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Maritime Medical News

A MONTHLY JOURNAL OF

MEDICINE AND SURGERY.

Vol. XVII. HALIFAX, NOVA SCOTIA, JUNE, 1905. No. 6

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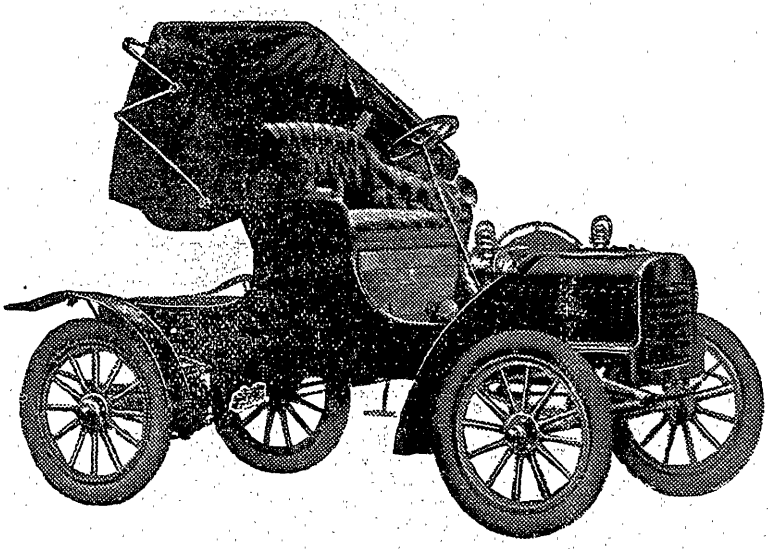

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THE

MARITIME MEDICAL NEWS.

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

VOL. XVII. HALIFAX, N. S., JUNE, 1905 No. .6

Orginal Communiations.

SOME COMMON AND UNCOMMON AFFECTIONS OF THE FEET MET WITH IN PRACTICE*

By ARTHUR BIRT, M. D. (Edin.) Berwick, N. S.

In receiving my hospital and general practice experience I have been struck by the frequency with which one has been consulted by patients for minor ailments either referred to or referable to the feet. Although, spoken of as minor ailments, many of these conditions entail considerable pain and disability; and, unless care is exercised in their investigation, may cause the practitioner marked loss of professional repute.

"WEAK" OR FLAT FOOT.

By reason of its great frequency of occurrence the "Weak" or "Flat" Foot deserves the first place.

Case 1. Female, aet. 40, single. Good condition. *Complaint* of "rheumatic" pains in legs and feet and distressing backache. Had been treated with anti-rheumatic remedies without effect and had had a uterine fixation done which had also failed to relieve.

Examination showed well-marked bi-lateral flat foot, moderate in degree.

Treatment directed to supporting and strengthening the arch and calf muscles resulted in prompt and very great improvement in the

*Abridged from paper, read before Maritime Medical Association, July, 1904.

symptoms, which continues so long as the sole-plates are carefully regulated to follow and sustain the weak longitudinal and transverse arches.

The symptoms of the "weak" foot vary in severity from a simple sensation of weakness referred to the inner side of the foot and ankle to marked aching, or neuralgic pains in calf of leg and the lumbar muscles, until in several cases even moderate use of the feet in walking or standing becomes intolerable. Coldness, numbness and sweating are often present. As in rheumatism, the symptoms are all aggravated by cold and damp, and are relieved by warmth and rest.

The diagnosis of flat foot is usually to be made at sight in marked cases—in the slighter and earlier forms it may be more difficult. As R. Whitman well says, the examination should include not only the appearance of the foot, but also an investigation of its functional ability and of the manner in which it is used.

The walk is slouchy. The leg is never fully extended and there is eversion of the feet. Bulging of the shoe inward at the arch or wearing down of the inner side of the sole is often noted—the normally outward curving inner borders of the feet (which when placed side by side should leave a distinct space between them), are apt to have a convexity inwards when weight is borne on the foot and the weakened arch sinks down.

Imprints on carbon paper, or obtained by painting the sole of the foot with Tinct. Ferri Perchlor, and standing on a sheet of thick, white paper, which is at once sprinkled with tannic acid, will give the amount and situation of the bearing surface in different attitudes, whilst the presence of calluses may also be of assistance in showing where undue pressure comes.

To investigate the range of movement and limitation of this is an early symptom. The normal range from full extension to full dorsiflexion is stated to be from 50°—60°. This angle is easily measured in practice. To test the more important power of inversion or adduction, extend the leg with the patella in the middle line, turn the foot inward as far as possible, elevating the inner border and turning the heel inwards (supination.) This movement will be found restricted in varying degrees in all cases.

The treatment of the weak foot, which offers a good prognosis in the milder grades at any rate, resolves itself briefly into two efforts, (*a*)

to support and brace the weakened arch by carefully fitted supports, and (*b*) to tone up the relaxed muscles and ligaments by appropriate massage, exercises, and hydro-therapeutics so that normal tone may be restored and the full physiological range of foot movements be regained.

A careful study of each individual case can alone dictate the most suitable form of support, and this decision is better made after a careful plaster cast of each foot separately (in bilateral cases) has been made. It is also important to recollect that as improvement takes place, and the weakened arches regain their tone and elasticity, it is very frequently necessary to raise the arch of the support to correspond. In marked cases, too much should not be promised, as it has been found that a large percentage have to use sole-plates for life in order to prevent partial return of symptoms.

The exercises are naturally those of the tip-toe order, especially which tend to develop the calf-muscles; and the great importance of manipulations and passive movements of the foot in stretching adhesions and restoring the normal range of movement should by no means be overlooked. Finally, the patient is instructed, (*a*) to guard against valgus by throwing the weight on the outer side of the foot. (*b*) To guard against abduction by holding the foot parallel in walking. (*c*) To cultivate the "leverage" action of the great toe in walking by pressing down the sole of the shoe with his toes at each stride.

I would again emphasize the risk of mistaking this condition and its sequelae for "rheumatism," and the point that as in the latter, the symptoms are aggravated by cold, damp and movement.

Congenital Talipes Equino-Varus.—One is, not infrequently, consulted by an anxious mother as to what is to be done to cure "turning-in" of the baby's feet.

Case 2.—Healthy looking infant of 22 months, both feet rotated in to a moderate degree at transverse tarsal joint, so that the inner border is raised and shortened, and is marked by a well-defined groove under the head of astragalus, while the outer border is depressed, (in older patients, a corn or callus often forms on the cuboid bone.)

Mild cases of equino-varus in very young children come properly within the sphere of the general practitioner, and are

curable in proportion to the promptitude and patience with which treatment is carried out from time of birth. Paralytic club-foot is of course here excluded.

If seen in the first weeks or few months of life the condition offers a good chance of almost perfect cure by manipulation and massage. Three or four times daily the foot is grasped from in front and well above the ankle, and the deformity forcibly corrected by straightening out the foot, correcting the inversion and bringing down the plantar surface. The corrected position is to be maintained for a gradually increasing time. Gentle systematic massage of the peroneal and other groups may be advantageously added. In mild cases taken early, these measures will usually result, when the child is ready to walk, in its setting the foot squarely on the ground instead of on the outer edge only. At 2 years, in a big, heavy child, such as the one referred to, the mal-position is usually too fixed for such simple measures, and forcible correction by stages is indicated. A light plaster cast is used which envelopes the foot and the leg nearly to the knee, after as good correction as possible has been obtained. The cast may be prevented from slipping by the incorporation of strips of adhesive plaster as recommended by Sherman, of San Francisco.

"One end of the strip is fastened to the skin and the other is "allowed to dangle below the foot. When the plaster cast is about "half finished the loose end of the plaster is turned up and incorpor-"ated in the cast."

I have found that a few months' careful treatment on these lines does a great deal for this second class of case, but to clinch the result, a club-foot brace may be required. The varieties of these are doubtless known to you. The essential points in the apparatus are that it shall be comfortable, light, and shall correct and tend to keep corrected the deformity. Home-made products have often in country practice to take the place of the instrument-makers masterpieces. In very obstinate cases tenotomy of the Achillis may be required to let the heel down, but I do not wish to poach on the preserves of the orthopedic surgeon to whom all the more obstinate and severe cases should be early referred when possible.

Metatarsal Neuralgia. (Anterior Metatarsalgia.) *Case 2.*—Female, aet. 62, was walking in my company, when she stopped suddenly, complaining of violent neuralgic pain in the fore-part of the right foot. The shoe was removed and gentle massage of the foot

soon relieved the symptoms. She had proceeded but a short distance when the pain returned suddenly with great severity and persisted for some little time in spite of my manipulations of the foot. Inquiry elicited the fact that she had suffered from many of these sudden neuralgias, and that massage and broadening out of the foot always relieved the symptoms for the time being. These symptoms are very characteristic of Anterior Metatarsalgia or Morton's disease, and so one was not surprised to find present in the affected foot the following conditions: Well marked breaking down of both the longitudinal and transverse arches, hallux valgus with bunion, depression of the 4th metatarsal-phalangeal articulation with a tendency to over-riding of the adjacent metatarsal bones, painful callosities over the heads of the 3rd and 4th metatarsals in the sole, and marked tenderness over the 4th, (and to a less extent the 3rd) metatarsal-phalangeal joint. Compression of the anterior part of foot resulted in a further squeezing down of the displaced meta-tarsal bone and the production of the characteristic pain.

(3) Goldthwaite, of Boston, has cleared up for us the pathology of this condition, showing that the symptoms really depend on weakness of the anterior metatatarsal arch of the foot formed by the heads of the metatarsal bones, that this weakness is of varying degrees and that the symptons and severity vary accordingly. Improper boots. as in so many foot deformities, are probably the great cause of the condition. In this particular case, practical immunity from the attacks of pain for about a year, has resulted from the simple expedient of banking up the shoe so as to support the arch, widening the tread of the sole and thickening the sole and heel slightly on the inner side, with simultaneous treatment of the painful collosities over the heads of the metatarsals.

As a rule, it is said, a metal or celluloid sole-plate is the best form of support, elevated a little at a point corresponding to the depressed articulation. It must be constructed on a plaster cast of the sole of the foot. The usual systematic attempts must be made to restore the flexibility and full physiological range of movement of the foot by manipulations, massage, suitable exercises and douches.

Ingrowing toe-nail. This familiar and troublesome ailment needs no description. The old treatment by avulsion should, wherever possible, be replaced by the little operation which was first taught to me by Chiene of Edinburgh, and which Gerster of New York has

described in his text book with minute detail. The toe is disinfected as carefully as for a major operation, is constricted at its root with rubber tubing, and local anæsthesia is induced. The point of a narrow bladed bistoury if placed against the granulation tissue adjoining the nail, and is thrust through the margin of the toe. A flap of integument is cut—first forwards and then backwards well beyond the matrix of the nail where the flap is cut off. The pointed blade of a straight pair of scissors is thrust under the anterior edge of the nail just beyond the limit of the disease and cuts through the nail from before backwards. One blade of a stout pair of dressing forceps is next insinuated into the slit in the nail and under the loose segment, which is twisted off with an outward rotating movement, taking care to leave no shreds of the cut-off matrix. Any granulations are curetted away with a sharp spoon and the wound is irrigated with corrosive solution and a moist antiseptic dressing applied, taking care not to compress the toe too much. It is almost needless to remark that the slighter cases often yield easily to antiseptic foot-baths (preferably formaldehyd), packing the diseased nail margin with gauze saturated with picric acid solution, properly constructed boots, and such like rational measures. For the *bromhidrosis*, which so often accompanies pathological conditions of the feet, I have found nothing equal to Formaldehyde in varying strengths. Gerdick's large experience with the French soldiery sustains this impression.

Hammer Toe. A number of cases of this deformity have come under my notice, It consists in a contraction of one of the toes, usually the second, in which there is dorsiflexion of the first phalanx, flexion of the second, and either flexion or extension of the third. The toe is forced downwards and overlapped by its fellows, there being usually a degree of hallux valgus associated. Corns and calluses and sometimes bursae are found above and below at the points of shoe pressure, and it is these that give rise to the pain and disability that usually result. The terminal phalanx becomes more or less clubbed and distorted, hence the name. The condition may be congenital, but is usually acquired, often at an early age, from the pressure of too short shoes and socks, the second toe suffering most on account of its relative length. It is usually bilateral. The treatment of this troublesome little deformity has not in my hands been always satisfactory, owing chiefly to the fact that in old-standing ases all the tissues are contracted, the chief obstacle to reduction

being the capsular and lateral ligaments of the first interphalangeal joint. I have tried (*a*) forcible correction; (*b*) forcible correction with subcutaneous division of the contracted ligaments and splinting; (*r*) amputation, the latter a clumsy way out of the difficulty, though many men, I fancy, adopt it rather than be bothered with this little surgical nuisance.

Some time ago, however, I noticed an article by Mr. W. Thomas, senior surgeon, Birmingham Orthopædic Hospital, in which a trial of the "Tomatoe" splint was urged. This splint, which I here shew you, is made in aluminium in six sizes by Messrs. Down Bros., of London, and from even a limited experience I can strongly recommend a trial of it. It is really surprising how an apparently hopelessly distorted toe will straighten out and regain its function with little discomfort to the wearer under a persistent daily (or nightly) use of this little apparatus. In the cases that are not cured by this method, resection of the joint, as recommended by R. Whitman, of N. Y., is certainly the game, and preferable to mutilating the foot by amputation. He points out that enough bone should be removed under strictest asepsis to allow of full correction of the deformity, and a splint of celluloid or some other light and firm material applied for some time. In the case of infants, correction of the deformity by manipulation and retention by adhesive plaster will suffice.

Charcot's Disease of the Joints. Case 5. Middle-aged female. Syphilitic history. Admitted to Durham County Asylum with diagnosis chronic mania with delusions. Developed a chronic arthritis ankle with little complaint of pain. Joint showed boggy swelling, marked stiffness, little tenderness or signs of inflammation. Gradually total disorganization of joint took place with a final stage of atrophy of articular structures, some effusion and finally subluxation of ankle-joint and flat-foot. Long before this stage was reached, a further careful examination of the nervous system was made, eliciting the presence of the Argyll-Robertson pupil and the absence of the knee jerks. A diagnosis of parasyphilitic tabes was thus established, previously overlooked owing to the generally excited and obstreperous behaviour of the patient. The diagnosis of arthropathies in posterior sclerosis, &c., depends of course on the recognition of the underlying nervous disease, and their treatment requires no comment.

Perforating ulcer I once saw in Gowers' Clinic in London.

Angio Neurotic Oedema. Case 6. Female, aet. 31. Good social position. Complained of attacks of swelling of feet and lower part of leg, coming and going in erratic fashion and attended with marked symptons of heat, tingling or numbness. Inspection during an attack showed a patchy phlegmonous oedema involving mainly the dorsum of one foot, and the anterior surface of the lower third of leg. There were traces of the same condition on the other foot. Inside two or three hours the feet looked normal. Inquiry showed that similar attacks had involved one side of the face where the skin was noticeably thickened and slightly pigmented around the angle of the mouth and over one half of the upper lip. As the patient also gave a history of sudden attacks of acute dyspepsia with vomiting and was very high strung, the diagnosis of Giant Urticaria or Angio-Neurotic Oedema was easily arrived at. The treatment was (on the advice of Dr. Allan Jamieson, of Edinburgh) chiefly electrical, and in the end gave, I believe, good results. Like erythro-melalgia this is considered to be a vaso-motor neurosis.

Case 7. Female, married, aet. 29. Complaint "rheumatism" of the foot, pain felt chiefly in heel and radiating up leg. Examination showed well marked synovitis of tendo achillis and a slight tenderness, heat and swelling over ankle and mid-tarsal joints. There had been definite attacks of pelvic inflammation previously, with a brownish vaginal discharge and some bladder irritability. One knee had also been slightly affected at an earlier date. A diagnosis of gonorrhœal teno-synovitis and arthritis was made, and under rest, massage and counter-irritation, the attack completely subsided. Treatment by antiseptic irrigation was directed to the genito-urinary tract. In the differentation of gonorrhœal arthritis from acute rheumatic arthritis stress is to be laid on the disproportion between general and local symptoms in the former, the absence of profuse sweating, acid urine and excessive plasticity of the blood occurring in rheumatic fever, and the frequency with which the gonorrhœal form is mono-articular. A bacteriological examination and a definite history are obviously of prime importance.

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[This paper was illustrated by diagrams.]

APPENDICITIS AND ITS TREATMENT.

By G. D. Turnbull, M. D., Yarmouth, N. S.

I have read with much interest the selected article "Where not to operate in Appendicitis," by Robert T. Morris, as published in the March number of the Maritime Medical News. The basis of the discussion, the original paper by Dr. Ochsner, published in 1903, has done much to place the appendicitis question on a plane acceptable alike to the general practitioner and ordinary surgeon, and proves beyond doubt that ultra operation is not essential to a low mortality.

As I do not remember having seen a resume of Ochsner's paper in the News, I beg permission to give a few extracts outlining his views as to the cause of mortality in appendicitis and as to treatment.

1st. The mortality in appendicitis results from extension of infection from the appendix to the peritoneum, or from metastatic infection from the same source, and can be prevented by removing the appendix while the infectious material is still confined to that organ.

2nd. The distribution or extension of infection is accomplished by the peristaltic action of the small intestines, and also by operation, if performed after the infectious material has extended beyond the appendix and before it has become circumscribed.

3rd. Peristalsis can be inhibited by giving no form of food or cathartic by mouth, and by employing gastric lavage to remove the existing food or mucus from stomach, the patient being nourished by nutrient enemata.

Regarding treatment, his views are as follows:—

1st. Patients suffering from chronic recurring appendicitis should be operated on during an interval.

2nd. Patients suffering from acute appendicitis should be operated on as soon as diagnosis is made, provided they come under treatment while the infectious material is still confined to the appendix, *i. e.* usually within the first 48 hours.

3rd. In all cases of acute appendicitis, without regard to treatment contemplated, the administration of food and cathartics by mouth

should be absolutely prohibited, and in cases where nausea, vomiting or gastric distension are present gastric lavage should be employed.

4th. In cases coming under observation after the infection has extended beyond the tissues of the appendix, especially in the presence of the beginning of diffuse peritonitis, the above suggestions as to feeding should always be followed until the patient's condition makes operative interference safe.

5th. In case no operation is performed, neither nourishment nor cathartics should be given by mouth until the patient has been freed from pain and otherwise normal for at least four days.

6th. By following the treatment above outlined, very dangerous cases of acute appendicitis may be changed into relatively harmless cases of chronic appendicitis.

7th. While such treatment cannot supplant the operative treatment of acute appendicitis, it can and should be used to reduce the mortality by changing the class of cases in which the mortality is greatest into another class in which the mortality after operation is very small.

It will be observed that Dr. Morris has somewhat misconstrued Dr. Ochsner's statements when he says that the starvation treatment is reserved for cases in which general peritoneal infection is under way.

However, the real point of issue, as brought out in Dr. Morris' article, is that he would operate during what is often termed the second stage of the appendicitis cycle, *i. e.*, from the second to fifth or seventh day, during which period the active inflammatory process is going on, while Dr. Ochsner would endeavour to tide patient over that period, and operate during the third or descending inflammatory period, should conditions so warrant, or still better, because safer, during the fourth or interval period.

Dr. Ochsner claims a death rate of 2 1-5% in 1000 consecutive cases of appendicitis of all sorts. Dr. Morris claims 2% mortality in 100 consecutive cases operated on, (Lectures on appendicitis, Robert T. Morris, Putnam's Third Edition, page 83) and states in his article, as it appears in the MARITIME MEDICAL NEWS, that "the list was a consecutive series of all the appendicitis cases that I had seen during the period covered by the statistics." However, it appears from summary on page 81 of the work above mentioned, that his first 100 cases gave a mortalitiy of 8%, and that the 2% mortalitiy was obtained by leav-

ing off the first thirty cases and adding thirty cases following, case 100. As far as the statistics are concerned, both have good records. Both are men of undoubted integrity, and both are equally clever operators, I have had the pleasure and privilege of seeing both men operate, the former at the Augustana Hospital in Chicago, the latter at the Post Graduate Hospital, New York, and consider them as two of the smoothest and quickest operators it has been my good fortune to see. So really the question is not so much as to which is the better or safer method in their hands, but which is the better and safer method in the hands of the country practitioner and surgeon of limited experience. Right here is where an impartial judge will decide in favour of the Ochsner method, because even among surgeons, there is not one in a hundred possessing the dexterity of a Morris, while the starvation treatment, as advocated by Ochsner, is applicable alike to the patient in the back woods and to the man in a modern hospital providing, in the former condition, that fairly intelligent care can be obtained.

The principle underlying the Ochsner treatment, however, is not new by any means. It is that of physiological rest so strongly urged in painful and inflammatory conditions by Hilton in his memorable work, "Rest and Pain," and at a later date applied to peritoneal affections by Alfonzo Clark, who advocated placing the inflamed intestines in a splint by means of opium. Ochsner does the some thing, quiets peristalsis, thus placing the intestine at rest by starvation, and keeps it so in cases where the infection has travelled beyond the wall of the appendix, by non-surgical interference until it has had time to become circumscribed.

Many surgeons at the present time, including Ochsner, advise operation in all acute cases seen early, *i. e.* within the first 24 to 48 hours. In country districts, however, such a course is, as a rule, impracticable. The patient often is not seen that early, and if so the consent of friends cannot be obtained. During that period, however, an operation should he comparatively safe even in the hands of a surgeon of moderate experience. Whether such a course is always advisable, however, is a point that may well be questioned. Many a sharp colicky pain in the lower right quadrant of abdomen with rise of temperature, etc., gets well within the 48 hours, especially when aided by a dose of castor oil or calomel. Whether such are cases of appendicular colic or due to some irritation about caecum and colon

is hard to determine. To subject these cases to operation within the first 48 hours seems scarcely in accord with general surgical principles.

Interval operations should have a very small mortality. Whether such should be urged after a first severe attack of acute appendicitis is another open question. Many a person has one attack, and one only. To insist on such a case submitting to a fairly severe operation can hardly be justified. Should the patient select operation there is no ground for refusal. The one great reason for not urging interval operation in such cases, in view of the possibility of recurrence in a more severe form, is that abdominal section even for exploration only has a mortality—very slight no doubt, with ordinary care—but still a mortality. Some unforseen and wholly unexpected thing occurs and a life is lost.

After a second severe attack we may assume that conditions are present in or about the appendix that will likely give rise to others. In such cases, or after a first severe attack where a patient is left with a more or less painful condition about the abdomen, I think we are justified in advising an interval operation.

Personally, I have notes of seventeen cases of acute appendicitis, by which I do not mean cases of appendicular or cæcal colic in which patient is about in two or three days, but cases of the severe illness. Of the 17 cases, one was a fulminating case, and patient died in 36 hours. Three were of moderate severity, and while very ill for a few days were convalescing in less than a week, while the remaining 13 were very sick from ten days to two or three weeks.

Of these cases, ten were under my own care prior to giving up visiting practice at the beginning of 1904. Two were seen in consultation during that period, while the remaining five have been seen in consulting practice since that time.

One case, as mentioned before, died in collapse in about 36 hours from time of onset. One had an interval operation after the fourth attack. One was operated on in a hovel during the period of descending inflammation, and about a quart of pus evacuated. Pus had been discharged from bowel a day or two previous, but nature failed to drain cavity. The patient made a good recovery. One other case had pus evacuated per rectum. She made a good recovery, and has remained well since, now eight years. Six, including the two abscess cases, had large masses of exudate form in right iliac region, which could be palpated readily per abdomen and felt per rectum, and

which disappeared completely as patient convalesced. One of these was the interval operation case, and contrary to expectation, not an adhesion existed. All that remained to show for his four attacks, each one of increasing severity, was a thickened appendix. Three only were recurrent cases, one of which I have already mentioned. The second was one of the milder forms. He gave a history of one previous similar, but less severe attack, but has had none since, now four years. The third has had four or five attacks. The last one, from which he is now convalescing, was very severe. During the intervals he has also suffered from sharp spells of colicky pains. With him shall strongly advise an interval operation. I have made careful inquiry whenever possible concerning the other cases, and have every reason to believe that not one of the fourteen has had a recurrence. The period covered is about twelve years, so two or three have so far escaped recurrence, and been in good health for at least ten years. The cases not described presented no unusual features, and made good recoveries. Of the seventeen cases, one died, giving a mortality of about 5.8 per cent.

Possibly the fulminating case might have been caused by operation within the first twenty-four hours. However, she was not seen till that length of time had elapsed. The patient was twelve miles in the country, with no telephone communication, so by the time preparation for an operation had been made she was moribund.

The treatment employed in my own early cases was very limited liquid diet, salines by mouth, if tolerated, and washing out lower bowel with enemata, if salines were not tolerated. Opium was given in quantities just sufficient to keep the patient comfortable. After the first year or so I modified the treatment by omitting the salines. In cases seen early I gave an initial dose of calomel; otherwise left bowels alone for a week, when enemata were used to induce them to act. The feeding was the least possible liquid nourishment I could get along with. If pain was severe when first seen, especially if vomiting was present, I usually gave a hypodermic of morphine, and then just opium enough to keep the patient from suffering pain. In several cases seen in consultation opium has been pushed not only far enough to quiet pain and peristalsis, but to keep patient drowsy, and the results have been good.

There seems, however, but little doubt in the minds of most authorities that opiates mask important symptoms, and many prac-

titioners at the present time, following that teaching, will not even give an initial hypodermic of morphia. That inhibition of peristalsis can be obtained by starvation, as far as feeding by mouth is concerned, has been demonstrated by Ochsner, but inhibiting peristalsis by that means will not lessen the shock which the sudden insult to the great abdominal nervous centres produces, nor can it quiet the extreme anxiety and restlessness which is kept up by the resulting pain. A moderate dose of morphine will quiet those conditions as nothing else can. The patient is made comfortable, confidence in the physician is established, and as the opiate tends to more quickly inhibit peristalsis than anything else, I see no objection to its use as the beginning of the starvation treatment.

In considering the Ochsner method from every point of view, it seems to me destined to bring the physician and surgeon closer together toward a common ground. It is radical enough to satisfy all but the extreme radicals, and is conservative enough to satisfy all except a possible few who never operate or have operations done except the opening of a superficial abscess or the sewing up of a clean cut. It does what the heroic doses of opium do, and without obscuring important symptoms. However, there are still cases in which the method cannot be carried out, as a certain amount of skill in nursing is required, and the country practitioner finds many cases in which he can obtain absolutely nothing in the shape of nursing. In such cases as little food as possible, and that of a liquid nature—milk and water—with opium enough to ease pain, is the nearest approach to the starvation method that can be attained. And the experience of many a country doctor will bear me out in saying that while such a course may mask symptoms, still the patients usually get well.

Regarding the other side of the question, I think Dr. Morris is fully justified in being indignant that the mortality rate should be placed at 10 or 15%, when Treves who thinks there is a medical as well as a surgical treatment for appendicitis places the mortality "taking all phases of the disease together"—the most trifling attacks with the most serious—at about 5%. The mortality in my 17 cases was 5.8%, and had there been included the trifling ones—well in 2 or 3 days—together with chronic interval cases, not seen during their acute attacks, the percentage would certainly have been reduced to 5%. D r.

while they may certainly be accepted as correct for the 100 consecutive cases, still, in fairness to the statistics of others, I think the first thirty cases should also be included in which case the mortality would go up to 5.9%. Certainly he claims that by his later methods of working a number of the first thirty cases would have been saved. Still he was gaining his experience by means of those thirty cases, and that is just where the advocates of no medical treatment for appendicitis exhibit their most vulnerable point. No surgeon however dextrous he may be, can approximate a death rate of 2% in all cases, until he has operated on his first *30 cases*. Experience in surgery cannot be obtained from another person's work, no matter how clever that person may be, nor how clearly his methods may be laid down.

Hence, any method of treatment that offers a chance to keep the mortality of appendicitis down to 2 or 3%, when such can be carried out by general practitioners and surgeons of limited experience, and especially when backed by the wide experience and statistics of a noted surgeon, cannot but be regarded as epoch-marking. Even if it does give a set back to the work of the operate-on-every-case surgeon in our big cities. Such is more than counter-balanced by the confidence it inspires in the minds of those who practice the healing art in less favoured localities.

Retrospect Department.

LET THE LUNGS ALONE IN CONSUMPTION.

W. Hutchinson says that we have learned by bitter experience that we must practically ignore the bacillus in our treatment of the consumptive, and that we are coming to the same point of view in regard to the lungs. Among the reasons for letting the lungs alone in treatment is the fact that very few remedial measures at our command have any specific action whatever on the lungs, and it is being more and more clearly recognized that consumption is not, properly speaking, a disease of the lungs, but is merely a local (pulmonary) expression of a disease which involves the entire system. We have no tonics or alteratives which will improve the nutrition of the lungs, and even the expectorant drugs have been proved to be lacking in the virtues formerly ascribed to them. Sprays, etc., are ineffectual in reaching the bronchi, and in most cases the so-called pulmonary gymnastics and exercises serve simply to drive the infectious material deeper into the hitherto uninvaded area of the lungs. The author has already shown that the chest of the consumptive is round instead of flat, and that exercises intended to develop the chest as such do harm instead of good. Bodily exercise of any kind is now believed to be distinctly injurious, and absolute rest is indicated in any case in which the afternoon temperature rises above 100°. Researches by Robin and Binet made over four years ago on the actual gaseous interchange in consumptives have shown that the tuberculous patient consumes a much greater amount of oxygen and gives off more carbon dioxide in proportion to his body weight than the normal individual. In short, it would appear highly probable that the tuberculous patient is to be regarded in the light of one who is pouring nearly half the heat of the fuel which is burned in his body furnace up the chimney, in the form of smoke. That the food which he takes, instead of being assimilated and decomposed by anærobic processes in the body cells, is burned in the blood and in the lungs. Any means, therefore, which will tend, so to speak, to clog the throat of his chimney and prevent this fatal escape of heat and energy, whether by drugs like creosote, iodoform, cod-liver oil and arsenic, or by pouring in an enormous quantity of food rich in heat value, will tend to restore the balance of gaseous interchange, and enable him to return to the normal.—*Medical Record*, April 29, 1905.

Correspondence.

RE LIFE INSURANCE.

EDITOR MARITIME MEDICAL NEWS:

At a recent meeting of the Colchester County Medical Society, an interesting "memorandum" signed by the Secretary of the Canadian Life Insurance Officers' Association, was read. It appeared to most of the Society present that if it was upon such representations that Drs. March, Chisholm and Clay agreed to recommend to the N. S. Medical Society a four-dollar examination fee, it will, at least, need more convincing proof to satisfy the profession generally that Canadian assurance companies cannot afford to pay a five-dollar fee.

We have in that memorandum a bare statement that 75 per cent. of applications are for $1,000. It is probably true that this percentage is less in the case of foreign insurance companies doing business. But we then have the assumption that the system would be whole life, and must conclude that these clever officers wish us to believe that 75 per cent. of their applications are for the whole life system, with annual premiums of only $24.25. The best insurance agents seldom, if ever, get such an application for any of these companies, and to convey the impression that 75 per cent. of the applications only call for a premium of $24.25 is utterly absurd. The very illustrative supposed transaction is of no value whatever.

But taking that illustration, the poor companies only receive 94 cents for agents' commissions and head office expenses! They admit they can manage to pay these two items if they only pay the examiners $5.00. This fee will leave them a balance on the transaction of $1.94 for these two items. Does that appear any more likely to fully remunerate the agents and head office expenses? They certainly would have to draw upon subsequent premiums to meet these two items. Why not add another dollar for the medical examiners and collect it from subsequent years?

But a fearful expense is 10 per cent. of applicants who are rejected by the examiners or the company's medical officer. This is the first time that rejected applications, due to a careful medical examination, was ever considered a loss to an insurance company. Had these applications been accepted, how much greater loss would the com-

panies sustain? We are also informed of another awful loss of 8 per cent. of these applications where the first premium is not paid, but the medical fee is paid nevertheless. But who stands this loss? Have the Canadian companies ever heard of agents being charged up with five dollars until this first premium is paid, in order to secure at least the payment of the examiner's fee without loss to the company?

We are informed that "a life company should endeavor to keep each year's charges associated with the contract within the amount of the premium receivable," this would be all right if the applicant's subsequent premiums were reduced by the amount expended in Medical fees, etc., chargeable to the first premium; but we do not hear of any such subsequent reduction. There does not seem then any valid reason why these charges should not be extended over subsequent premiums until they are discharged.

Doubtless an authority could mercilessly criticise this "memorandum," when such discrepancies are apparent to an inexperienced observer like myself.

Why should a company pay a larger fee when a policy is for five thousand? Do they think that the doctor does more conscientious work over a larger than a small policy? Does the nature of his work depend upon the size of the fee? Do they mean to tell us that in 75% of the examinations we are not as conscientious as in the remaining ones at a higher rate? But this is apart from my text, the "Memorandum," so I desist.

Truro, N. S., June 1st, 1905. SMITH L. WALKER.

RE OPTICAL BILL.

123 STANLEY STREET, MONTREAL.
February 17th, 1905.

DEAR DOCTOR,—I think your letter of the 13th inst. must have been snow bound a bit, as it took three days to reach us. I have done all I could at present to carry out your wishes. I have written to Dr Pyne, Registrar for the Province of Ontario, to answer your questions by wire, which answer or answers you should receive to-day.

I am reasonably sure that no attempt has been made to secure recognition in the legislature of Quebec, but I am not so sure of

Ontario,* nor can I answer your other two questions, positively, though I am under the same impression that you are. I trust Dr. Pyne will be able to give you more definite information on these points. I have asked Dr. Byers to communicate such information to you as in his opinion may be of service in opposing the proposed legislation. This, I suppose, he is sending you to-day, together with his own views on the matter. You may state, for me, that in the course of thirty years' practice I have repeatedly known of instances in which the patients have been advised by opticians to purchase the inevitable glass or glasses, the real ailment having been entirely overlooked. Such persons have, in consequence, failed to receive proper treatment until disease had made such progress that irreparable damage had been done. For instance, it is not uncommon for persons suffering from chronic glaucoma to require somewhat early use of glasses. This disease causes no external manifestations, and is habitually overlooked by the opticians, and the patient gets past the stage during which efficient and curative treatment might have been instituted.

This is only one of the many instances in which the optician's want of knowledge, a knowledge which can only be gained by a thorough general and special medical education, has resulted in disaster to an ignorant and confiding public. I am quite sure that any legislative enactment tending to weaken the barrier which all civilized nations have seen fit to place between the work of properly qualified skilled professionals and that of irresponsible charlatans can result in nothing but calamity to many individuals and act as a constant menace to the public. It is obviously impossible to qualify any man or woman to prescribe for the ailments of any organ or region of the human body without first providing him or her with a sound medical education. This takes years of hard study. No trumpery course on finding and fitting glasses can ever be made a proper qualification, but it would serve admirably to enable unscrupulous spectacle vendors to bamboozel and defraud the public even more successfully than they are doing now.

If I hear of anything else likely to aid your efforts within the near future I shall communicate with you at once.

Yours very truly,

F. BULLER.

Doctor Kirkpatrick, 221 Pleasant Street, Halifax, N. S.

* No attempt has been made by opticians to gain recognition in Ontario, nor, in fact, in any British country, excepting Nova Scotia.

MONTREAL, February 17, 1905.

MY DEAR DOCTOR KIRKPATRICK,—Doctor Buller has shown me your letter regarding the attempt of the opticians of Nova Scotia to obtain incorporation as an examining body from your local Legislature; and I am writing you to assure you of my cordial sympathy in your attempt to frustrate their efforts, which could only result in consequences baneful alike to the inhabitants and educational standards of the province.

But the representatives of the House, who are, we may be sure, from the very nature of the position they occupy, men of thought and judgment, will require not mere assertions but sound arguments to convince them of the rightness of our side.

The whole question turns it seems to me on one point, viz: can the eye be intelligently dealt with by one who has not had a previous sound training in Medicine? I would voice my answer to this by quoting a recent utterance of Mr. John Tweedie, President of the Royal College of Surgeons of England and of the Ophthalmological Society of Great Britain. "The eye," he says, "is not as the optician is so apt to consider, only an optical instrument, it is a living organism, made up of the most elaborate and most highly differentiated structures in the body, in intimate and constant relations with the cerebrospinal system, the blood-vessels, the lymphatics, and other organic systems of the body; living the life of the whole body, absorbing its modes of nutrition, participating in its diseases, and responding to its various pathological manifestations. No one can safely and intelligently deal even with the optical defects of the eye unless he has an adequate knowledge, not merely of the structures and diseases of the eye but of the varied relations of the eye to the whole organism."

To this may be added that only in the dissecting rooms and laboratories of our colleges, which have been set aside by our various legislatures as the proper places for the pursuit of studies of this kind, can the absolutely essential knowledge of the anatomy, histology and physiology of the eye be acquired; and only in our hospitals can one learn to know the numberless local and systemic diseases which are constantly expressing themselves in the organs of sight.

The optician is trying to find a royal road to one of the most difficult branches of medicine. Almost without exception they do not possess the preliminary education required by our medical

colleges, and they cannot therefore from lack of opportunities consequently denied them, prepare themselves in the preliminary studies which are absolutely essential to the work. In the ordinary course of events an optician can not even look upon a dead eye much less a dissected one; and is never admitted to the only places in our land where eye diseases are studied and treated, viz: the clinics and wards of our hospitals.

And can the simple testing of the eyes be dissociated from the purely medical and surgical aspect of eye work? I think this question can be answered in an equally strong negative manner. Leaving aside altogether the higher standards required for medical men who make a specialty of Opthalmology, so long as manifold local and systemic diseases produce diminution of vision, so long only can one thoroughly acquainted with diseases of the eyes determine whether the condition is the outcome of a want of glasses or is the result of disease; and so long as highly poisonous drugs are absolutely essential to the perfect working out of the optical defects of the eyes, this work must remain in tne hands of those versed in the strictly medical subject materia medica.

That the little knowledge of opticians is dangerous, is a matter of almost daily demonstration; and that it can bring about highly disastrous consequences is likewise familiar to us all. Recently there came to my knowledge a case of a mother of a large family who gradually became hopelessly blind from Glaucoma through being deterred from seeking proper advice by a local optician who assured her that everything was all right; and I have under treatment at the present time a young man with advanced syphilis of the brain whose sight and life were placed in the greatest jeopardy by the criminal and procrastinating ignorance of an optician who is rated about the best in this city.

The head of the London (England) Spectacle-makers' Co., himself spoke strongly against the attempt of the members of his own craft to secure similiar legislation in Great Britain; and lately the efforts of the opticians of the State of New York have likewise been repulsed.

I feel sure the habitual good sense of the people of Nova Scotia will not allow them to fall into error in this matter.

Wishing you every success in your efforts to maintain the high standards of medicine, and with kind regards, believe me,

Yours very sincerely,

W. Gordon M. Byers,

Assistant-surgeon Eye and Ear Department, Royal Victoria Hospital.

Lecturer in Ophthalmology, McGill University, Montreal.

THE

MARITIME MEDICAL NEWS.

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

VOL. XVII. HALIFAX, N. S., JUNE, 1905. No. 6

Editorial.

THE RESIDUUM.

In our April and May issues we were privileged to print a paper of unusual value by Mr. George W. T. Irving, of the Department of Education, Nova Scotia, entitled, "The Residuum." The paper was prepared for and originally read in connection with a very excellent course in Sociology conducted last winter by the Young Men's Christian Association of Halifax, and there was at the time no thought in the author's mind that he would subsequently be asked to read it before an assembly of physicians, but Mr. Irving showed good judgment in giving his paper to the local branch of the British Medical Association in exactly the form in which it was presented to his first audience, and it lost nothing in its forcefulness nor in its appeal to the physician's interest because it was couched in language intended for the layman's ear. Our readers have already had an opportunity of perusing the paper, and will, we are sure, agree with us in our opinion that Mr. Irving has brought forward tersely and with rare skill a subject which is of the most vital interest from a sociological standpoint, and one which appeals very strongly to the sympathy of the physician. In inviting a layman to furnish the principal paper of the evening, the Branch of the British Medical Association made a marked departure from the usual procedure, and it is to be congratulated that, in taking this course, the choice fell upon one who was able to so ably discuss, from a layman's standpoint, a subject having distinctly medical bearings.

While commending Mr. Irving's paper, and gladly according it our unstinted admiration, we cannot but regret that such a paper should have had to be given to a medical audience by anyone who is not a member of our profession. It may not be truthfully said that doctors, as a class, do not recognize the seriousness of the sociological problems which are constantly forced upon their observation. nor can physicians be accused of lacking in sympathy with any well-directed effort by way of remedy of existing conditions, But inasmuch as there is no other class of men who see so much of the distressing and distracting evidence of the strict visitation of the iniquity of the fathers upon the children unto the third and fourth generation, and none to whom is given more positive proof of the importance of good environment than to the physician, it would appear but fitting that a paper such as that which Mr. Irving has composed should be the work of a physician—that to members of our own profession should be due the credit of putting before the public such a statement of fact and such an appeal to humanity and to common sense as are to be found in Mr. Irving's article.

We are apt to credit ourselves with a keen desire to do all that lies in our power for the benefit of humanity. The amount of service given by every physician without any hope of reward, and the constant endeavour put forth by the profession to prevent the incidence and spread of disease, may be set forth as evidence of good intent on our part. But Mr. Irving has shown us a field wherein we have as yet done comparatively little; one which is of quite as great importance and which should appeal to us quite as strongly as any which we have exploited. We must admit that we have scarcely done our full duty in this field, which might well be called medico-sociological, which appeals very strongly to our sympathy, and which is of such vital importance to the future of our nation.

Amongst the numerous things that might be done to lessen the proportion of "the residuum" in our population, two stand out very prominently. One is the provision of such institutional treatment for the defective classes as will ensure their comfort, an opportunity of contributing under proper direction something towards their own support, and at the same time eliminate the possibility of them procreating their kind. The other is to provide for our poorer classes such good hygienic conditions as will tend to foster morality rather than immorality. In this connection the medical profession must

appreciate the duty it owes to humanity, to the state, and to itself, to promulgate by example as well as precept the virtue of temperance. Consistency demands that the man who will willingly sacrifice time, treasure, and life itself for the good of a patient, should not allow the small pleasure which the "social glass" affords him dwarf his influence in the upbuilding of a physically and morally strong race. It is quite time for the admission to be made that the drink habit persists only because of the wretched selfishness of strong men, whose only plausible reason for drinking is sociability, and whose example is the justification offered by weaklings for the indulgence which works their ruin. An estimate of the benefit which total abstinence would bestow upon the race is quite impossible, but no one will gainsay that there could be no more potent factor in the elimination of "the residuum."

In his annual reports, Dr. Sinclair, Inspector for the Humane and Penal Institutions of Nova Scotia, has been for some years urging the provision of a proper school for feeble-minded children, and a suitable reformatory for erring youths. In this contention for institutions which are admittedly needed in our Province, Dr. Sinclair should have the hearty and outspoken support of every member of the profession. Because of a position which demonstrates to us the necessity of such institutions, and at the same time gives us a certain influence in the community, there is no class of men who can do more to foster such a cause than physicians. Let it not be laid to our charge that we have failed in this duty!

THE PRETENSIONS OF OPTICIANS.

In the *British Medical Journal* of May 27th we find the following under the above heading;

"We have received an advertisement, issued by Spiers and Proud's Stores, entitled, "Fair Prices in the Optical Trade," in which we find the following statement: 'We have at our disposal a staff of the highest skilled opticians, fully qualified by examination to efficiently prescribe for all errors of refraction, however complicated.' This is the sort of claim against which we shall not cease to protest, for, as has repeatedly been pointed out in this journal, it is impossible to estimate correctly the true refraction of many eyes without the use of some drug for paralyzing the muscle of accommodation. In the

interests of the safety of the public it is undesirable that non-medical persons should use the highly-poisonous drugs needed for this purpose; so far the organs of the trade have uniformly disclaimed all desire to do so, and we believe that the examining bodies which issue certificates forbid the use of these drugs. These so-called skilled opticians are, therefore, in this dilemma: They are either violating the rule under which they obtained their certificates, or they are making claims which are misleading to the public. In either case they come under the censure of those bodies from which they profess to hold their authority."

In Halifax and throughout the Provinces we see similar advertisements to the one quoted, and we would urge that the time has arrived for the medical profession to begin a campaign of education, that the public may be better able to differentiate between the faking optician and the qualified oculist. A large number of druggists are advertising that they possess a complete knowledge of refraction, and do not hesitate to examine eyes and prescribe glasses for all ages. In many cases getting into the hands of such people, the real ailment is overlooked until irreparable damage has taken place.

We claim that druggists who pretend to a knowledge of this subject are not worthy of the confidence of the medical profession. We call attention to two letters in this issue from Dr. Buller and Dr. Byers, which treat of this subject. These letters were used in argument before the legislature in opposing the Optical Bill.

SANATORIUM FOR NEW BRUNSWICK.

The medical profession of New Brunswick is again moving in the direction of sanatorium treatment for tuberculosis.

The St. John Medical Society has dealt with this matter on several occasions during the past four years, the Medical Society of New Brunswick has had discussions thereon, and the Provincial Board of Health, more especially through its former chairman, Dr. William Bayard, has made exertions to obtain a Sanatorium, and finally there was a cessation from further effort.

Lately the St. John Medical Society has deemed it an opportune moment to again raise the question, and has appointed a committee to undertake this important and imperative work. This committee is now collecting information from various sources in reference to

the whole matter of sanatorium treatment of tubercular subjects, such as the cost of buildings, the cost per patient, suitable locality, the mode of administration, and all other particulars which enter into the subject.

A well-considered and well-informed report will then be submitted to the Society. This report will then be referred to the New Brunswick Medical Society at the next meeting in July for its approval and support. No doubt this subject will then be heartily taken up by the Provincial Society, and the next step taken, that of laying the matter before the Provincial Government.

It is hoped that a definite, well-arranged proposal and recommendation will be made to the Government, and it will then be for the Government to act.

Public opinion is in our favour. The public is now fairly well aware of the importance of the subject, a carefully-prepared plan having been submitted with the approval of the profession of the Province. Surely the Provincial Government will feel compelled to act. Let us hope so. In any case, the burden will be on the Government, which must then take the responsibility.

But the conditions and circumstances are such at the present time that the profession may have good hope of success.

CANADIAN MEDICAL ASSOCIATION.

The approaching meeting in this city from August 22nd to 25th promises to be a large and representative gathering. The co-operation of every physician in this province is earnestly desired, so that our visitors may speak with high terms of praise of their reception here. The different medical societies throughout Nova Scotia are actively engaged in furthering the financial details, for without money all hopes of entertainment are futile. The counties where societies do not exist will be appealed to by means of a circular letter, and we trust that the required amount will be forthcoming. The Medical Society of Nova Scotia will be the host of the Association, and let each member feel that he is a committee of one to do his individual best, and forward his contribution on receipt of letter.

All delegates will travel on the usual *Standard Certificate*, which must be obtained from the ticket agent for himself and his wife or daughters, if they accompany him.

The meeting will be held in the handsome new building of the School for the Blind, where ample accommodation will be obtained for all purposes, such as special rooms for committees, exhibits, post office, etc.

Besides the names already mentioned who are to contribute papers, will be the following so far received:

Address in Surgery—Francis M. Caird, Edinburgh.
Address in Gynecology—Howard A. Kelly, Baltimore.
Address in Obstretrics—T. Walker, St. John.
Address in Medicine—D. A. Campbell, Halifax.
Address in Ophthalmology—J. W. Stirling, Montreal.
A. Primrose, Toronto—Renal and Ureteral Surgery.
Dr. Geo. H. Burnham, Toronto—Two cases of Retro-Ocular Neuritis.
Dr. Herbert A. Bruce, Toronto—(Title to be announced).
Dr. D. A. Shirres, Montreal—The Symptoms, Diagnosis, Prognosis and Treatment of Neoplasms affecting the Central Nervous System.
Dr. Robert King, Montreal—Chorea, with an Analysis of 130 cases.
Dr. Maude E. Abbott, Montreal—Rare forms of Aneurysm.
Dr. J. M. Elder, Montreal—The Buried Suture.
Dr. M. C. Smith, Lynn, Mass.—Dentigerous Cysts, or the Removal of the Inferior Dental Nerve for Tic.
Dr. F. N. G. Starr, Toronto—Combination Operation for the Radical Cure of Inguinal Hernia.
Dr. Myron Metzenbaum, Cleveland—Physical and Clinical Researches of Radium.

MEDICAL SOCIETY OF NOVA SCOTIA.

It has been decided that the Annual Meeting, which will take place at Lunenburg this year, will be strictly a business one. The question of Insurance Fees, which has interested the profession throughout this province, will be considered by the Society, and no doubt an interesting discussion will be the result. The Lunenburg-Queens and Colchester Medical Societies have considered this important matter in all its details, and in this connection the letter

from Dr. Smith L. Walker, of Truro, in this issue, will bear careful consideration. Among other important matters, representatives to the Provincial Medical Board must be appointed at the approaching meeting. The Society will likely be in session the afternoon and evening of July 5th, but the usual post card from the Secretary will convey the required information. The steamer "Bridgewater," from this city, will leave on that morning and return the following morning. It is probable the South Shore Railway will run a daily train before that date. The Lunenburg-Queens Society are hopeful of a large delegation at this convention, so that important matters concerning the welfare of the profession in this province may be discussed and acted upon.

HONORS AT McGILL.

The fact of Maritime Province students winning honors in the medical examinations at McGill is not an uncommon occurrence. We may be pardoned, however, in drawing particular attention to the results at the recent annual convocation. H. C. Mersereau, of Doaktown, N. B., carried off the Holmes Gold Medal for highest aggregate in all subjects. H. C. Burgess, of Sheffield Mills, N. S., was third in honors, and H. A. Leslie, of Souris, P. E. I., fifth. When it is considered that out of the 73 graduates, only eight received honors, all praise must be given our maritime boys. The third year prizeman was R. S. MacArthur, of Summerside, P. E. I., while C. S. Williams, of Tyne Valley, P. E. I., is a close second. R. C. Weldon, Halifax; E. J. Ryan, St. John, and P. A. McDonald, Alma, N. B., are also in the third year honor list. R. M. Benvie, of Salt Springs, Pictou Co., N. S., finished ahead of the second year class, and R. H. McDonald, North Bedeque, P. E. I., the first year. We likewise find that the Sutherland Medallist is D. R. Fraser, of Montague Bridge, P. E. I., and R. B. Dexter, of Wolfville, N. S., wins the Junior Anatomy Prize.

We heartily congratulate these maritime boys in their great success. May they ever uphold the high standard which students from our provinces usually attain.

Society Meetings.

ST. JOHN MEDICAL SOCIETY.

The President, Dr. McCully, in the chair.

March 29th.—*Pathological specimens.* Dr. Murray MacLaren exhibited. (1.) Gall stones removed from common bile duct; (2.) Fæcal concretion from a case of appendicitis; (3.) Enlarged liver of infant.

Dr. Corbet read a paper on the "Duality of Mind," (published in April number of the NEWS.)

April 5.—A paper on "Irritation of Prostate," was read by Dr. Case. The causes, symptoms and treatment were fully considered. (This paper will appear in the NEWS.)

April 12.—*Pathological Specimens.* Dr. MacLaren exhibited a brain, shewing a tumour on the occipital lobe. The President read a paper entitled "Conservatism in Medicine."

April 19.—Dr. S. H. McDonald reported a case of extreme valvular disease of the heart in a child. Much relief is obtained through severe attacks of epistaxis. The fat free tincture of digitalis as prepared by M. V. Paddoch was found to be of much service.

May 3.—Dr. Bentley read a paper on the "Complications of Gonorrhœa." The following were mentioned and reports of illustrative cases given,—(1.) Ophthalmia Neonatorum, (2.) Epididymitis and Orchitis, (3.) Gonorrhœal Rheumatism, (4.) Salpingitis.

May 10.—Dr. Grant read a paper on "Diphtheria," in which the diagnosis was more especially considered and the differential diagnosis between tonsillitis and diphtheria fully dealt with.

May 17.—Dr. White brought the subject of a Sanatorium for treatment of tubercular cases before the Society. The meeting unanimously endorsed the proposal to again undertake the work of bringing it before the profession and later the Government, and the following committee were appointed to collect information and report: Drs. J. A. B. Addy, White, T. D. Walker, Skinner, Murray MacLaren, Inches and Lunney.

Dr. Skinner reported three cases of empyema, and one case of ectopic gestation.

May 31.—ANNUAL MEETING.

The Secretary, Dr. Lunney, read his report. During the year there were 24 meetings, the largest attendance at any one meeting was 19. The average attendance at meetings was between 8 and 9. There was not always a quorum present. Five new members have been added to the Society, and there was one loss by death. The membership stands at 53.

The Treasurer, Dr. Jas. Christie, reported that the Society was $50 in debt.

The election of officers resulted as follows:—President, Dr. J. M. Barry; Vice-President, Dr. T. H. Lunney; Secretary, Dr. Pratt; Treasurer, Jas. Christie; Librarian, Dr. Margaret Parks; Room Committee, Drs. W. W. White, G. A. B. Addy, Crawford and T. D. Walker.

"So you have decided to get another physician."

"I have," answered Mrs. Cumrox; "the idea of his prescribing flaxseed poultices and mustard plasters for people as rich as we are."

Ex.—

Quite right. If he had been up-to-date, he would have used Antiphlogistine, whether his patients were rich or poor.

FOR SALE.

House, lot, etc., with medical practice "thrown in." Apply to,

DOCTOR,
c/o Maritime Medical News,
Halifax.

Personals.

Dr. Robert King, for the past two years one of the resident physicians to the Royal Victoria Hospital, Montreal, is now associated in practice with Dr. A. I. Mader of this city.

Dr. M. D. McKenzie, of Advocate, has recentlv returned from post graduate work in London.

The NEWS extends its sympathy to Dr. J. A. Sponagle, in the death of Mrs. Sponagle, of Middleton, which occurred last month.

Dr. Osler and family sailed from New York, May 18th, on the S. S. "Cedric."

Obituary.

Dr. E. E. Dickey.—The death occurred at his home, 14 Church Street, on the morning of May 29th, of Dr. Edwin Egbert, son of the late Clement Dickey, of Upper Canada. The death was a particularly sad one, as Dr. Dickey had only been married a little over two months to Miss Anna Louise Tremaine, daughter of R. W. Tremaine. The deceased for nearly a year had been a sufferer from progressive muscular atrophy, but his death was quite sudden. He was 27 years of age, and after graduating from Dalhousie University, practised his profession at Wolfville, coming to Halifax about a year ago. Dr. H. L. Dickey, of this city, is a brother.

Dr. F. W. Campbell.—The death occurred on May 5th, of Dr. F. W. Campbell, Dean of the Medical Faculty of Bishop's College, aged 67 years. His two sons had died within a year, one of whom was Dr. Rollo Campbell. The Medical Faculty of Bishop's over which Dr. Campbell had been Dean for over twenty years, has now become amalgamated with McGill.

Dr. James Thorburn.—At Toronto, on May 26th, Dr. James Thorburn of that city passed away in his 75th year. He had been many years an active teacher in the Toronto School of Medicine, and latterly appointed Emeritus Professor of Therapeutics and Materia Medica. He possessed many admirable qualities, and had the honor to being President of the Canadian Medical Association in 1895.

Book Reviews.

A Text Book of Obstetrics.—By Adam H. Wright, M. D., M. R. C. S., Professor of Obstetrics, University of Toronto. Price $4.50. D. Appleton & Co., New York, Publishers.

Following the valuable works on this subject which have been recently added to our library, this one is worthy of special consideration. The superiority of type and clearness of illustrations, and the size and arrangement of the work, give it a place at once for the student and general practitioner. The chapters on the anatomy of the pelvis and the physiology of its organs are concise and treat the subjects from a purely obstetrical standpoint. The treatment of the subject of the impregnation of the ovum and development is clear and the description of the growth of the amnion, chorion, decidua and placenta is particularly suited to the requirments of students. The development of the embryo and fœtus with measurements of fœtal skull given definitely for memory in both English inches and centimeters, is commendable. The mechanism and conduct of normal labor is explained, and many practical hints given which will be welcomed by the obstetrician. Face and breech presentations are carefully considered. The treatment is arranged in a tabulated form, which conveys a conviction that the methods have been well considered and come from an authoritative pen.

The chapter on puerperal sepsis is worthy of perusal by young and old practitioners, offering resourceful and practical suggestions, which will be welcomed by those having an extensive practice in any of our cities. The treatment of the subject of major obstetrical operations may not be as thorough as their importance would indicate, but the description and expert use of the forceps is very ably dealt with, and the merits of the axis-traction, especially those designed by Porter Mathew and Milne Murray, fully illustrated. For the work, we would predict a hearty reception by the medical fraternity; its indivuality and arrangement for ready reference give it at once a conspicuous place on the shelves of the libraries of all active practitioners. The reviewer, who has had some years of teaching the subject of obstetrics, can state that it is by far the best book so far perused which will meet the needs of the advanced student.

Clinical and Microscopical Diagnosis, with 188 Illustrations and 9 Colored Plates.—By Francis Carter Wood, M. D., Adjunct Professor of Clinical Pathology, College of Physicians and Surgeons, Columbia University, New York; Pathologist to St. Luke's Hospital, New York. Price, Cloth, $5.00; Half Leather, $5.50. Published by D. Appleton & Co., New York.

This is one of the many books whose aim is the examination of blood, stomach contents, fæces and urine, as well as the various transudates and exudates, etc., as an aid in the diagnosis of disease.

It is written in a pleasing style, the author stating the different procedures as he has found them. He gives only the best and most practicable methods so that the reader is not compelled to review a tiresome list of details.

From a review of the methods described, we are convinced that the author is familiar with the technique of the different procedures and is in a position

to emphasize the relative value of the different methods, so that the reader has the advantage of the author's extensive work in this field, and is not compelled to go through many different tests in order to find a practical and workable method.

The work is so uniformly excellent that it would be difficult to point out any special feature. The chapter on blood, while covering the same grounds, is stated more clearly and simply than in many books on the same subject. The blood plates are good and are well arranged.

In the chapter on serum reactions, the known limitations in this field are well defined, so that men who for different reasons have been unable to keep themselves fully posted on this subject, are not led to erroneous conclusions.

The different methods in the examination of urine, sputum, milk, gastric contents, etc., are dealt with and are uniformly reliable

All readers of this book would undoubtedly conclude that, without any exaggeration. the author might have added to his preface, the following: "the work is especially designed so that the general practitioner and those interested in clinical diagnosis might have a reliable guide."

L. M. M.

International Clinics.—A Quarterly of Illustrated Clinical Lectures and Especially prepared Original Articles Volume. I., Fifteenth Series, 1905, J. B. Lippincott Company, Philadelphia, Publishers. Canadian representative, Charles Roberts, 1524 Ontario Street, Montreal.

The constant reader of the Clinics cannot fail to assimilate knowledge that must prove of material advantage to him in his practice. This has been verified in the experience of the reviewer, who hopes to substantiate this statement shortly in at least one instance. Some of the practical articles in the last volume are: "The Treatment of Cardiac Asthma," by P. Merklen, M. D., Paris; "The Carbohydrates of Human Urine in Health and in Disease," by Carstairs Douglas, M. D., Glasgow; "The Eye and the Hand in the Diagnosis of Heart Disease," by J. J. Walsh, New York; "The Starvation of Malignant Growths by Depriving them of Blood Supply," by R. H. M. Dawbarn, M. D., New York. Especially have we read with profit the able and instructive article entitled, "Skin-Grafting in the Late Treatment of Severe Burns Involving Extensive Areas of Skin," by Archibald Young, M. B., Glasgow. The diagrams and plates in the contribution referred to, which comprise some thirty pages, are likewise of great value. Progress of Medicine during 1904, comprising Treatment, Medicine and Surgery, deals with recent researches in every domain of medicine. These hundred and ten pages will be found a valuable reference guide for most of the common as well as rare conditions.

Therapeutic Notes.

LISTERINE DERMATIC SOAP.—The Lambert Pharmacal Co. has lately inaugurated a new venture in the way of an antiseptic soap which possesses the virtues of Listerine in so far as a soap may. It is only a matter of recent years that especial attention has been given to producing soaps which shall possess a degree of curative power in disease of the skin and in the care of surgical conditions. A considerable variety of such soaps is now on the market, and the mission of the lot is wide; it is safe to say that Listerine Dermatic Soap will prove one of the most serviceable, and will soon make for itself a popularity with the profession in keeping with that which has been established by Listerine.—*Medical Fortnightly, Jan. 25, 1905.*

SOME FACTS ABOUT SANMETTO.—Sanmetto is a combination of the virtues of santal and saw palmetto in a pleasant menstrum of aromatics. In your practice you will find many diseases and diseased conditions in which Sanmetto will be indicated. I will name some of these diseases, and you have only to prescribe this remedy. Be careful as to diet and exercise as you would in prescribing any other remedy, and you will soon find it the best friend you ever had,—Cystitis, both acute and chronic; enlarged prostate with its usual irritation of neck of bladder and sensitive urethra; urethritis, both specific and non-specific; impotence, either due to excess or premature decay; and simple irritation of any part of the genito-urinary tract. It is also a great aid in treating many diseases of the pelvic organs in the female. Also seminal emissions and prostatorrhea, hæmaturia and enuresis are well treated with this remedy, except where surgical interference is necessary.

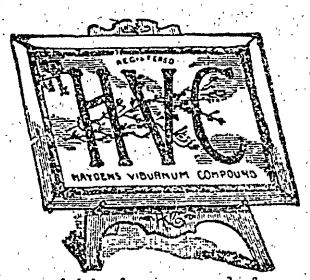
Orkney Springs, Va. C. W. CANAN, M. D.

ANTIKAMNIA, (Therapeutic Indications).—Antikamnia is an American product, and conspicuous on this account and because of the immense popularity which it has achieved, it is to-day in greater use than any other of the synthetically produced antipyretics The literature is voluminous, and clinical reports from prominent medical men in all parts of this country, with society proceedings and editorial references, attest its value in actual practice in an endless variety of diseases and symptomatic affections, such as the neuralgias, rheumatism, typhoid and other fevers, headaches, influenza and particularly in the pains due to irregularities of menstruation. Antikamnia has received more adverse criticism of a certain spiteful kind, particularly directed against its origin—aud because of its success—than any other remedy known; critics have seemed personally aggrieved because of its American source, and that it did not emanate from the usual "color works," but their diatribes have fallen flat as do most persecutions and unreasonable and petty prejudices. The fact stands incontrovertible that antikamnia has proved an excellent and reliable remedy, and when a physician is satisfied with the effects achieved he usually holds fast to the product. That is the secret and mainspring of the antikamnia success. It is antipyretic, analgesic, and anodyne, and the dose is from 5 to 10 grains,

in powder, tablets or in konseals taken with a swallow of water or wine. When prescribing Antikamnia, particularly in combination with other drugs, it is desirable to specify "in konseals," which are rice flour capsules, affording an unequalled vehicle for administering drugs of all kinds.

TREATMENT OF FELONS.—Felons are classed as minor surgery, and yet many a finger has been lost through their careless treatment. Antiphlogistine is a specific in incipient cases. Apply hot, change every six or eight hours and resolution will, as a rule, occur without the formation of pus. If pus has already formed, incise deeply and freely. Thoroughness is essential. Evacuate and cleanse with a suitable antiseptic. Insert a drainage tube. Surround the finger with Antiphlogistine. Cut the drainage tube one-quarter inch above the surface of the Antiphlogistine. Cover all with absorbent cotton and a bandage. The results will be satisfactory.

NUTRITION IN HEART LESIONS.—A most successful factor in the handling of cardiac lesions, either functional or organic, is proper nutrition. In fact, I know of no other disease where failure attends the proper selection of remedies so often as in cardiac trouble the cause being due to improper feeding. In functional derangements, the most carefully selected remedies fail to bring about the desired result if the diet of the patient be improper or he be overfed, while in structural lines we are defeated before we begin, if we neglect the nutrition. When we take into consideration that nearly every functional disturbance of the heart, in perhaps forty per cent. or more cases, can be traced directly to gastric intestinal disturbance, we will all the more rightly appreciate the great importance of a proper diet. In handling these nervous conditions or functional abnormalities, one can accomplish very little with medicine unless his patient's diet is properly selected. The diet should be one requiring little or no digestion, and yet supplying in proper proportion a full quantity of the elements of an absolute nutrition. When we come to prescribe for structural lesions, we find the diet most important, for every organic lesion is not only aggravated by faults of digestion, but the nutrition of the organ itself relies largely upon the diet furnished. If we take into consideration the various valvular derangements, it will be found that the heart is able to do its work owing to compensatory changes that have gradually taken place, and that the case only becomes grave when compensation fails. The chief aim in the treatment should be to maintain this stage of compensation, and while the drugs usually employed in these conditions bring about desired results in part, complete results are not obtained unless proper and complete nutrition is supplied. In cardiac enlargement the same state of affairs prevails. To maintain the heart, when hypertrophied, a uniform degree of nutrition is most essential and should receive the physician's careful consideration. In the handling of all cardiac conditions, and my experience has been a large one, I have found that Bovinine was the ideal food and tonic. It does not over-stimulate the heart, but supplies sufficient stimulation. It gives to the system a proper proportion of every element of nutrition and a normal amount of assimilable iron. Each individual case must be studied and the quantity of Bovinine administered, suited to that case.—T. J. BIGGS, M. D., Stamford, Conn.



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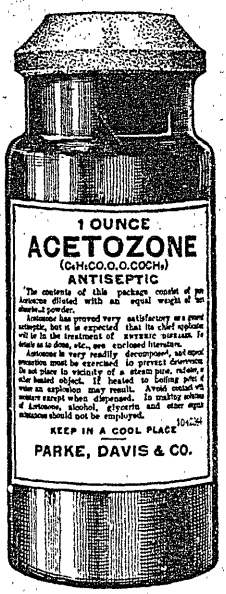

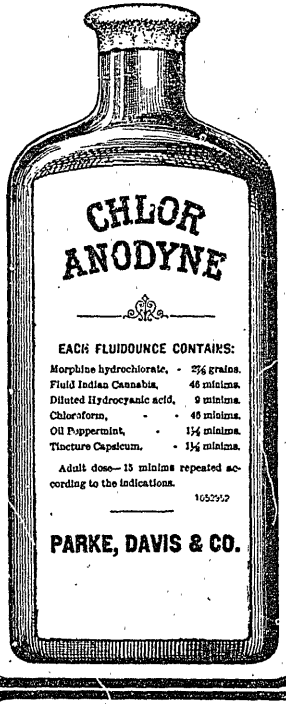

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