had been a natural colour, perhaps slightly

flushed, became cyanosed and the veins became turgid. I at once began artificial respiration. but the enormously distended veins called for venesection, and I had no lancet or knife of any kind by me. I was alone, but I called a nurse, who happened to be in the corridor, and sent for Dr. W. D. Finn who, I knew, was in the house. He had his operating case with him and with a scalpel I opened the basilic vein, but very little blood came. Then I opened the external jugular and a few ounces of very dark blood poured from it, but this soon ceased, and there was little or no change in the cyanosis. With Dr. Finn's assistance we kept up artificial respiration for over an hour, and also used hypodermic injection of strychnia and rectal injections of hot black coffee, but all in vain. There was not the slightest sign of life from the moment the pulse ceased so abruptly.

There was no autopsy and it is impossible to say with certainty what was the cause of this appallingly sudden death. I was at first inclined to think the eucaine and adrenalin had to do with it, but on the whole I think it more likely that it was due to an embolus: that thrombosis had occurred in the veins of the urethra and the prostatic plexus and that a clot had passed into the circulation. The rapidity of the events, the suddenness of the cyanosis and the great engorgement of the veins, involving those flowing into the superior cava would lead one to think that an embolus had lodged in the right auricle and blocked both venous openings.

Post Script.—Since the above note was set up in type I have been reminded by my friend Dr. Arthur Birt of a somewhat similar case which was reported in the *British Medical Journal* in October, 1906 In this case, the fluid injected was a ten per cent. solution of cocain, the alarming symptoms came on very rapidly. and the patient was dead in about three minutes. There are numerous cases on record of misadventure with cocain, but eucaine has been considered practically safe. In any case, and whatever the cause of these terrible accidents, there can be little doubt that the injured condition of the urethra has had something to do with the untoward result.

LUMBAR PUNCTURE IN DIAGNOSIS.

By ROBERT KING, M. D.,
Ogdensburg, N. Y.

THE operation of lumbar puncture was proposed in 1891 by Quincke, to relieve pressure on the cord and brain in cases of meningitis. The brain and cord float freely in cerebro-spinal fluid secreted by the choroid plexus in the ventricles, and escaping to the sub-arachmoid space by the foramine of Magendie and Luschka. The spinal cord reaches no lower than the second lumbar vertebra, while the dura with its contained fluid passes down into the canal of the sacrum, and may be safely punctured in the third, fourth or fifth lumbar interspace. A line joining the highest points of the iliac crests passes over the fourth lumbar spine, and gives orientation. The surgical technique is the same as for thoracentesis and the difficulty of the operation only slightly greater. Local anæsthesia is useful for nervous patients. The patient may be sitting, or lying on either side; the back must be strongly flexed and movements controlled by an assistant. The needle used is two to four inches in length, quite small and provided with a stylet. It is inserted horizontally directly in the middle line, or a little to one side with necessary lateral deflections. No force is necessary.

The danger is probably not greater than in puncture of the pleura. Death has followed in thirty-four cases, of which twenty-three were brain tumour, five cerebral hæmorrhage, three uræmia, one acute myelitis, one relapsing fever, and one tuberculous meningitis. In nine of these cases the autopsy showed intense congestion of the cerebral vessels with rupture and fatal hæmorrhage; in the other twenty-five the cause was obscure. It is recommended that the operation be avoided in cases of suspected brain tumour; that the patient lie down for the remainder of the day; and that not more than 10 c.c. of fluid be withdrawn at one time for diagnostic purposes. Minor symptoms, such as headache, lasting a day or so, and sometimes vomiting, are not uncommon. Pain may be felt in a foot, or the foot may move involuntarily from a nerve trunk of the cauda equina being touched.

The flow from the needle varies from slow dropping to a decided spurt; the rate indicates roughly the degree of intraspinal pressure, provided obstruction of the needle can be excluded. The pressure may be accurately measured by a vertical glass tube connected by a rubber tube to the needle; it varies up to 800 m.m. of water.

The fluid is generally clear like water, but may be cloudy from pus. In tuberculous meningitis a fine cob-web-like, fibrinous clot forms, which may be readily picked out on a platinum needle, and in which tubercle bacilli are found in nearly all cases. In other forms of meningitis the causative micro-organism is found by staining the deposit from the centrifuged fluid; most common are the meningococcus, pneumococcus, streptococcus, typhoid bacillus, and bacillus coli.

The diagnosis of syphilitis and metasyphilitic affections by the spinal fluid depends on inflammatory reaction, indicated by increase in white cells, and excess of globulin and other chemical products. The number of

cells per cubic millimeter may be readily and accurately estimated by the Thoma-Zeiss blood counting machine. Normal fluid never contains more than five cells to the c.m.m., and as a rule even four cells suggest a pathological condition. In eleven cases of undoubted general paresis of which I have record, the average count is 54, the lowest 26, the highest 174. One case of cerebral hæmorrhage with softening gave 10 cells. Three normal fluids gave counts of one, two, and three cells respectively. Fluid taken post-mortem is unreliable for cell count. It generally shows increase of cells; one paretic gave 1,220 cells; five non-paretics average 35; two others, of whom one was clinically a paretic, gave three and four cells respectively.

It will be noted that this test and all the others are not specific, not tests for syphilis or metasyphilis, but for inflammation. In a small percentage of cases of syphilitic origin they are negative, and in certain inflammatory conditions other than syphilis they are sometimes positive. Among the latter chronic alcoholism is, perhaps, most important as otherwise sometimes presenting features of paresis. I have had one such case, a patient who showed persistent tremour, fibrillary twitching, and speech defects, and in whom the tests were rather strongly positive, but who went home improved with a diagnosis of chronic alcoholism; the final diagnosis must await his return.

Spinal puncture is only an aid to diagnosis, and other methods must not be neglected, but it is worthy of most careful consideration. I have a record of one case, clinically paresis, and so diagnosticated, but the tests were negative and autopsy proved the tests correct.

The Thoma-Zeiss count is subject to possible errors from sedimentation or clotting of the fluid, or from mistaking red cells for white; for these reasons and for differentiation of cells, and permanence of the preparation, the stained slide has come into favour. The fluid is placed in a centrifuge for fifteen minutes, then gently poured off and the deposit collected in a capillary tube. The smallest possible drop is placed on a slide or cover glass and fixed and stained by any blood method. Red cells are easily distinguished by their colour; over twelve white cells in a No. 6 field is a positive finding.

For excess of globulin, which varies directly with increase of white cells, Noguchi, of New York, has devised a test, which is easily and quickly performed. .2 c.c. of spinal fluid is placed in a test tube with .5 c.c. of ten per cent. butyric acid, and brought to a boil; .1 c.c. of deci-normal sodium hydrate solution is added and the mixture again brought to the boiling point. The appearance of a flocculent precipitate which gradually settles indicates a positive reaction: a diffuse haziness occurs often with normal fluid; as a rule a precipitate, which appears promptly, which is abundant and settles quickly, indicates paresis; one which is scanty and appears and settles more slowly, syphilis. Fluid obtained post-mortem is satisfactory for this and the following test, and may be used to clear up a doubtful diagnosis. Excess of globulin occurs also in meningitis, and contamination of the spinal fluid by red cells invalidates the butyric acid test.

A test for globulin invented by Jones of Toronto, exceedingly simple and equally reliable with that of Noguchi, is performed by floating up the spinal fluid in a test tube on top of a

saturated solution of ammonium sulphate. With positive fluid a white contact ring appears precisely as in Heller's test for albumen in urine with nitric acid. The test needs no special equipment and is most expeditious and satisfactory.

Finally, there remains to be mentioned the Wessermann reaction almost absolutely reliable in these latitudes as a positive test for syphilis and metasyphilitic affections. The words "toxin," "antitoxin" and "immunity," have long been familiar to the medical profession. The accepted theory of acquired immunity postulates that protoplasm has a central arrangement in its chemical molecule, and in addition side chains of unsaturated ions, which readily unite with other suitable unsaturated molecules of food or poison floating in the blood, and thus introduce these molecules of food or poison into the cells. If a poison is not so excessive in amount or in virulence as to overwhelm the cell, the original elements of the side chains, called "toxophiles," are thrown off and new ones rapidly produced. They are produced in excess, and soon thrown off unsaturated to float free in the blood serum, and to unite with and neutralize any molecules of the particular poison, which has provoked their multiplication; an immune serum, containing free toxophiles, i. e., antitoxin, is acquired.

For the union of toxin and antitoxin a third substance is necessary; it is known as "complement," and is present in all blood serum; it partakes of the nature of a ferment, and is destroyed by heating it to 56° C. The process of destruction of complement is called "inactivation." Complement in the form of fresh serum may be added to inactivated fluid, which is then said to be "reactivated."

In place of the word "toxin," the wider term "antigen" is used, and is defined as any substance which, when injected into an animal, will cause the production of immune serum; the essential antagonizing substance is called "antibody" or "amboceptor," in place of "antitoxin." Blood corpuscles of a sheep, or of a man, injected into a rabbit are destroyed, and the power of the rabbit serum to destroy such corpuscles is increased. The corpuscles are antigen; the rabbit's serum is rendered immune to sheep's corpuscles or human corpuscles as the case may be—a "hæmolytic amboceptor" is produced. The reaction readily takes place in a test tube: sheep's corpuscles (in normal saline solution) plus rabbit's serum (immune to sheep's corpuscles and inactivated) plus complement gives hæmolysis.

Wassermann argued that the spinal fluid in a metasyphilitic disease contains syphilitic antitoxin or amboceptor; that if the right quantities of syphilitic toxin or antigen and of complement were added to this in a test tube, the complement would be used up in the resulting reaction; and that for lack of complement the subsequent addition of sheep's corpuscles and hæmolytic amboceptor would not result in hæmolysis. In spinal fluid not containing the antitoxin of syphilis the first reaction would not take place, the complement would not be used up, and an addition of corpuscles and hæmolytic amboceptor, hæmolysis would result. Experiment proved his theory correct, and though subsequent investigations have shown that the antigen employed is not the toxin of syphilis, and the amboceptor not the antitoxin of that disease, yet the reaction is practically specific, and has proved of great value.

Wassermann used for antigen the extract of the liver of a syphilitic fœtus, and though other substances, as extract of normal liver, and lecithin, have been found to give reaction, yet the original contract is most satisfactory. Standardization of all the reagents is necessary and the test in its original form, from its complicated and exact technique, is only available in a well equipped laboratory.

Noguchi has devised modifications, which, while not lessening the sensitiveness of the test, enable it to be carried out anywhere, the whole equipment necessary being a few test tubes, and the reagents, standardized, and preserved dry on filter paper. These reagents will probably be placed on the market at an early date.

The reaction may be written as follows: Spinal fluid plus antigen (prepared paper) plus complement (prepared paper, or fresh guinea pig serum); incubate two hours at body heat. Add human corpuscles in normal saline solution and amboceptor hæmolytic to human corpuscles (prepared paper). Incubate one hour. If the corpuscles are unchanged in appearance the reaction is positive; hæmolysis indicates a negative reaction.

SOCIETY MEETINGS.

ST. JOHN MEDICAL SOCIETY.

AT the annual meeting of the St. John Medical Society, held May 26th, the following officers were elected: President, J. S. Bentley, M. D.; Vice-President, T. D. Walker, M. D.; Secretary, G. G. Corbett, M. D.; Treasurer, James Christie, M. D.; Financial Secretary, Wm. Warwick, M. D.; Librarian, G. R. J. Crawford, M.D.; Pathologist, G. G. Melvin, M. D.; Room Committee, C. M. Pratt, M. D.; S. Skinner, M. D.; W. F. Roberts, M. D.

The first regular meeting of sessions 1909-10 was held Oct. 6th, when a programme was submitted to this Society. On the programme we have some of the best talent in the United States and Canada, who will address us this winter, such men as Dr. C. F. Painter, Boston; Dr. E. D. Archibald and Dr. H. S. Birkett, of Montreal.

Dr. Thomas Walker gave a synopsis of the trial of Lugi vs. Dr. Myers. It seems that Lugi sued Dr. Myers for damages for amputating his foot, as he says, without his consent. Dr. Myers was exonerated by the jury.

Dr. Bentley, in his presidental address, gave an interesting paper on "The Relation of the Physician to the Law." He discussed Dominion Registration, reciprocity, medical certificates, expert medical evidence, abortion, etc. After the meeting adjourned, Dr. Bentley invited the members to his home, where he had provided a bountiful repast of all good things, which, as they disappeared into the abdominal cavity of each one present, improved his humour and wit. After many toasts, the company broke up in the wee sma' hours, when those present wended their way homeward and arrived there safe and sound, voting that Dr. Bentley, our president, was "a jolly good fellow."

October 26th, paper by Dr. T. D. Walker, "Gall Stones." This was an interesting clinical paper, enjoyed by all present.

Dr. F. Wetmore read a synopsis of case reports treated by him successfully with "Bier's Method." Both papers were discussed by the members present.

Nov. 3rd, Dr. White exhibited a specimen of chronic bursitis, excised from the knee.

Drs. C. H. L. Johnston, H. D. Fritz, D. E. Berryman, D. C. Malcolm, F. Kenney, G. D. Baxter, were elected members of this Society.

A very able paper was given by Dr. J. Gray on "Placenta Previa," the doctor going fully into details of case he reported.

Nov. 7th, Dr. S. Skinner exhibited two cases: 1st, congenital dislocation of left hip; also skiagram of same. Case 2, boy who had tibia and fibula fractured, which united, but boy has lost power of flexing foot, due to some interference of nerve supply.

Dr. Thomas Walker gave an interesting discussion on the treatment of pneumonia. The doctor handled his subject in a very clear and lucid manner. His plea was for less medicine in pneumonia and for more good, fresh air, cleanliness and good nursing. Our present drug methods are no better than they were forty years ago in treating pneumonia.

Dec. 1st. Drs. T. D. Walker and A. F. Emery exhibited specimens of fibroid uteri, demonstrating all the varieties of fibroids.

Dr. Melvin, in his usual and masterly manner, gave a paper on "Medical Examination of Schools," and Dr. Anglin read a paper on "Paresis," Both papers were fully discussed.

Dec. 15th. Meeting held in Union Club in honour of Dr. C. F. Painter, Boston, who addressed us on "The Occurrence of Deformity in Joint Diseases: its importance in perpetuating latent lesions and the necessities for its correction." This paper we expect to shortly appear in the MARITIME MEDICAL NEWS, and those who read will have a surgical treat.

After the thanks of this Society was tendered Dr. Painter, we adjourned to the table of feasting, around which many toasts were offered and a very enjoyable two hours was spent.

So far this year our average attendance per night is 21. This is an excellent showing, proving that the medical men of St. John and vicinity are alive to the good things of a medical society.

DISEASES OF THE EYE AND THE GENERAL PRACTITIONER.*

By F. H. KOYLE,
Hornell, N. Y

THAT the thorough study of the whole body is a necessary preliminary to the specialization of one of its parts is a truth which no one may venture to gainsay. The interdependence of the various parts of the body through its vascular and nervous systems precludes the idea that any organ may be locally treated without the intelligent exhibition of rational therapeutics directed to the upbuilding of the body in all its parts.

To ignore this principle is to precipitate disaster; at least it serves to nullify one's efforts to promote rapid recovery, even in those cases of the diagnosis of which we are not in doubt. In the study, however, of the manifold diseases of the human body, it has been found impossible for any one man to thoroughly master the knowledge necessary to the highest efficiency in the treatment of all its diseases. But as our knowledge has broadened and increased, and it has been found that the study and practice of any one branch of medicine is a sufficient tax on the time and energy of most men, a subdivision of labor has been necessary in order that our knowledge and efficiency may be still further broadened and increased. The evolution of the specialist is therefore the necessary corollary to human progress along medical and surgical lines. Of what avail, however, is the specialist or his specialty if he has not laid a proper foundation, and if he does not keep in touch with the wonderful progress being made by the astute clinicians whose bedside studies, assisted by bacteriological research, have revealed to us so many of the mysteries of Nature. This amplification of his field of labor should not be thought a hardship. It should be his duty and his pleasure if he is to improve in his special field of diagnosis and treatment.

If these things may be told and said of the specialist, what shall be said of the general practitioner who prides himself on keeping abreast of the times, but who, without shame, professes to know nothing or next to nothing about the eye? *Is* he keeping abreast of the times if he ignores general principles as applied to one of the most accessible organs of the human body? Diseases of the eye are universal; specialists congregate in the large towns. What is to become of our country friends in districts so remote that the family doctor can see them only once in two or three days? Some of them are crippled, or sick in other ways, and cannot travel. Others are too poor to pay even their travelling expenses if urged to consult an ophthalmologist. Shall the family physician not administer timely aid in such cases and thus save many eyes otherwise doomed to greatly impaired vision, perhaps destruction? It may be said in all truth that he does the best he can, but does he do the best he ought? Sometimes he hews closer to the line than he knows when he insists on thorough sterilization of the eye and leaves the rest to Nature For, as is well known, injudicious meddling is often more harmful to a diseased eye than a severe letting-alone would be, provided the physician devotes care and attention to those details which make for greater resistance on the part of his patient.

*From the New York State Journal of Medicine.

In these cases good food, properly cooked and thoroughly masticated, fresh air, rest, and attention to elimination will be of the greatest assistance. For example, take ulcer of the cornea. It must be determined, in general terms, whether the ulcer is the result of an injury or whether it is a symptom, a local manifestation of an unhealthy state of the system. If an injuyr, and on the cornea of a healthy person, it can probably be cured by of the system. If an injury, and on the cornea of an unhealthy person, bacterial toxins will be formed in the blood and tissues of the body and cannot be eliminated or overcome by antibodies until general is added to the local treatment. In this connection it may not be amiss to suggest the propriety of thoroughly washing out the nose with a mild antiseptic several times daily, no matter what the origin of the ulcer may be. It is not the author's purpose, however, to enter upon a detailed description of the source and treatment of the easily recognizable diseases of the eye. He would suggest the purchase of Haab's External Diseases of the Eye, one of Saunder's Medical Hand Atlases, a low-priced book, thoroughly illustrated, by any physician who desires to equip himself with a good working knowledge of those diseases, among others, to which your further attention is invited.

Of course the simplest and most common eye disease we have to treat is conjunctivitis. But we know it to be this and nothing else. Both irtis and scleritis cause redness of the white of the eye. So does conjunctivitis. A very ordinary knowledge of ophthalmology and a little care in studying the clinical manifestations will enable us to make differential diagnosis. It is especially important that a correct diagnosis be made in case of iritis for here we have a disease which in a very large percentage of the cases is caused either by syphilis or rheumatism, both of which conditions can probably be better treated by the family physician than by the specialist. Scleritis and episcleritis, being mostly seen in people of rheumatic diathesis, should be early recognized in order that constitutional treatment may be begun at once. It must not be forgotten, however, that tuberculosis and syphilis are predisposing causes of these diseases. Keratitis, or inflammation of the cornea, is a most important disease and is of several varieties—viz., eczematous or phlyctenular, fascicular, marginal, neuroparalytic, parenchymatous, or interstitial, sclerotizing and scrofulous. It would be useless at this time to enter upon a detailed description of each of these varieties of keratitis, for to do so would consume more time than is permissable. It is enough for me to say that each has its own cause and treatment, the diagnosis being the essential factor in the successful handling of the case. By preference, it would be well to have counsel in all cases of keratitis, both to reinforce your own opinion and to secure advice as to the rhinoparyngeal disease which always accompanies them. One of the diseases of the eye with which every physician should familiarize himself is glancoma. In general terms it is a hardening of the eyeball. Violent pain in the eye, accompanied by more or less rapid loss of vision, should at once suggest the propriety of taking the tension of the eyeball as well as making an exhaustive examination subjective and objective, to determine the presence or absence of this dread disease. If the cornea is found hazy, the pupil more or less dilated, a greenish reflex in the depths of the pupil, a shallow anterior chamber and an increased tension, there can be little question as to the character of the trouble or what to do for it.

BOOK REVIEWS.

SELECTIONS FROM THE WRITINGS, MEDICAL AND NEUROLOGICAL, OF SIR WILLIAM BROADBENT, BART., K.C.V.O., M.D., F.R.C.P., F.R.S. D.Sc., L.L.D., Etc., Etc. Edited by WALTER BROADBENT, M.D., M.R.C.P., Oxford University Press Toronto, D. T. McAINSH & Co. Price, $4.50.

It is not easy to review a book of this kind. Forty-five different subjects are discussed, and in all the clear thinking and lucid teaching of the writer are conspicuous. For many years to come the influence of Sir William Broadbent upon medical thought will be gratefully remembered by those who have felt the charm of his teaching—whether by the spoken or the written word. Characterised as he was by originality and lucidity, he was able to present his views in a manner which carried conviction, and he was recognized as one of the most brilliant members of the profession in England. His contributions to medical literature were numerous and varied, and this volume, which contains some of the more noteworthy of his shorter articles, will be welcomed by all who prize really meritorious work. It would be impossible to even mention by name the various subjects treated in each volume under review, and it would be unfair to make any selections for particular comment. We suspect, however, that the various articles dealing with the circulation will appeal more strongly to the average practitioner. This would be but natural in view of the author's great reputation in this particular. We confess pleasure in finding reproduced the article on the application of Carpenter's theory of the function of the sensori-motor ganglia in hemiplegia, to which the term "Broadbent's Hypothesis" was long ago applied. We trust that this delightful selection of essays will receive the reception from the profession which their excellence merits.

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"MANUAL OF DISEASES OF THE EYE," FOR STUDENTS AND GENERAL PRACTITIONERS. By CHARLES H. MAY, M.D., Chief of Clinic and Instructor in Ophthalmology, College of Physicians and Surgeons, Medical Department, Columbia University, etc., etc. Sixth edition, revised. With 362 original illustrations including 22 plates with 62 coloured figures. Price, $2.00. PUBLISHED BY WILLIAM WOOD & COMPANY, New York.

We have already reviewed in commendatory terms this excellent manual, and note with pleasure the marked favour with which it has been received by the profession. The first edition appeared in 1900, and of the succeeding editions all have been reprinted, the second and third edition having been reprinted twice. We now have a complete revision in the sixth edition, and the insertion of a number of new paragraphs, notably those on transillumination, the conjunctival tuberculin test, and cerebral decompression, brings the volume fully up-to-date. We feel sure that these conditions will render the work even more popular than it has been, and we unhesitatingly commend it to our readers as one of unusual value.

NOTES ON SPECIALTIES.

DOUBLE PNEUMONIA.

(By H. S. Emerson, of Paterson, N. J.)

Mrs. E. D., aged 74 years, of New Durham, N. J., was taken ill in February, 1905. A local physician diagnosed the case as one of acute lobar pneumonia (both lungs) with grave complications. The third day found the patient much worse, and her attending physician and a consultant said there was no possible chance for recovery. At this critical moment, I was called in after the other medical men were out of the case.

I found the patient unconscious with marked consolidation of both lungs, stertorous breathing, temperature 105 3-5°, pulse 142—feeble and irregular, respiration 35, and every indication of complete prostration. The previous treatment had consisted of an ordinary fever and cough mixture, French brandy at frequent intervals, and the local application of flaxseed to the chest. Little or no nourishment had been taken.

I suggested the immediate discontinuance of the flaxseed, which apparently had no effect, but was merely sapping the little vitality which remained.

My treatment was as follows:

The immediate substitution of Antiphlogistine in place of flaxseed to the thorax, front, back and sides at intervals of eight to ten hours, and hypodermics of digitaline and whiskey at proper intervals.

The following morning found the patient slightly improved, fever 104°, respiration 28, pulse 132, and still unconscious. I was delighted, however, to find that ten hours afterward she had regained consciousness and that the general symptoms were still further improved.

I then ordered nourishment in the form of milk, broths, etc., and the addition of aconite to the treatment. From that time on the patient continued to improve daily with no further aggravation of the symptoms, and at the expiration of two weeks she had quite recovered.

While I am willing to give the digitaline, whiskey, aconite and nourishment proper credit for their part of the work, I am thoroughly convinced, and do not believe I could be persuaded to the contrary, that the persistent and proper use of Antiphlogistine was responsible for the woman's recovery.

THE AFTER CARE OF OPERATIVE CASES.

It is a fact well established by hematologists, and well known to the surgeon, that a large majorty of surgical diseases, requiring operative interference, are preceded, accompanied or followed by hemoltyic changes. In addition to the more or less devitalizing effect of the original condition which brings the patient to the operating table, the necessary anæsthesia, if at all prolonged, reduces the hemoglobin percentage and the shock incident to the operation contributes, to a certain extent, to the surgical anemia. Hemorrhage, Suppuration or Sepsis, precedent to the use of the knife, of course intensifies the post-operative chlor-anemia and renders more than ever necessary the employment of hematogenic measures during surgical convalescence. Judicious but generous feeding is of prime importance in such cases and sedulous attention should therefore be paid to the patient's dietetic requirements. Feeding, alone, however, will not hasten recovery as rapidly as a judicious combination of feeding with a hematinic reconstituent such as Pepto-Mangan (Gude). Except in cases in which it is not permissible to introduce food or medicine through the mouth, this palatable, readily tolerable and promptly absorbable organic combination of iron and manganese is dis-

tinctly indicated in preference to other blood building agents, because it is agreeable, non-irritant and free from constipating effect. Its hematinic, appetizing and general reconstitutent properties are quickly evidenced subjectively, by a general feeling of well-being, objectively, by increased color of skin and mucous membrane and hematologically, by a progressive increase in the number of erythrocytes and percentage of hemoglobin.

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Battle & Co., of St. Louis, have just issued No. 11 of their series of charts on dislocations. This series forms a most valuable and interesting addition to any physician's library. They will be sent you free of charge on application, and back numbers will also be supplied. If you have missed any of these numbers, better write Battle & Co. for them before the supply is exhausted.

CYSTITIS.

In the treatment of all cases, rest in bed, with the hips elevated, will often give more or less relief from the strangury and constant desire to urinate; by elevating the hips the urine accumulating in the bladder flows away from the most congested and sensitive part of the bladder. Some recommend opium and belladonna to control the pain. Heat to the perineum and above the pubis, and hot sitz baths, will greatly relieve the tenesmus, and to some extent lessen the congestion of the mucous membrane of bladder. Sanmetto should be freely given, each dose in half wineglass of hot water, and if the urine is acid potassium citrate will render the urine less irritating.

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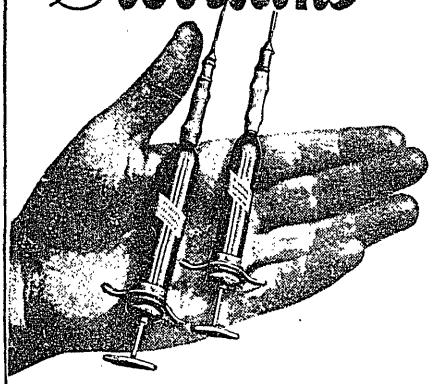

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