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THE ROENTGEN RAYS IN THE DIAGNOSIS OF URINARY AND BILIARY CALCULI.

BY S. CUMMINGS, M.D., HAMILTON.

The Roentgen Rays may be said to have opened up a new era in the diagnosis of calculous diseases, for by their intelligent use a positive opinion may be expressed as to the presence or absence of all calculi, with the exception of biliary. Judging from my own experience, I believe that any error is due to faulty technique and inability to correctly interpret the skiagrams, and not to the method itself.

The classical symptoms of renal and ureteral calculi are often absent, and in many cases which only complain of vague urinary symptoms calculi are to be found. Ureteral calculi have no diagnostic symptoms, yet they are far from uncommon. Leonard has found them in 50 per cent. of his cases, and in my limited experience the percentage is even higher.

I believe that X-rays are of as much value in urinary calculi as the ophthalmoscope is in the diseases of the eye, or as the laryngoscope in diseases of the larynx. One case has come under my observation in which the appendix had been removed for supposed appendicitis. The symptoms still persisting, the case was examined with the X-rays, and a large calculus was discovered in the right kidney. This was removed, with the result that the patient was completely cured. On account of the comparatively small number of my cases, I prefer to give a short history of each.

My first case was skiagraphed in 1898.

1. Mr. B., age 50, complained of great pain in the right lumbar region. There was no renal colic, but he passed large quantities of blood by the urethra, so much so that the urine

looked like porter. A cystoscopic examination of the bladder showed nothing abnormal, but from the right ureter blood could be seen oozing at intervals, like smoke from the crater of a miniature volcano. The skiagraph showed a large calculus in the right kidney. The patient refused operation, recovered from the attack, but has had several similar ones since.

2. Mr. H., age 35, patient of Dr. Anderson, in the spring of 1897 had an attack of left renal colic; in 1898 had recurring attacks of pain on the right side, confined to the region of the kidneys and not radiating to any extent. The urine was acid, and contained only a few white cells, which disappeared from time to time. The patient continued in this condition, having recurring attacks and becoming almost a complete invalid, until 1899, when, the diagnosis of renal calculi having been made, I examined him with the X-rays, and found a large calculus in the pelvis of the right kidney. This Dr. Anderson removed by nephrolithotomy. During convalescence the patient had an attack of left renal colic, two small calculi were passed; these had been overlooked in the interpretation of the plate, and a re-examination of the negative showed that there were three distinct shadows of small calculi in the left kidney.

3. Mr. K., age 35, a moulder, patient of Dr. J. E. White, for a number of years has had pain in the right shoulder and side: no urinary symptoms; for the last four years attacks of renal colic, which recurred so frequently that he was forced to abandon his trade. During the last two years has had frequency of micturition, urine reveals no abnormality, except crystals of oxalate of lime. Renal calculus was diagnosed, confirmed by the skiagraph, which showed a large calculus in the pelvis of the right kidney. Dr. White removed an oxalate of lime calculus by nephrolithotomy, with the result that the patient was entirely relieved of his symptoms.

4. Mr. A., age 36, patient of Dr. Balfe, had typical renal colic on the left side for several hours, blood was found in the urine, sudden cessation of pain; skiagraph two days after, no calculus could be found, showing presumably that it had escaped from the ureter and been voided with the urine.

5. Mr. C., age 33, for the last five years has had pain in the back, but mostly in the region of the stomach, to such an extent that he was treated by specialists in Chicago for gastric disorder. He never had any symptoms of renal colic, urine only contains crystals of oxalate of lime. His condition became so bad that he resigned his position and spent two years in the south. He consulted Dr. Thompson, of this city, who advanced the possibility of the presence of renal calculus, and referred the case to me. The skiagraph showed a large calculus in the right kidney, which I removed by operation.

6. Mr. H., age 48, had the classical symptoms of left renal and ureteral colic, sudden intense pain shooting to the groin, retraction of the testicle, blanched facies and considerable shock, tenesmus and frequent urination, but no blood in the urine. After eight hours he experienced sudden and complete relief, no doubt due to the escape of the calculus from the ureter. Three days subsequently a skiagraph was taken, but after the most careful search no calculus could be found in the kidneys, ureters or bladder, demonstrating conclusively that it must have been voided from the bladder.

7. Mr. R., age 44, has had several attacks of renal colic on both sides; urine normal. Skiagraph shows three small calculi in the right kidney and one in the right ureter at the brim of the pelvis, and one small calculus in the left kidney. Operation not advised.

8. Mr. T., age 63, has had several severe attacks of renal colic affecting the left side, urine normal; for the last two years no attack. Skiagraph fails to demonstrate the presence of any calculi, showing evidently that they have all been passed.

URETERAL CALCULI.

Nearly all these have been found accompanying renal or vesicle calculi.

Miss C., age 34, a patient of Dr. Olmstead, urine acid, some pus and frequency of micturition, family history strongly tubercular. Dr. Olmstead cystoscoped the bladder and found it normal, catheterization of the ureters showed that the right one was normal and that some pus came from the left. With a Kelley's bougie tipped with wax he obtained a scratch from the left ureter. The case was referred to me for X-ray examination; skiagraph showed a small calculus the size of a pea in the left kidney. The second skiagraph, taken some days later, showed the interesting condition that the calculus had descended the ureter and was lodged about one and a half inches outside the bladder walls. The wax-tipped bougie confirmed it in this location. The ureter was dilated with bougies, and the calculus subsequently was passed, demonstrating the value of this method of treatment of ureteral calculi in the female.

Mr. —, age 69, complained of chills at times, frequent micturition and purulent urine swarming with bacteria, but never had any pain. The skiagraph taken in October, 1900, showed three minute calculi in the right ureter, about one and a half inches from the bladder, and one small calculus in the left kidney. The patient was placed on urotropin and large quantities of distilled water, with the result that the urine improved, but the skiagraphs, taken at intervals of three and six months,

show the calculi to be still in the same position. In June, 1901, this patient, after spending the day at Niagara, was seized with a slight pain in the region of the left kidney and profuse hematuria to such an extent that it was necessary to catheterize the distended bladder several times, and wash out the clots of blood. A complete blood cast of the ureter, about ten inches in length, was obtained in one of the washings. A skiagraph was taken and compared with that of April, 1901, and it was now noticed that the calculus in the left kidney had descended the ureter to within one inch of the bladder. While cystoscope was not employed to actually see if the blood came from the left ureter, it seems to me, when taking into consideration the slight lumbar pain on the left side, and the descent of the calculus, that the explanation of the hematuria is obvious.

The following is a case which shows the existence of calculi for over 40 years.

Mrs. G., age 70, passed, in 1860, a small mulberry calculus after an attack of renal colic; since then there has never been any colic or pain, but since 1880 the urine has contained pus. The patient has had for years spells of vomiting and nausea, which were diagnosed as nervous dyspepsia by the successive family physicians and consultants. When I assumed charge of the case I was forced to be content with the same diagnosis. The urine was acid and contained considerable pus. I noticed that during the attacks, which had now become more frequent, the urine was somewhat suppressed. I advised the use of the cystoscope to make an intelligent exploration of the urinary tract, but this was refused. One year ago the first skiagraph was taken, and a veritable mine of calculi was shown on the plate—there were four in the right kidney, two in the left, eleven in the right ureter, seven in the left ureter, and two small calculi in the bladder. On account of the advanced age no operation was advised; pyonephrosis developed, and the case ended with uremia and terminal infection.

Miss R., age 29, was considered to have a movable kidney on the right side which suddenly disappeared; never any renal colic, urine normal. Skiagraph shows a small ureteral calculus two inches distant from the bladder. Ureter was dilated with Kelley's catheters, but the subsequent skiagraph still shows the calculus in the same position.

The advantages of the Roentgen rays in ureteral calculi may be summed up by stating that they render the diagnosis of the calculi certain. Heretofore the only means at our disposal have been palpation, provided the calculus was of sufficient size, or the somewhat uncertain use of the wax-tipped bougie in the female. The ureteral are the easiest of all calculi to detect, and an operation for their removal can be directed with mathemati-

cal accuracy by reference to the skiagraph. In cases of hydor or pyonephrosis due to ureteral calculi, the obstruction can be removed and the kidney left intact.

VESICLE CALCULI.

Stone in the bladder can usually be discovered by the ordinary means, such as the sound and the cystoscope, but I believe that one possessed of the necessary knowledge of the X-ray technique can diagnose calculi in the bladder more simply and more accurately. A positive or negative diagnosis can be rendered at once. There is no danger of infecting the bladder with instruments. The size, position and number of the calculi can be estimated. We know that even the most skilful surgeons have failed to detect stone with the sound. If there is enlargement of the prostate, or a urethral stricture that prohibits or renders difficult the use of the sound, the X-rays are invaluable. All encysted calculi can be recognized. This method has the further advantage of causing the patient absolutely no pain or disturbance.

Mr. T. had classical symptoms of vesicle calculus. The skiagraph which I pass around shows the presence of a large calculus which was crushed and removed.

Mr. R., age 55, had ordinary symptoms of stone, urine alkaline 1015, offensive, and containing triple phosphates, pus and bacteria. He was sounded twice with negative results, and I also introduced a searcher, but could not detect the stone. Skiagraph showed a calculus the size of a bantam egg which was removed by litholopaxy.

Mr. D., blacksmith, age 56, has had several attacks of renal colic on both sides. One year ago symptoms of vesicle calculus appeared, urine acid 1010, some pus. During my absence in Europe last year he was sounded for stone with negative results. The skiagraph showed three small calculi in the left, and one in the right kidney, and several multiple calculi in the bladder. That these stones were not encysted in the bladder was proven by the simple expedient of turning the patient on his abdomen, and taking another skiagraph, when the stones could be seen in an altered position, lying on the anterior wall of the bladder.

Mr. McK., age 56, about one year ago he consulted me for symptoms of stone in the bladder, the urine was alkaline 1012, contained pus, bacteria, triple phosphates, and had a very offensive odor. A skiagraph was taken and a large stone two inches by one and a half was observed, which was crushed and thoroughly removed by operation. For six months he was perfectly well, then he began to have symptoms of recurrence, for which he consulted me in May. A skiagraph was again

taken. A large stone one and a half inches by one inch was seen in the bladder, in the right ureter about an inch from the bladder wall were two calculi, one the size of a hazel nut, and the other very minute, in the left ureter in the same position was a calculus the size of a pea. I am thoroughly satisfied that the removal of the bladder stone was complete at the first operation, for after the last fragments were removed the washing bottle was used several times but no clicking could be obtained. The stone was removed by litholopaxy. A subsequent skiagraph showed the bladder to be perfectly free of any fragments, but the ureteral calculi were in the same position as previous to the operation. There is very little doubt in my mind that a small calculus emerged from the ureter, and, lodging in the bladder, rapidly grew to the size of the present stone. Many recurrences both after lithotomy and litholopaxy probably arise in this way.

BILIARY CALCULI.

In these cases the Roentgen method is not of so much value as in urinary calculi, because many difficulties surround the technique of skiagraphing gall stones. In many cases, in which gall stones are present, we are unable to obtain the desired skiagraphic evidence, but in time I think that all the difficulties will be surmounted. If by means of the X-rays we obtain shadows of the calculi, we can render a positive diagnosis immediately. If the calculi are small it indicates that a course of medical treatment, such as the intelligent use of the Carlsbad Sprudel Salts should be advised, as there is a possibility that the calculi may be passed. If the calculi are large and there is no possibility of their passing the biliary ducts, an operation should at once be recommended.

Mr. F., age 52, a patient of Dr. McClenahan, has had several attacks of biliary colic, but never any jaundice. Skiagraph shows numerous small calculi very distinctly. The patient was placed on medical treatment and many small stones were passed in the stools. When last heard from he was entirely well.

Mrs. H., age 40, had several attacks of biliary colic, gall bladder very much distended. Many small and large stones were shown in the skiagraph.

Mrs. H., patient of Dr. Boyes, had persistent vomiting and nausea, but never any colic or jaundice. Distended gall bladder could be palpated. Skiagraph negative. I removed two enormous calculi by cholecystotomy, with complete recovery from all symptoms.

Mrs. M., has had biliary colic for years, no distention of bladder. X-rays showed several large calculi and numerous small ones. Operation confirmed the skiagraph. Recovery.

Mr. W., age 45, patient of Dr. Rogers. A case of suspected cancer of the liver and gall ducts, with intense jaundice and a metastatic deposit in the umbilicus. Skiagraph showed enlarged liver but no calculi could be observed. An operation was performed for relief of the distended gall bladder, the diagnosis of cancer was confirmed, but a large gall stone of very soft consistency and many very small ones were found in the gall bladder.

Mrs. C., age 43, referred by Dr. Gaviller, had several attacks of biliary colic, gall bladder distended. A large calculus was seen in the skiagraph. Confirmed by cholecystotomy. Complete recovery.

A REPORT OF THREE CASES OF DIABETES MELLITUS.*

By DR. GEO. HODGE, LONDON.

Diabetes mellitus is always a grave disease, and especially so in young adults and children. Under a recent method of treatment—a diet regulated in *quantity* as well as in *quality*—many cases, which would heretofore have run an unfavorable course, are now treated with a considerable measure of success. A knowledge of the pathology of the disease is essential to its rational treatment.

In health, carbohydrate food is taken into the system, and in the alimentary canal is converted into a soluble product, which is absorbed and carried to the liver, where it is stored as glycogen. The liver, by a regulating mechanism, converts glycogen into sugar, which is carried to the tissues and assimilated. By abnormal conditions these functions are upset, the liver does not store glycogen, but allows the carbohydrate food to pass directly to the circulation as sugar. Not only is there an interference with the glycogenic function of the liver, but there is also a failure of the sugar-destroying function of the tissues. This latter fact has been established by Professor Bouchard, who has worked out the consumption of sugar in health and disease. He has shown that young, thin persons, in health, consume much more sugar, per kilogramme of body weight, than aged, fleshy people. He has also calculated the amounts of sugar consumed per kilogramme of body weight by a number of diabetics, and has compared the results with the figures obtained from normal individuals of the same age and weight, and found that all diabetics exhibit a very great reduction of their sugar-consuming power.

The treatment should aim at restoring the sugar-consuming power of the tissues. This is to be done by constructing a diet, as far as possible free from carbohydrate, and which will contain an amount of heat units proportional to the weight of the patient. According to Bübner, a man consumes the following quantities in twenty-four hours for each kilogramme of body weight: During repose, 32.9 heat units; on slight work, 34.9 heat units; on moderate work, 41.0 heat units; on hard work, 48.0 heat units. So that a person weighing 150 lbs. (75 kilos.) would at slight work require daily a food equivalent to about 2,600 heat units. A diabetic would require, in addition to this, a quantity of food equal to the amount of sugar excreted daily by the kidneys. Thus given the heat units of certain articles of diet and the percentage of carbohydrate they contain, it is

* Read at meeting of London Medical Association.

an easy matter to construct a diet suitable for any case that may come under one's care. By, from time to time, estimating the amount of carbohydrate food taken and the quantity of sugar excreted, we are able to say how much sugar is being assimilated, and as the power of the tissues to assimilate sugar increases, we must carefully add more carbohydrate food to the diet.

In cases of glycosuria and the more chronic cases of diabetes, this mode of treatment will be attended with excellent results. In acute cases, met with most frequently in young adults and children, no method of treatment seems to exert any beneficial influence.

The following cases will illustrate the hopelessness of this disease in children:

CASE I.—George N., a lad aged 16 years, consulted me on the evening of August 11th, 1896. He worked in a store, and on his way home from work called at my office, complaining of feeling weak and of severe headache. He was thirsty, and had a temperature of 103°F. From his appearance and symptoms, I thought he was developing an attack of typhoid fever. I advised him to go home at once and go to bed, and remain there till I saw him. On the morning of the 12th I saw him, and found his temperature normal, but he still complained of being thirsty, and also of feeling weak and tired. I was at a loss to know the cause of his symptoms. I saw him again during the forenoon of the 13th. I now got a history of frequency of passing urine. I asked for and obtained a sample of urine, which, on examination, showed that it was acid. sp. gr. 1025, contained sugar in large quantity, but no diacetic acid. The quantity passed during the next twenty-four hours was 150 ounces. At midnight of the 13th I was called to see the patient, whom I found restless and complaining of great oppression of breathing. During the 14th he continued restless, and gradually passed into a condition of coma, and died at 9 a. m. on the 15th, *i. e.*, just three a half days after I first saw him, and two days after I found sugar in his urine. Careful inquiry regarding his condition prior to the time when I first saw him failed to elicit any evidence which indicated that his illness was otherwise than of short duration. He slept with an elder brother, who was quite positive that he had not been rising during the night to pass urine, and that he did not complain of weakness till two days before I saw him. On Sabbath, the 9th inst., he went to church in the morning, but was compelled to leave during the service because he felt faint. He felt well enough on the afternoon of the same day to go to Sabbath school. He went to work on Monday, but said he felt weak. On Tuesday he again went to work, but was compelled to leave his place of business during the day.

CASE II.—On July 20th, 1900, Olive S., aged 7 years, was referred to me by Dr. Meek, who, upon examination had found sugar in her urine. A maternal aunt died of diabetes mellitus some years ago. This child had complained of weakness, loss of flesh and the passing of too much urine since April, 1900, but continued to go to school till the end of June. The parents did not consider her condition sufficiently serious to warrant them in consulting a physician till the present. Examination of the urine on the 22nd showed it acid, sp. gr. 1034; albumin, a slight quantity; sugar in large quantity; no diacetic acid. I saw the child on the afternoon of the 22nd, and found her restless, complaining of oppression of breathing and listlessness. I understand that she gradually sank, and died on the 23rd. This child was evidently ill for a little over three months.

CASE III.—On December 16th, 1900, the father of Isabel C., aged 5 years and 4 months, called me by telephone, and said he wished to tell me about her. She had been passing urine too frequently, and had been rather easily tired for some days. He did not think there was much wrong, but thought he would like to report her condition. I asked for a sample of urine, which I obtained the following morning. It was clear: sp. gr., 1045; sugar in large quantity; acid in reaction; no albumin. Amount passed during the 24 hours after the urine was examined and the diet restricted, 30 ozs. No auto-acetic acid. After examining the urine I told the parents of the hopeless condition of their child. It was difficult for them to realize what I said, inasmuch as the child had been going about as usual, was at Sabbath school the day before I gave the grave prognosis, and was at that very time quiet, as much engaged with her dolls as she had previously been and was looking forward with much delight to the coming of Santa Claus one week hence. There was no history of unusual thirst. When the parents were asked regarding this, they said that possibly she did drink more water than usual latterly, but added that all their children drank a great deal of water; but they did not think she drank more than the others. The father volunteered the statement that she had lost flesh lately. Her appetite was less than usual for some time. She had suffered from a slight cold for about a month. On Dec. 20th, *i.e.*, three days after I examined the urine, I was called to see the child, and found her complaining of breathlessness and very restless; 21st, 8.30 a.m., Still recognizes friends. Slept little during the night; hands and feet cold; almost pulseless; 9.30 p.m., patient continued restless during the day, but now did not recognize anyone—comatose. The coma became more profound, and she died at 3.15 a.m. of the 22nd inst., *i.e.*, in less than five days after I examined her urine, or about five and a half days from my attention had first been called to her case.

THE REDUCTION OF TURBINAL HYPERTROPHIES.

BY D. J. GIBB WISHART, B.A., M.D.

This subject is perhaps worn threadbare—or it is too trivial a one with which to detain the members of a learned society—and yet I believe that you will all agree that on the question of the reduction of a turbinal hypertrophy something still remains to be said, and, further, that a great deal of what has already been said has led to abuses in the way of treatment.

It is true, and probably will always remain so, that a “stuffy nose” is the most common of the complaints of those of our patients who have become conscious that they own a nose, a condition that we describe under the title of “Chronic Hypertrophic Rhinitis,” although there is frequently little true hypertrophy to be found present. The tissues that are the offenders in this instance are the inferior turbinal bodies, with the mucous membrane covering them, and the sub-mucous erectile, or vascular tissue, that lies between this membrane and the bone.

Either through an increase in the connective tissue elements themselves, or through a multiplication and distension of the blood interspaces or sinuses, these tissues occupy a relatively greater space than they should, and cause a narrowing of the respiratory area of the nose.

The process need not be confined to the inferior turbinal body, but is to a lesser extent often found in the middle turbinal, chiefly at its anterior extremity and lower border, and in a still lesser degree in the coverings of the septum, anteriorly over the cartilage, and posteriorly just at the edge of the posterior nares, or over and around the apex, or sharpened edge of a septal deflection, which is chronically in contact with the outer wall.

Again, as we well know, while the process may be co-extensive with the inner or free surface, and the lower or free border of the turbinal body, it is apt to be exaggerated at one or more points, the favorite being the anterior and posterior extremities, the former interfering with free inspiration, and the latter with free expiration.

There are other elements which assist in producing the nasal stenosis, if not by direct influence upon the turbinal bodies, at least by so narrowing the passage that a lesser hypertrophy of the turbinal bodies suffices to produce obstruction; the commonest of these are deflections and irregularities in the surface or in the position of the septum, but we also find variations in shape, projection, and position of the turbinals themselves, and at times the whole nasal cavity is contracted congenitally without any of the component parts being chiefly to blame.

The above description has been necessary, because I have desired to show that respiratory insufficiency is not a simple, but a complex problem, requiring the most careful exploration by the eye and probe, and always with the assistance of cocaine and supra renal extract. This exploration must be done deliberately, after obtaining the patient's own account of the difficulty experienced, and with the elucidation provided by further questioning as we proceed with the examination.

More remote, but still most important considerations in a proper estimation of these cases, are the occupation, the environment, the climatic conditions which obtain, the nervous mechanism of the patient, the habits of life, the use of alcohol, tobacco, etc.

In no case can the surgeon rightly hope to arrive at a just conclusion of the precise measure to be adopted to relieve the nasal respiratory insufficiency, until he has canvassed each and all of the above elements in its production and maintenance, and has applied his matured experience to the solution of the problem.

In defiance of the considerations involved, and of the frequency with which the surgeon is called upon to deal with these cases, there is only too great reason to believe that they do not receive either proper diagnosis or treatment at the hands of the general practitioner, or, let us but whisper it, at the hands of the specialist.

If this be so—and every year of experience convinces me that a nasal insufficiency is always a difficult problem, and that failure to relieve is generally due to a failure to obtain a grasp of the elements of the problem—is it not the case that we are ourselves to blame?

How often do we read articles in which some "blanket" form of treatment is set forth in the well known terms of the patent medicine, as curing insufficiency and all allied near and remote conditions; and the general practitioner, for whose benefit these particular articles are always copied whole and scattered widely by means of the \$1 a year medical journal, furnished to all the profession, thinks that he has found a sovereign specific, and hastens to the assistance of his victim, confident in the fact that Dr. Blank, the eminent specialist, has "abandoned all other forms of treatment" in favor of this new method.

I desire to dissent most vigorously from such careless bargain day method of treating any form of nasal complaint, and especially turbinal hypertrophy, because it is so common, and because it is the one form of nasal trouble which the general practitioner is most likely to consider himself able to deal with. No, every case of nasal insufficiency requires careful diagnosis, and as careful treatment, each case strictly upon

its own merit, and from this it will follow certainly that every case may have a treatment differing in some detail from any other of its class, just to the extent that the shape of the turbinal bone, the position of the septum, the degree of the hypertrophy, the occupation of the patient, etc., may determine.

Turbinotomy, partial or complete, supra or a sub-mucous, cautevization, swabbing, spraying, linear incision, the cold or hot snare, all have their uses, but must not be abused, nor can the surgeon limit his treatment to any one of these. The utmost judgment is required in their use, and none of them are to be trifled with.

It is to be noted again that it is frequently urged by the advocates of some particular method of treatment that the others have been abandoned because the results were not permanent. Their result of treatment—permanency—is surely not one that can legitimately be expected in the treatment of the great majority of cases of turbinal hypertrophy, namely those where a reduction of the soft tissues will relieve the stenosis; in other words, it can only legitimately be expected where there is removal of bone or cartilage. This fact, however, is one that seems to be forgotten, or perhaps the surgeons believe permanency can be attained, and they endeavor to give effect to their beliefs.

How is it possible to so alter the turbinal tissues, that a patient may live on in the old surroundings, at the old trade, with the same nervous system and exposed to the same climatic conditions, and yet expect that these will not reproduce the nasal stenosis which they had so large a share in producing before.

It is certainly true that nasal insufficiency is a very common disorder in the cities which border our large lakes, whose inhabitants are exposed to such varying conditions in the temperature and moisture of the air they breathe; with the thermometer ranging from fifty degrees above to ten degrees below zero, in the twenty-four hours or less; with the wind that brought us snow from the north-west, veering round to the south-east, from whence it brings us rain next day—conditions which prevail on our great lake shores for at least four months of every year. It is nonsense to expect that the application of any drug or instrument to a turbinal hypertrophy can forever free the nasal passages of these citizens from the necessary effects of this climatic strain.

The tendency of turbinal hypertrophy is always toward a return, and the manner in which this should be met is not by wholesale destruction of the turbinal tissue, or by the securing of a patency of the respiratory area by an extensive removal of bone. We should advise our patients that they must sub-

mit themselves for regular examination, and regular treatment every six months, or at the utmost every year, and that if they but comply with this simple request, they will continue to enjoy at slight expense, and with moderate treatment, comparative immunity from the nasal insufficiency.

This is but urging the same line of action as we adopt with regard to the care of the teeth, and as we would probably adopt with regard to any other part of the body which was liable to break down.

In the December, 1900, issue of the *Laryngoscope*, Jackson mentioned a surgeon who for years had been cutting out both middle and inferior turbinals on both sides for the cure of every human ache and ailment wherever located. He should go further and substitute for the nasal mucous membrane and the structures upon which it is super-imposed, some device of equal usefulness with a complete set of artificial teeth, or the artificial larynx, and I ask their pardon for introducing them to such a companion, although the patient would be rendered immune to the effect of climate and entourage, and the surgeon's name would become immortal in Hades.

I am thankful to say that I have but once done a complete turbinotomy, and that was an accident. Total removal of a turbinal for nasal insufficiency I can hardly conceive of as possible, and it must be very clearly indicated indeed if even partial removal is thought of. The aim must always be to save every line of nasal mucous membrane that is possible, and therefore I would prefer to adopt the sub-mucous galvanopuncture, or the turbinal trocar, or the anglar handled Graefe knife, introduced through a linear puncture, in every instance that will admit. The spokeshave is inadmissible in the nose except for uses which I have indicated elsewhere. (See *Laryngoscope*, July, 1900), and the scissors or snare can accomplish all the clipping of the turbinal that is required.

Let us unite in advocating a conservatism in our methods of treating nasal insufficiency, and our patients will thank us, and our influence upon our fellow-practitioner will be for good and not harm.

47 GROSVENOR ST., June 20th, 1901.

Society Reports.

ONTARIO MEDICAL ASSOCIATION.

The twenty-first annual meeting of the Ontario Medical Association was held in the Educational Department, Toronto, on the 19th and 20th of June, 1901, the President, Dr. Angus McKinnon, of Guelph, in the chair. The secretary read the minutes of the last session of last year which were adopted.

The report of the Committee on Papers was presented by Dr. Machell, of Toronto, and the report of the Committee on Arrangements by Dr. Bruce L. Riordan.

Three Recent Gall-Stone Cases.

Dr. Wm. Oldright, Toronto, said that these cases had occurred recently in his practice. They present features of interest to the profession. The first case occurred in a woman about fifty-five years of age. He was rather surprised to be called upon to see her in a hurry, to find symptoms of gall-stone obstruction. The late Dr. Little had seen the patient and had endeavored to obtain purgation without effect. Powerful cathartics were unavailing. About nine months previously she had a similar attack, but Dr. Oldright had heard nothing about it until this attack. The symptoms were: somewhat elevated temperature (about 100 to 101), constant vomiting, obstruction, and, of course, intense pain. He supplemented Dr. Little's catharsis, but without any effect. On examination he could map out a distinct tumor, and told her that she had a distended gall bladder; advised her to go into the hospital, which she did that night. She was operated on in the afternoon, and he removed some gall-stones and endeavored to establish patency of the duct. He could feel no stones left behind, but there was some stenosis of the duct. There was a great deal of inflammatory action in this case. The gall bladder was stitched into the abdominal wall and drainage established in the usual method; bile flowed freely. The patient made a good recovery. The second case was one Dr. Oldright saw in consultation with Dr. McLean, of Woodbridge. She was sixty-five years old. The prognosis was certainly death without operation, and provided there was no malignant trouble she would probably recover. In this case one could imagine the difficulty there would have been had it been his first case of operation, as he could not locate the gall bladder. He came to the conclusion that it was not a case for further interference. Within twenty-four hours she succumbed to the shock, and probably to some hemorrhage. There was

no doubt after passing the finger in that it was malignant. If this woman had been operated on some years before, Dr. Oldright thought that malignancy would not have occurred and her life would have been saved. The third case occurred in a woman forty years of age. Upon her the surgeon operated last February. Here was a case in which there had been gall-stone symptoms, obstruction, for about eighteen months. She consented to an operation. The obstruction was in the cystic duct. He opened the gall bladder and took out the stones which he exhibited to his audience. The operation occupied about forty minutes. The patient made an uneventful recovery, and left the hospital thirteen days after the operation.

Dr. Garrett, of Kingston, said that operative interference in gall bladder surgery had only recently been brought into prominence. Early diagnosis is very important. We should operate at once when we make a diagnosis. He referred to a case which had been diagnosed as catarrh of the stomach upon which he had operated and had extracted 170 stones from the gall bladder.

Dr. T. Shaw Webster, Toronto, asked Dr. Oldright if there are not some cases where it would be better to wait for a little while, in cases where there is a strong probability that the condition will disappear in a short time.

Dr. Oldright in reply: As soon as we are satisfied of gall-stone obstruction, as soon as acute symptoms have subsided, we should operate, and not allow repeated attacks to go on until malignant disease is established.

Excision of Upper Jaw for Sarcoma.

Dr. Herbert A. Bruce, Toronto, presented this paper, whilst Dr. G. Silverthorne exhibited the specimen. Dr. Bruce also presented the patient, a woman thirty-four years of age, from whom he had removed the upper jaw for sarcoma. The patient had been sent to him by Dr. Bowles, of Woodhill. The history of the patient is, briefly, as follows: During the last week of January of this year she felt, for the first time, a slight swelling over the alveolus of the left jaw, which she thought to be a gum-boil. She consulted Dr. Bowles at the end of March, and Dr. Bruce saw her about the middle of April—that is less than three months after the first symptoms. Dr. Bruce operated upon her on the 29th of April, exactly three months after she had the first symptom. On examination he found a very hard swelling just behind the second bicuspid tooth and extending backwards to the full extent of the jaw. Internally, it had not extended to the middle line, and bulged externally to the extent of half an inch beyond what would be the line of the teeth. It extended backwards towards the antrum, but the latter did not

seem to be implicated externally. The growth in the roof of the mouth was covered by mucous membrane. On looking into the nose a polypoid mass was seen, and the patient had some difficulty in breathing through the left nostril. The cheek on the affected side was slightly more prominent, and it moved freely over the growth. No prominence of the eye on the affected side was to be made out. A small portion of the growth was removed under cocaine, and Dr. Silverthorne reported to Dr. Bruce that it was sarcoma. The patient left the hospital on the 18th of May and made an uninterrupted recovery.

Dr. Silverthorne presented the specimen to the members of the Association. It was the size of a large-sized orange, containing spindle cells with a cartilaginous basis.

Dr. Bruce stated that the history of the patient showed that a polypus had been removed about eight years ago, but he thought that it must have been a simple polypus.

Ectopic Gestation.

Dr. R. W. Garrett, Kingston, extended his thanks to the Committee on Papers for placing under his care a subject of such great magnitude. The subject is one of vital importance to every practitioner, for at any time he might be called upon to differentiate the condition from others with which it might be confounded. The responsibility of a life was in his hands, and demanded accurate diagnosis, medical acumen and judgment and ability to conduct the case to a favorable termination. He entered at considerable length as to the causation and earlier changes consequent upon ectopic gestation, and stated that every physician is expected to make a correct diagnosis of tubal pregnancy on the occurrence of rupture; and in a fairly large proportion of cases, to make a diagnosis before the occurrence of rupture. Theoretically the arrest of a fructified ovum may occur first in the ovary; second, in the abdominal cavity between the ovary and tube; third, within the tube; and fourth, between the tube and the uterus. He would direct the attention of his audience to but one kind only,—arrest within the tube, or tubal pregnancy, as all other varieties are but merely developments of this kind, owing to secondary invasion of the fallopian tube. These he divided into three groups: First, tubo-abdominal, or simply abdominal pregnancy, in which there is a secondary invasion of the abdomen; second, tubo-ligamentary, in which there is a secondary invasion of the broad ligament and subperitoneal tissues; and, third, that sub-division of the tubo-uterine in which there is rupture into or secondary invasion of the uterus. At considerable length he discussed the etiology, then the

symptoms, pointing out the difficulties that lie in the road to making a diagnosis owing to the absence of many, if not all of the classical symptoms generally enumerated. Having dealt in a masterly manner with these, he recited a very interesting case in illustration of his contention of the difficulties of diagnosis.

Dr. J. F. W. Ross followed Dr. Garrett in the discussion regarding the diagnosis as the most important point of all, and especially the diagnosis before rupture. He thought that we ought to be able to diagnose these cases before rupture had taken place. What are the symptoms? Generally four or five symptoms. He referred to the pain that is indefinite, not severe, not acute, but a feeling as if something were wrong. He referred to several cases recently seen in practice.

Dr. Powell referred to a case where Dr. Ross had diagnosed these conditions before rupture had occurred.

Dr. Oldright mentioned a double rupture of both tubes.

Dr. A. A. MacDonald complimented Dr. Garrett on the careful manner in which he entered into his subject, and thought it was one of the greatest importance to the general practitioner. He remembers the time when it was stated that no one could make the diagnosis before rupture. He referred to a case which came into Bellevue Hospital, in Toronto, comparatively recently—a case of twins, in which one child was delivered in the natural way, and the other child ectopic.

Dr. T. S. Webster said that the subject was one that he had taken a great deal of interest in, and has had to deal with four of these cases.

Dr. Prevost, Ottawa, showed a specimen and said that sometimes, in spite of the most accurate diagnosis, we make mistakes. He described the case, the specimen of which he presented.

Dr. A. F. McKenzie, Monkton, referred to a case seen in his practice, which went on to full term and was delivered of a large child and no trouble. He further spoke of the difficulty in making the diagnosis in these cases.

Dr. Machell thinks the interest centres in the diagnosis.

Dr. McKinnon, the President, stated that he had not had much experience with these cases before rupture, but had had a little experience after rupture. He thought frequently there might be danger in making a mistake. He also cited a case occurring in a young married woman with a little child five or six years old.

Dr. Garrett closed the discussion, and thanked the members for their generous treatment of his paper. He considered that discussions of this character were of the greatest moment. Rupture is generally about the third month, and interstitial pregnancy can go on to a much longer term than tubal pregnancy, and in this form we generally have external rupture.

FIRST DAY—AFTERNOON SESSION.

PRESIDENT'S ADDRESS.

Dr. McKimmon delivered a very able address on the opening of the afternoon session. He considered that it was a great honor to be elected president of this, the largest and most influential medical association in the Dominion of Canada. Having referred to the success of the meeting so far, he proceeded to contrast the state of medicine at the beginning of the last century with that of the present, and compared the vast advantages we to-day possess over those of one hundred years ago. Anesthesia, antiseptics, asepsis, vaccination, the anti-toxin treatment for diphtheria, the discovery of the bacillus of tuberculosis were mentioned, and he looked for the dawn, in no far-distant day, of that grand and glorious day when we can say to the world that tuberculosis and cancer can both be cured. He deplored the growth in the employment of new proprietary remedies, and thought that harm was being done to the medical profession by manufacturing firms making up pills for neuralgia, for malaria, etc. He considered that the literature and drugs sent out to medical men by these manufacturing houses had become an intolerable nuisance. The electric belt man, the Christian Scientist, the advertising cancer-curer, the osteopath, and many other such like fakes which hang on to the skirts of medicine, he scored most unmercifully, and regretted that the public press, both secular and religious, opened their columns freely to these fulsome, untruthful, and sometimes immoral advertisements, because they pay well. There was great danger to the public in permitting Christian Scientists, the "pray-for-hire healers" and the "Dowieites," impudently undertaking to cure infectious diseases, such as diphtheria, scarlet fever and smallpox—diseases which they are unable to recognize, and he thinks that we have come to a point where toleration and forbearance become criminal. The 2,500 medical men in Ontario should have influence enough to obtain from the Legislature an amendment to the Medical Act that will put an end to this trifling with human life. He directed attention to the delay that occurs in securing admission to the asylums for people, the subjects of acute mania, and thought it was high time the necessary steps in this department in the practice of medicine should be simplified.

Pulmonary Tuberculosis—Its Treatment in Special Sanatoria.

Dr. J. H. Elliott, Medical Superintendent of the Sanatorium at Gravenhurst, read this paper. Speaking generally, it may be said that from fifty to seventy per cent. of the incipient

cases are restored to health, while from all classes from fifteen to thirty per cent. are reported cured or arrested; in sixty to seventy per cent. a marked improvement. The first thing noticeable after entering the sanatoria, in most cases, is an improved appetite, a gradual gain in weight, and a decline in the evening temperature. With this improvement night sweats disappear without medication, the cough and expectoration noticeably lessen, and the patient sleeps until morning. The principles generally adopted are: First, a continual life in the open air, with rest or exercise as indicated; second, a liberal, suitable diet; third, medicinal treatment according to indications, and to a great extent symptomatic; fourth, hydro-therapy; fifth, a strict medical supervision of the patient's daily life.

Speaking of the "rest-cure" in febrile cases, the object is to reduce muscular exertion to the least point consistent with the ingestion and proper assimilation of a good diet. Referring to medical treatment, with a hygienic life pure medicines are required. The various tuberculins and serums are being used both in America and Europe, with the prospects of yet securing a specific for those cases where mixed infection is absent. Constant supervision of the patient is the most important point in which the sanatorium treatment must necessarily differ from that adopted by the general practitioner. Living, as he does, with his patients, adopting their mode of life, having his meals in common with them, the physician is enabled to individualize the treatment, and though on broad lines the patients all receive the same treatment, each one has to be studied in detail, and the indications met accordingly. The chief point, under all circumstances, is that the patients, wherever they be, live prudently, and be under the care of an intelligent and firm physician.

Dr. Price-Brown referred to the advisability of sending patients for sanatorial treatment, and stated that we have for every disease places to send our patients—hospitals throughout the length and breadth of the land—except for tuberculosis. Having recently been at Asheville, N.C., he described the treatment which he had seen carried on in that institution.

Dr. John Hunter, Toronto, deprecated sending these patients long distances away from their homes, which was formerly the custom, but is not so now. He hoped to see the time when there would be a large number of these institutions established in this country.

Dr. Elliott, in reply, emphasized the point that there should be no exercise when the evening temperature is above ninety-nine degrees; it may be permitted in the morning if it reaches one hundred or one hundred and a half, but not in the evening.

Vaccinal Protection Against Smallpox.

Dr. P. H. Bryce, Toronto, the Secretary of the Provincial Board of Health, presented this paper. In the introduction to his paper he expressed the belief that although the practice of vaccination against smallpox has existed for a century, there never was a time since it was formally accepted by the profession, when there was so much expressed scepticism as there was to-day on the part of the laity with regard to its protective qualities, and never a time when the profession has been so indifferent as to impressing the necessity of its proper performance upon the public. In Ontario, between 1898 and 1899, there were but twenty-two recorded deaths from the disease. He made special reference to the art of vaccination and the quality of the lymph, and thought five separate insertions should be made in each case. The quality of the lymph was very important. He thought that a medical man going out from college did not receive sufficient practical instruction on this most important subject.

Mr. I. H. Cameron discussed Dr. Bryce's paper and stated, as a matter of fact, he had no hesitation whatever in seeing a case of smallpox himself, nor would he object to any member of his family seeing it, if he knew that they had sufficient protection through vaccination. He warned the profession against laxity in dealing with this most important subject.

Dr. Harrison, Selkirk, stated that he had had considerable experience with smallpox, and on account of that experience he entered a vigorous protest against the prevailing carelessness in insisting on vaccination and re-vaccination in the laity as well as the profession.

Dr. John Hunter, stated that in many cases he had failed to secure successful vaccination.

Dr. Geikie considered that Jenner's discovery was one of the greatest and grandest achievements in medicine.

Dr. Price-Brown referred to a case in the General Hospital in the year 1866.

Dr. Rudolf asked Dr. Bryce whether the instructions given along with lymph supplied by different firms were not partially to blame for the insufficient vaccination among the profession. He considered that no one should be guided by those instructions.

Dr. Bryce, in reply, thanked Mr. Cameron for taking up the discussion. He considered that the profession was lamentably ignorant of the nature of protection and protective qualities of vaccination itself.

Dr. D. J. Gibb-Wishart suggested that a resolution be passed by the Association expressing its approval of from three to five insertions and advising manufacturers interested in the matter.

Dr. Thistle thought that they should not stipulate the number of marks, that it would not be wise, as many successful vaccinations had been obtained from one mark.

Dr. Stewart, of the Ontario Vaccine Farm, Palmerston, thought four or five marks better, so situated that there would be no coalescence.

Dr. McPhedran did not wonder that the younger members of the profession were weak as regards the diagnosis of smallpox when facilities for instruction in clinical work was absolutely nil, he had repeatedly asked to be permitted to take a class to the Infectious Diseases Hospital, but had always been denied.

Dr. Noble, Philadelphia, thought as a surgeon that something else might have been said about the care of the vaccination wounds. The wounds should be protected, so that there would be no chance of infection.

DISCUSSION ON EMPYEMA.

Medical Aspect.—This subject was introduced in a well prepared paper by Dr. Ferguson, London, who said that the treatment of this condition was essentially surgical, and that the medical aspects of the disease were limited to a consideration of its pathogenesis and prophylaxis. He considered that the conditions of non-purulent or primary effusion indispensable to an understanding of the pathogenesis of empyema. He gave a description of the pleura and discussed the bacteriological aspect of purulent pleurisy, which he divided into four classes: First, those due to pneumococci; second, those due to streptococci (and staphylococci); third, those due to the bacilli of tuberculosis, and fourth, those caused by saprogenic organisms. In nine cases, extending over eleven years in his practice, three were diagnosed tubercular, three meta-pneumonic, two due to the streptococci, and one undermined. The prognosis varies with the micro-organism present, the pneumococci being the most benign. It is the only variety of purulent empyema that may possibly yield to treatment by mere aspiration, especially in children. Tubercular empyema is usually mixed infection. The prognosis here will depend upon the general condition of the patient and the character of the mixed infection. We therefore see the importance of a bacteriological examination as in any other debilitating disease, supporting and tonic treatment is essential. With the advent of pus, surgical means must be adopted.

Surgical Aspect.—Introduced by Dr. J. L. Turnbull, Goderich. When the presence of pus is determined it should be evacuated at once, as there is always the danger of the abscess bursting into or through the chest wall, or even through the diaphragm and producing peritonitis. Aspiration need not be

described; remember not to remove the fluid too rapidly. In this, as in an ordinary abscess, it is not necessary to open at the most dependent point. The preferable way, and the one which Dr. Turnbull always uses when a diagnosis of pus is made, is to remove a portion of a rib; an inch and a half may be cut out, preferably with the saw, under strict antiseptic precaution. Dr. Turnbull advises washing out every day when pus is offensive, and the drainage tube gradually shortened until it can be removed altogether. Where a cavity and sinus remains after this operation, the sinus may become closed and a second empyema established. This requires an Estlander's operation, and one of the best ways is to carefully locate size and boundaries of cavity with a probe, and after dissecting up a flap of skin, to be sure to remove enough bone. The hard fibrous tissue beneath the ribs, which is always present in quantity there, must be thoroughly removed. Dr. Turnbull advises mopping out with pure carbolic acid, then with alcohol to prevent poisoning and then with sterilized water, the part being carefully dried.

Dr. J. C. Mitchell considered that these cases shou'd be dealt with purely on the same principles as an ordinary abscess. He has seen more cases in adults than in children. He considers that a good many of them are tubercular.

Dr. Powell took exception to Dr. Mitchell styling empyema as being only ordinary abscess. He considered that it was something more, because lung was pressing on one side of it. He exhibited an instrument which he used in the operation.

Dr. John Hunter mentioned a case where air entered the cellular tissue in the skin, and universal empyema set up.

Dr. Primrose considered it an important point to know whether the case was one of mixed infection. He does not think we have taken all the advantage we might do of the researches that are made in the bacteriological laboratory.

Dr. Thistle said that one point had not been referred to which he considered of first importance in successful treatment—the time at which operation should take place. That is the crucial point in securing success in these cases. The earlier the operation is done the speedier the cure, and in many of the cases which run into chronic empyemata, the result was due to the lateness of the operation.

Dr. McKeown said that there were three points of importance, to his mind—recognized that pus is present; that we want to get at it; and that we want to get the cavity closed up.

Dr. McPhedran considered that these cases should be diagnosed very early, and are easily treated, as a rule. One should be on his guard in a case of pneumonia when the temperature

falls about the eighth day to near the normal; if it commenced to rise again it is suspicious of empyema.

Dr. Freel, Stouffville, considered that it was better to resect the rib with proper dressing and tube than to aspirate.

Dr. Rudolf—So far it seems to be the opinion of this meeting that where pus is discovered in the plural cavity it should be removed by operation. He thinks there is one exception to that; that is, where an empyema exists along with tuberculosis of the lungs. In this condition, where pus is found, it should not be at once removed without careful consideration.

Dr. Turnbull, in reply, considered that it was best that the rib should be removed in every case. He does not think it necessary to wash out the cavity in every case; only where the discharge is offensive. The tube should be long enough to go into the cavity.

Dr. Ferguson, in reply—Early diagnosis, with the aid of the bacteriologist, will add much to the after treatment.

FIRST DAY—EVENING SESSION.

Open-Air Treatment of Disease.

By Dr. George H. Carveth, Toronto, who described his method of treating different forms of disease: First, in the house with wide-open windows; second, in beds on the verandah; third, in beds under tents on the lawn. At first he experienced some difficulty in getting his patients to consent to be treated in this manner, but after they had become habituated to life in the open air, they returned indoors reluctantly. Some of the cases that he has treated in this way are iritis, cases of fracture, cases of the radical cure of hernia, rheumatoid arthritis, tubercular disease of the spine, typhoid fever, and a case of hysterectomy. His address was illustrated by lantern slide projections on the canvas, which proved very interesting to the members of the Association.

Dr. P. H. Bryce spoke of the value of treating smallpox patients in tents. The tents should be double roofed, and double floored, and double walled, and each tent provided with a stove. The patients lived in these when the thermometer was 20 degrees below zero, being quite comfortable. Nobody died, although many were seriously sick.

Dr. Freel, Stouffville, recited the history of the case of a clergyman, the victim of tuberculosis, who lived in his tent all winter when the thermometer was 20 degrees below zero, and the wind blowing a perfect gale, and he was very comfortable. In a few months' time he ceased sweating, and gained very rapidly in weight, to such an extent that delivering a sermon

would not throw him into a perspiration, as it always did before he took up tent-life on his lawn.

Dr. J. H. Elliott, Gravenhurst, saw no reason why out-door life should not be employed in the treatment of other diseases as well as tuberculosis. It is not specific, and the only reason it is used is to strengthen the organism to resist disease. It is practically returning to primitive life, and it is so comfortable and pleasant that you find it very difficult to get patients to return to the house.

Dr. John Hunter referred to the Orphans' Home, Toronto, where they keep about two hundred children. These are admitted about four years of age and they are kept there until they are about fourteen. Their mortality in that institution is about three in one thousand. They are practically kept out of doors all the time, and comparisons between the children of the Orphans' Home and the children of the well-to-do people of the city are greatly in the former's favor.

Dr. Webster—The trouble is not so much to get the patients to sleep out of doors as it is to get them to return to the house when they have once been out of doors.

Dr. G. S. Ryerson, speaking of his visit to South Africa, said that at Bloemfontein the typhoid fever patients did particularly well in tents. The mortality was much larger in buildings improvised and used as hospitals. He considered that it was well to have the roof of a tent of material of some dark color, such as green or brown, because the patient, lying on his back, begins to complain of the color of the roof.

On the Use of Nitrous Oxide and Ether as an Anesthetic.

This paper was prepared and read by Dr. L. Coyteux Prevost, of Ottawa, and it proved to be highly interesting, carefully prepared, and ably delivered. He considers that a good and satisfactory anesthetic must possess the following qualities: First, offer the least possible harm for the patient; second, be rapid; third, complete; fourth, permanent; fifth, followed by as few disagreeable post-operative effects as possible. He then proceeded to relate the results of his personal experience during the last two years at the hospital in Ottawa, as well as in his private practice; Dr. Carroll, of Ottawa, was his assistant in this work. The agent they employ is ether, with which they lately have associated nitrous oxide, which is given at the beginning of anesthesia by the means of Clover's inhaler. He considers this method as absolutely ideal, as much for the rapidity with which the patient becomes anesthetized as for the freedom from all unpleasant sensations during the process of anesthetization and the diminution of after-symptoms so fre-

quent after operations. The apparatus which they have been using for the nitrous oxide and ether is Hewitt's inhaler, which is a modification of a Clover inhaler, with the rubber bag replaced by a large bag with valvular attachments. Within the last two years they have used this method almost exclusively, and the results are as follows: Anesthesia in one minute, twenty-four times out of three hundred and seven cases recorded; in one and a half minutes, fifty-five times; in two minutes, ninety-four times; in two and a half minutes, forty-seven times; in three minutes, forty-four times; in three and a half minutes, nine times; in four minutes, nineteen times; in five minutes, fourteen times. Dr. Prevost then entered into his observations with regard to the effect of the anesthetics upon the kidneys, and stated out of 434 observations albumen was found twenty-six times. He drew attention to the fact that post-operative vomiting was very rare. Dr. Prevost was the first surgeon in Canada to employ intro-spinal cocainization. He believes that so long as the old and well-tried anesthetic agents, handled by competent men, continue to give good satisfaction that it will not be wise to abandon them until medullary narcosis has been clearly demonstrated.

The Complications and Degenerations of Fibroid Tumors of the Uterus.

Dr. Chas. T. Noble, Philadelphia, delivered an able and exhaustive paper under the above heading, an abstract of which will be published in a subsequent issue.

Drs. J. F. W. Ross, N. A. Powell, McKinnon, and Clouse discussed the paper, to which Dr. Noble replied.

SECOND DAY—MORNING SESSION.

The Relations of Nasal Obstructions to Obscure Cases of Asthma.

This paper was read by title by Dr. Arthur W. Mayburry, of Toronto. Patients suffering from nasal obstruction are frequently coming before the notice of the busy practitioner. Asthma has a complex etiology, and the close association of this disease with nasal trouble is sometimes very remarkable. Adenoid growths in the pharynx frequently cause asthma, and in recent years much stress has been laid on the nasal origin of this disease. The author quoted Bosworth, who goes so far as to assert that asthma, in a large proportion of cases, is attributed to some form of nasal obstruction, the bronchial spasm being caused through reflex sympathy conducted along the fifth nerve.

On the importance of an Early Recognition of Locomotor Ataxia.

Dr. J. T. Duncan, Toronto, read this paper, and emphasized the importance of being able to diagnose this disease in order that prompt treatment might be applied. To do this we must be able to recognize the pre-ataxic stage. What are these symptoms? Professor Osler gives them as pains, ocular symptoms, and loss of the knee jerk. What are the ocular symptoms? Strabismus or squint; ptosis or drooping of the eyelid; the fixed pupil (the Argyll-Robertson pupil); inequality of the pupils and optic atrophy.

Notes on the Use of Adrenalin.

Dr. D. J. Gibb-Wishart, Toronto. This is the formula which Dr. Wishart has been using in his office practice, having made several hundred applications, chiefly to the mucous membrane of the nose; one in one thousand, the chloride being dissolved in normal salt solution containing 0.5 per cent. chloretone solution. A 10 per cent. dilution of the above solution, which dilution is equivalent to one in 10,000, has been sufficient to contract the blood vessels in the membranes in a few seconds, and a repetition of the same, or the use of a stronger dilution, will blanch these membranes; especially is this seen to be marked in the nose, where the membranes will become tightly drawn over the turbinated bones, which show up white through them. It has proven itself to be highly useful in rendering operations about the nose practically bloodless; it is not found to answer so well in the removal of adenoids or enlarged tonsils. Dr. Wishart mentioned two cases in particular where it acted very promptly. The bottle in which it is kept must be tightly corked; and the properties of the substance are not destroyed by heat. Since he has added chloretone he is perfectly satisfied as to the stability of the preparation for all practical purposes. In no instance has there been a tendency to increase in the amount of the bleeding. Dr. Wishart considers that the drug is a valuable addition to our armamentarium.

Dr. Duncan's paper was discussed by Dr. Wishart, Dr. Trow, and Dr. Hunter; while Dr. Wishart's paper brought out a discussion from Dr. Trow, Dr. McPhedran, and Dr. Graham Chambers. Dr. Wishart and Dr. Duncan replied respectively.

DISCUSSION ON GASTRIC ULCER.

Medical Aspect.—This was introduced by Dr. R. D. Rudolf, Toronto. In opening the discussion from a medical point of view, he gave a short historical sketch of the chief literature of the subject, and said during the last thirty years only one important symptom had been added to those mentioned by previous writers, viz.: the very common occurrence of hyperchlor-

hydria. Avoiding the consideration of the well-known points on the subject, he propounded five questions in connection with gastric ulcer which seemed to him to specially merit discussion. First, is there any relation between gastric ulcer and cancer? Trousseau believed that an actual antagonism existed between the two conditions, while Lebert considered that 9 per cent. of all gastric cancers so arose, and Rosenheim states that 5 to 6 per cent. of all gastric ulcers became carcinomatous. Clinically, the speaker had never seen a case of simple ulcer end in cancer, nor had he seen a case of cancer preceded by ulcer, although such cases undoubtedly occasionally occurred. Dr. Rudolf had seen pathological specimens illustrating both. Second: Can we diagnose the site of gastric ulcer? This question is becoming more important on account of operations. Ewald states that in 90 per cent. of cases it is impossible to tell whether the ulcer is in the stomach or duodenum, and that usually it is hard to diagnose the site in the stomach. Most gastric ulcers occur on the posterior wall, near the pyloric end. The site of the pain and tenderness; the time the pain occurs after food; the position in which the patient is free from pain, and the presence or absence of gastric dilatation may help, but these are very uncertain facts to lean upon. Thus, in Pinel's famous case, mentioned by Abercrombie, where the patient was *known* to have ulcers near the pylorus, the pain used to occur *immediately* after taking food. The taking the food may not only mechanically irritate the ulcer, but by stimulating the acid secretion peristalsis may cause pain without touching the ulcer. It must further be remembered that there are sometimes several ulcers present. Third question: Does ergot ever stop gastric hemorrhage? Most authorities recommend ergot without question, but we must remember that the hemorrhage tends to be self-limiting from the lowering of the blood pressure and the forming of a clot, and ergot may interfere with this natural cure by raising the blood pressure. Turpentine and other local styptics have no such objection, and calcium chloride increases the tendency to clotting. Fourth question: Are cases of apparently "cured" gastric ulcer "first-class lives" for insurance? The speaker did not think that they were, because sudden perforation might occur after years of quiescence (he had seen two such cases). Ulcers were apt to relapse or to break out in new places. The severer the symptoms the ulcer had been at the time, especially the hemorrhage, and the shorter the period since its occurrence, the worse the "life" was. Fifth question: As regards operation, as soon as perforation into the peritoneal cavity be diagnosed operation should at once be performed; as regards operation where no perforation exists the question was not so easily settled. Severe, uncontrollable hemorrhage might

occasionally call for surgical treatment, but the mortality from hemorrhage is surprisingly small, even when this is severe. Dr. Mayo Robson had recently recommended "that after a second bleeding, even during the course of the hemorrhage, if the patient can stand it, or as soon after as his condition will admit, the operation should be done." The speaker was glad to see that his old teacher, Dr. Byrom Bramwell, challenged this advice (*The Lancet*, March 9, 1900, page 687). Operation for the less urgent symptoms of gastric ulcer would occasionally be necessary, but in this direction we should proceed with great caution. Dr. Moynihan, in a recent paper (*The Lancet*, April 27, 1901,) gave a summary of all the cases to date in which gastro-plasty or gastro-gastrostomy had been performed for "hour-glass stomach." They amounted to thirty-eight in all, and nine of them were fatal, while in many complete relief of symptoms occurred.

Pathology.—This branch of the discussion was led by Dr. H. B. Anderson, Toronto. In his opening remarks he said he would make no reference to ulceration resulting from the breaking down of tubercular foci, syphilitic gummata, or malignant growths, nor of ulceration occurring during the course of acute infective diseases nor resulting from the action of corrosive poisons, but would limit the discussion to a consideration of the commonly designated simple, round, perforating or peptic ulcer. From the similarity in all essential points, however, he included the corresponding ulcer at the lower end of the esophagus and in the first part of the duodenum. From post-mortem statistics the frequency of gastric ulcer was in about 5 per cent. of cases, cicatrices being found about three times as often as healed ulcers. From his own experience at autopsies in Toronto he was sure that gastric ulcer did not occur in Ontario so frequently as indicated by the above figures.

The condition occurred most frequently in adults from twenty to forty years of age, but was by no means rare at the extremes of life. The mortality was greater from forty to sixty years of age, no doubt from the lessened reparative power at that period of life. Females were affected more frequently than males, in about the proportion of two to one.

The etiological import of other diseases, especially chlorosis, was dwelt upon. Injury was a factor in rare instances, a statement substantiated by certain experimental data. Occupation, race, climate, habits—all had an indirect influence in some cases, and arterial sclerosis, thrombosis and embolism of the gastric vessels were occasional factors in the etiology of the condition.

All these facts were, however, of secondary importance, and were only active in the presence of an altered condition of the

gastric secretion. The localities where this form of ulceration occurred—at the lower end of the esophagus, in the stomach, and in the first part of the duodenum—situations exposed to the action of the gastric juice, as well as the not infrequent occurrence of post-mortem digestion of the walls of the stomach, were strongly suggestive of the importance of this factor, and this had received further direct proof from the discovery of the frequent occurrence of a hyperchlorhydria associated with gastric ulcer from a chemical analysis of the stomach contents obtained after test meals. The failure to find this condition in some cases was not proof that it had not existed at an earlier period in the disease, for the hyperchlorhydria might afterwards have been lessened as the result of the greater or less degree of gastritis following on the wake of the ulcer. Ulceration did not occur unless there was a disproportion between the acidity of the gastric juice and the condition of the blood. Normally autodigestion of the walls of the stomach was prevented, not by a simple chemical action in which the acid was neutralized by the alkalinity of the blood and fluids in the tissues, but by the vital resistance of the living cells of the part. He did not think there was anything to uphold the bacterial origin of this form of ulcer urged by some authors.

The pathological anatomy of gastric ulcer and its various terminations were discussed and illustrated by specimens. Healing was the fortunate result in the majority of cases. At other times a fistulous communication was formed with the duodenum, colon, or the cutaneous surface, or a subphrenic abscess might result. Adhesion to the pancreas, liver, or to the omentum frequently walled the trouble off. Not infrequently, however, peritoneal infection from perforation occurred, and the symptoms might be so intense as to simulate irritant poisoning. Gastrectasia, or "hour-glass" deformity, from cicatricial contraction at the pyloric orifice, or in the centre of the organ, at times gave rise to serious results. A specimen, showing the development of a carcinoma at the base of an ulcer, with a clinical history extending over many years, was presented.

Surgical Aspect.—Dr. Henry Howitt, Guelph, conducted this part of the discussion, and said: Did it never strike you as being peculiar that the best remedies, nitrate of silver, and so forth, are germ destroyers? He first took up the procedures for dealing with the ulcer or its results, in which perforation is not a factor. In all the operative procedures it was essential to prevent infection of the wound; stomach should be thoroughly washed with aseptic water, by means of siphon tube, immediately before the anesthetic is administered. It is not necessary to make the abdominal incision extensive; the length of the incision would depend upon the amount of contraction, and it is

sutured in such a manner that when closed the line of union is at right angles to the original incision. This gives excellent results when properly done. Adhesions render this ideal operation impracticable. The first successful operation in Canada was performed in Toronto, 1894, by Dr. Atherton. Up to last September in the neighborhood of 300 operations were reported, with a mortality of a little over 45 per cent. Dr. Howitt then referred to cases in his own practice. With regard to the treatment, Dr. Howitt said that as soon as we are satisfied that perforation has taken place, referring to acute cases, he believes it is good practice to give morphia hypodermically, and it further lessens the amount of the anesthetic, in the opinion of many. Success largely depends on the shortness of time before operation; delay is dangerous. It is Dr. Howitt's practice to eviscerate the bowels; one or more small incisions in the prominent coils soon overcome the distension, and each one is closed before another is made. Attention is now turned to the stomach and the part brought into the wound. The ulcer is incised and opening closed with two or three layers of sutures. When the trouble is in the posterior wall it may be impossible to excise it, in which case it can be generally inverted and closed by layers of sutures. The abdominal cavity should be thoroughly flushed with a stream of saline solution. When drainage is necessary the tubes or gauze should not be introduced through a large wound. The object should be to have primary union to take place in the incision.

Dr. McPhedran, referring to the treatment of simple ulcer, said that the treatment for this is one that is not carried out very effectively. If not successful after a month of rest in bed with medicinal treatment, he would advise operation.

Dr. J. F. W. Ross referred to a case of catarrh of the stomach in a woman of fifty-nine pounds, and where he was satisfied before operation that he had to deal with a cancer of the stomach. She recovered and rapidly gained in weight until she reached 140 pounds.

Dr. Bruce referred to a case upon which he had operated.

Drs. Rudolf, Anderson and Howitt replied.

Vaginal Section, Exploratory and Operative.

Dr. T. Shaw Webster read a paper with the above title describing several operations performed in that way, one being for ectopic gestation. He reported good success in them from the vaginal route.

Dr. Noble thought the vaginal route all right for abscesses, but had a preference for the abdominal in pelvic operations.

Drs. Bruce, Macdonald, Oldright, Ferguson. (London), W. J.

Wilson and Clouse discussed this paper, the discussion proving an interesting one.

Dr. Webster replied and defended his position ably.

Dr. Bruce L. Riordan now passed through the theatre announcing that luncheon was now ready in the dining-car, so there was an immediate bolt for the door, and all were soon enjoying themselves at a very fine spread provided by the Committee on Arrangements. Afterwards, bright and happy speeches were made by several of the members, the audience simply calling for their favorites, and no one being specially set down for any toasts. Amongst others who said some good things were Drs. Harrison, Dean Geikie, J. C. Mitchell, N. A. Powell, George Bingham and the President.

SECOND DAY—AFTERNOON SESSION.

The Roentgen Rays in the Diagnosis of Urinary and Biliary Calculi.

This paper, X-ray photos and specimens of calculi, which proved a very interesting demonstration, was presented by Dr. S. Cummings, of Hamilton.

Dr. McGillivray, Toronto, asked if the diagnosis is always positive.

Dr. Cummings replied that if any errors, they are due to operator, not to X-ray itself.

There was a demonstration of skiagraphs in an adjoining room.

Preliminary Report on the Relations of Hyperchlorhydria to "Bilious Attacks," Some Forms of Eczema, Gout and Muscular Rheumatism.

Dr. Graham Chambers, Toronto, stated that on several occasions he had examined the gastric contents of patients of apparently normal digestion and found hydrochloric superacidity, although in some of them there was a history of "bilious attacks," which were probably attacks of hyperacidity. He considers that the gastric distress, which is present in these cases, is more or less due to the hyperesthesia of the mucous membrane of the stomach, as well as to the excessive acid contents. The commingling of these two neuroses, hyperchlorhydria and hyperesthesia gastrica, makes an investigation into the relations of the former to "bilious attacks," eczema, muscular rheumatism and gout a very definite one, but he cannot but think that a general irritable condition of the gastric nerves must produce some changes in the sympathetic and cerebro-spinal centres, which would no doubt lead, or tend to lead, to

disease in other organs. Dr. Chambers' attention was first called to this subject about two years ago, when he observed that the internal treatment, both dietetic and medicinal, which he was accustomed to give in cases of hyperchlorhydria, was approximately the same as that which he was using in some forms of acute eczema, and in both cases it gave very satisfactory results. In his experience "bilious attacks" are very frequent in cases of chronic hyperchlorhydria; he has also found that symptoms of indigestion are of frequent occurrence in eczema, and are usually of a character which indicates hyperchlorhydria. He has examined the gastric contents of six cases of eczema, with symptoms of dyspepsia, and in five of these there was an excess of HCl. in the gastric contents. He gave notes of cases in illustration of his researches. "Acidity" is a common symptom in gouty subjects, and Dr. Chambers believes that a thorough investigation of the subject would prove that the "acidity" of the gastric contents is not due to organic acid at all, but that hydrochloric acid will be found to play an important part in it. With regard to muscular rheumatism, we know very little about the etiology of it. Clinically, we have found that muscular rheumatism and gout are in some way related; and in regard to relations of hyperchlorhydria and muscular rheumatism, Dr. Chambers has observed that they are frequently associated, but whether the muscular rheumatism is the result of the hyperchlorhydria, he is at the present time unable to say.

Dr. Bryce discussed the paper.

Medical Treatment of Surgical Tuberculosis.

Dr. W. B. Thistle, Toronto, said: It is important to remember this fact, that there is no difference in the nature of the disease, whether considered surgically or medically, and especially is this so when we come to consider treatment. We hear on all sides that it is a curable disease, and complete cure often now happily results from medical treatment. Dr. Thistle has observed that tubercular cases requiring surgical treatment in the great majority receive little or no medical treatment. The subjects of surgical tuberculosis should have the fullest advantage of sunshine and fresh air as well as those suffering from the disease in its medical aspect.

Treatment of Post-operative Peritonitis.

By Dr. Walter McKeown, Toronto. The paper suggested that this condition should be treated by the use of decinormal salt solution, either subcutaneously or intravenously, and enemata of strong solutions of sulphate of magnesia. The toxins will dialyze; the antitoxins will not. If, then, the toxins can be

eliminated with sufficient rapidity, the disease will limit itself as a result of the formation of antitoxin together with the plugging of the peritoneal lymphatics. The blood is diluted by the addition of the salt solution, and this is drawn out into the rectum by means of a higher osmotic pressure carrying the toxins with it. He claims that even with a condition of paralysis of the bowel, toxins will dialyze in this way. He suggests that if a patient were placed in a salt bath, the toxins would probably osmose directly through the skin. That osmosis does not take place from without in through the skin, does not prove that the reverse process will not occur. Osmosis is known to take place much more rapidly in one direction through the shell membrane of the egg than the other.

SECOND DAY—EVENING SESSION.

Dr. R. A. Pyne, the First Vice-President, occupied the chair.

The Committee on Credentials recommended the following for membership, which was adopted: Dr. R. W. Garrett, Kingston; George Sherk, Cheapside; W. A. Scott, Courtright; Daniel Buchanan, Galt; L. C. Prevost, Ottawa; Milton Baker, Springfield; Donald McGillivray, Toronto; A. E. MacColl, Belleville; Arthur I. Brown, Holstein.

The following constituted the Nominating Committee: Drs. Geo. A. Bingham, A. McPhedrân, Burt (of Paris), Powell (of Toronto), Mitchell (of Enniskillen), Harrison (of Selkirk), and Macdonald (of Toronto), Drs. E. Clouse and Price-Brown acting as scrutineers.

This committee reported as follows, which, on motion, was received and adopted:

President, Dr. N. A. Powell, Toronto; First Vice-President, R. Ferguson, London; Second Vice, R. W. Garrett, Kingston; Third, L. C. Prevost, Ottawa; Fourth, R. L. Turnbull, Goderich; General Secretary, Harold C. Parsons, Toronto; Assistant, George Elliott, Toronto; Treasurer, A. R. Gordon, Toronto.

The report of the Committee on Public Health was presented by Dr. Roseburgh, seconded by Dr. William Oldright, and adopted.

That on Tuberculosis, by Dr. W. B. Geikie, seconded by Dr. H. J. Hamilton, and adopted.

That on Hospital Abuse was presented by Dr. Webster, in the absence of the chairman, Dr. W. J. Wilson, seconded by Dr. W. A. Young, and adopted.

The Committee on Inter-Provincial Registration had nothing at the present time to report.

Treasurer's report was presented by Dr. G. H. Carveth, and showed last year's receipts to have been \$376.30, and expendi-

tures \$340.66, leaving a balance of cash in bank of \$35.64. This was audited by Dr. R. D. Rudolf, and, on motion, adopted.

The report on Necrology was presented by Dr. George Bingham. It included the names of C. W. Covernton, Toronto; C. E. Martin, Toronto; J. D. Macdonald, a Past President, Hamilton; J. E. Eakins, Belleville; Isaac Ryall, Hamilton; A. K. Sturgeon, Petrolia; Dixon, Pembroke; Mennie, Toronto; J. A. Watson, Toronto; T. H. Little, Toronto; Jonathan Robinson, Toronto; J. H. Parsons, Toronto, and Irving, St. Mary's.

The Ontario Medical Library was voted \$50, on motion by Dr. R. A. Reeve, seconded by Dr. H. T. Machell.

A notice of motion was given by Dr. Graham Chambers, and seconded by Dr. H. B. Anderson, that the business session at future meetings be held on the evening of the first day. This will be referred to the Committee on By-laws.

Resolutions of regret *re* non-payment of the annual \$2.00 fee of the Ontario Medical Council was introduced by Dr. Ferguson, of London, seconded by Dr. Gibson, of Belleville, that some members of the profession in the province had refused payment of this annual fee. This Association regards the imposition of this fee as most reasonable, payment of which should meet with a cheerful response on the part of every member of the profession. This was carried unanimously, amid much applause and without a dissenting voice.

Dr. Wishart, Toronto, chairman of the Special Committee to draw up a resolution *re* vaccination.

Resolved, That the Ontario Medical Association desires hereby to re-assert the opinion of the medical profession of this province:

1st. That the principles of Jennerian vaccination against smallpox, which have been now attested by the experience of more than a century, are scientifically correct.

2nd. That in order to carry out the protection through vaccination against smallpox it is necessary that the lymph used in the operation be of normal quality, and that this can be shown only by a proper amount of systemic reaction to the vaccine, as determined by the character of the vesicles, and that the absence of a normal reaction, as shown by the presence of vesicles, is no positive evidence of the immunity of the person either against vaccinia or smallpox.

3rd. That this Association emphasizes the urgent necessity that the sacrifice of the skin be sufficiently extensive to secure such reaction, and to this end recommend that from three to five insertions, each of a quarter of an inch square, be made in each vaccination. This was carried.

Medical Defence Union.—On motion of Dr. J. F. W. Ross, seconded by Dr. A. Primrose, a committee was appointed to

inquire into this matter, to report at the next meeting of the Association in 1902.

Votes of thanks were passed to the Minister of Education for the use of the building, and also to the President, Dr. McKinnon, for his exceedingly able address.

During the progress of the meeting it was addressed by the Honorable the Minister of Education, Mr. Harcourt, who advised them strongly to keep up the standards of matriculation and the professional examinations.

Dr. N. A. Powell was then installed in the office of President, and, after brief acknowledgement, the 1901 meeting adjourned.

THE EXHIBITS.

The members of the Association were also treated to a very interesting exhibit by many of the wholesale pharmaceutical houses and book-dealers. The only firm of instrument makers exhibiting was the Hartz Co., who showed a very beautiful and complete static machine, made by the H. P. Engln Co., of Cleveland. The plates of this machine are of glass and mica. The afternoon we saw it working was a very damp day, yet the spark was almost equal to the working of the machine on the succeeding night, when the atmosphere was exceedingly dry. They also exhibited in connection with the static machine a very fine X-ray tube, which gave a very clear definition. We cannot speak too highly of this machine. The S. B. Chandler Co. had on exhibition a globe nebulizer, and also a large number of medical works. They have recently added a publishing department to their already extensive establishment, and it has been placed in the charge of Mr. Watt, who for so long a time has been connected with the Medical Publishing business of Toronto. Carveth & Co., who make a specialty of medical works, also had a very large exhibit from the leading publishers. The well and favorably known house, Parke, Davis & Co., of Detroit and Walkerville, confined their exhibit to a few specialties. They had a very full sample line of their serums, antitoxine and vaccine. These quite made up by quality for the usual quantity. Mercuriol, the new preparation of mercury, introduced by this well established firm, has been receiving a double amount of attention, both as an injection in gonorrhoea and also as an internal remedy for syphilis. It has been used also subcutaneously under the skin, and the reports are exceedingly flattering as to its efficiency. They also presented Adrenalin, the blood-pressure-raising principle of the suprarenal gland. This remedy has evidently come to stay, and from the researches that have been so ably carried out by most distinguished men, there is no question whatever that this

solution is a very great hemostatic. While it is at present principally used in nasal surgery, its field of usefulness appears to be spreading to general surgery.

The well established firm of Frederick Stearn & Co., of Detroit and Windsor, Ont., also confined their exhibit to two or three of their special productions. The Vibutero, a new preparation of this firm, combining the properties of the two Viburnums with Palmetto and Pulsatilla and other sedative and anti-spasmodics. This preparation bids fair to meet with very great success with the profession. They also showed a new diphtheritic antitoxin syringe; it is an exceedingly unique affair, it is cheap and perfectly aseptic. The parts of it are so arranged that the serum can be injected through the original container, which renders the injection thoroughly aseptic. A new syringe is used in each case. For the first time this firm introduced antitoxin to the Canadian profession. It has met with great success in the United States and will undoubtedly be well received here. They showed many of the bacteria under the microscope, and supply slides of these to the profession.

R. L. Gibson, the Canadian representative of the Palisade Manufactory Co., showed their hemaboloid plain and hemaboloid arseniated. These preparations give a very fine tonic effect in cases where now in other forms quite disagree with the stomach. Phosphogon, a new preparation by which the phosphorus is administered in a most easily assimilated form.

Messrs. Henry K. Wampole & Co., of Philadelphia, and whose Canadian laboratory is located at Nos. 36 and 38 Lombard St., Toronto, made a most extensive display. The name of "Wampole" is famous both among the medical profession and laity, as a result of the almost universal use of their Tasteless Preparation of the Extract of Cod Liver Oil, which during the past eighteen years has been introduced and exploited only through the medical and pharmaceutical professions. In addition to this preparation, Messrs. Wampole & Co. are now calling particular attention to their Milk Food, Antiseptic Vaginal Cones of Boroglyceride Compound with Ichthyol, and Haemogen.

Their Milk Food is shown to simulate more accurately and uniformly human milk than any other similar food. Briefly stated, chemically it is simply pure milk, largely deprived of its casein, partially predigested by the diastase of the malt, and its nutritive principles enhanced by the beef, and the extra percentage of soluble phosphates obtained from the inner cortical of the whole wheat grain.

As regards the Antiseptic Vaginal Cones of Boroglyceride Compound with Ichthyol, these are most appropriate for those diseases in which their use is indicated, offering an acceptable method for the treatment of vaginal ailments without incon-

venience, pain, or discomfort, and without necessary exposure unavoidable in the introduction of tampon or other local applications, giving prolonged contact of very efficient antiseptic and mild astringents, besides the medical activity of the Ichthyol.

Wampole's Haemogen is an organic combination of Iron and Manganese with Beef Peptone, and will be found of especial value in the treatment of those diseases where their origin is traceable to an impoverished condition of the blood, or where the administration of an iron tonic would be indicated.

LONDON MEDICAL ASSOCIATION.

At the May meeting, after the presentation of a number of pathological specimens, and a discussion thereon, the Rev. C. S. Eby, Secretary-Organizer of the Anti-Consumption League of Ontario, addressed the members on the steps that are being taken to erect sanatoria for consumptives throughout the province.

On Tuesday evening, the 14th inst., an enthusiastic public meeting was held, which was addressed by Mayor Rumball, Rev. Dr. Eby, Drs. Cl. T. Campbell, Niven, and English.

On Monday evening, the 20th inst., at Strathroy, Rev. Dr. Eby addressed another large and interested gathering on the sanatorium question, and on Wednesday evening, the 22nd inst., another successful meeting was held.

It is the intention of the local association that a by-law be submitted to the ratepayers at the December elections for the erection of a sanatorium jointly by the City of London and County of Middlesex.

W. W. ENGLISH,
Secretary.

Editorials.

GONORRHEAL RHEUMATISM.

The subject of urethral arthritis is an important one. The term gonorrhœal rheumatism limits the etiology too closely to one germ. There are several germ sepses of the genito-urinary tract that may cause the arthritis. The arthritis may follow septic inflammation of the vagino-uterine canal.

The gonococcus is the cause of gonorrhœal arthritis. But once the inflammation has been set up the urethra, or vagina, is soon invaded by other pus-producing organisms. This accounts for the fact that, in the inflamed joints and lymphatic channels, there are several germs, as a rule, namely, the gonococcus, the streptococcus and the staphylococcus. The system may become infected through the mucous membrane by the active power of the living germ to penetrate it. Generally, however, there is some abrasion, caused by syringes or other instruments, through which the infection finds its entry into the general circulation. Though gonorrhœal rheumatism resembles acute rheumatism in clinical features, there are good reasons for placing it with the pyemic or septicemic conditions.

Urethral arthritis occurs more frequently in males than females. This is likely due to the fact that the urethra is shorter and wider in women than men; but more especially to the fact that gonorrhœa in women affects the vagina, the urethra escaping. Previous attacks of gonorrhœal arthritis, exposure to cold, former acute rheumatism, the existence of gout, are considered as predisposing to attacks. The same joints are usually invaded in second attacks. The fibrous tissue suffer most, as ligaments, tendons, nerve-sheaths, fascia, pericardium, etc. Frequently it attacks only one joint, and does not tend to clear up in the affected joint first, if a second joint is invaded. It is more persistent than ordinary acute rheumatism. The knee, ankle, wrist, hip, shoulder and elbow are most frequently affected.

There are all the appearances of acute suppuration, heat, swelling, pain and redness. Suppuration, however, is very rare, notwithstanding this cellulitis. The sheaths of the tendons

around the joint are involved, and movements very painful or impossible. Sometimes the synovial membrane is inflamed when there may be more or less fluid in the joint. There is a marked tendency to ankylosis in the joint. This is due to adhesions and contractions in the tendons, sheaths, fascia and ligaments. In some cases the main feature of the case is a large accumulation of fluid in the joint; in others, the attack is most marked by pain of a very persistent character and considerable liability to deformity. This is a rare form of the disease, but very chronic.

In the treatment of these cases, it is of the utmost importance to disinfect the urethra. It cannot be expected that the joint symptoms will at once subside, but there is generally great improvement as soon as the urethra receives proper treatment. For this purpose boric acid, perchloride of mercury or chloride of zinc may be employed. A good injection is zinc chloride, gr. $\frac{1}{4}$; bismuth subnit., gr. xx; aqua, dram 2; four or five times every twenty-four hours. Protargol in the strength of half a grain to the ounce is useful. Salicin, salol and their allies are not of much value, either to cure the disease or relieve the pain. Quinine and potassium iodide have yielded the best results. Serum therapy is spoken well of by some. In cases where streptococci are present it might prove serviceable. Fixation of the inflamed joint is called for. The application of glycerine and belladonna is useful for the relief of the pain. Massage and passive motion are indicated in the management of the swelling and stiffness that remain so often after the acute stage subsides.

FUNCTIONAL PARALYSIS.

Down through the centuries there have been a class of cases that have been the wonder of the ignorant and the prey of the designing. These cases of loss of the power of locomotion, of sensation, of speech, of sight, or of hearing, and that have made recoveries, often quite suddenly, after some quite ineffectual chant was sung, or prayer said, or nostrum administered, or movement performed, have been the foundation for all sorts of claims to supernatural intervention, or miracle working on the part of the agent or curer.

Paralysis, of a purely functional type, may affect the motor or sensory side of our nervous system, or both. It may come on suddenly and pass off soon, or last long and end as it began, in the twinkling of an eye. It may be local or general, or very mixed in type, and entirely unlike any recognized form of organic disease of the nervous system.

In an instant blindness may come upon a person, and, after lasting for a time, disappear, leaving the vision unimpaired. Hearing may be lost and regained in like manner. Here we have blindness and deafness of such a type as to be amenable to the tricks of the trickster; and yet the recoveries be recorded as so many miracles. For thirty years a person was known to be bed-ridden, and yet without the stigmata of organic disease. All of a sudden a certain event happened in the home, and the person, seized with an irresistible impatience to see what was going on, got up and walked.

Changes in the action of the nerve control of some of the muscles of the body and we have a phantom tumor. Sudden loss of control over the stomach and diaphragm, and the person is distended with flatulence and feels as if going to die of pressure and fulness. A volatile stimulant, some sweet smelling carminative in the form of valerian or assafetida, and they are relieved. The consoling word of a shrewd fakir may do as much.

So there may be pains in the joints or viscera, there may be derangements of function, as vomiting or diuresis or diaphoresis, and no change in any portion of the nervous system to explain such phenomena. The fingers may be numb, or the cheeks may be burning subjectively, or the heart may feel as if it was going to act after the manner of the grandfather's clock.

These are the cases on which the thaumaturgist has made his reputation in all ages. The miracle monger there has always been, and, so long as human nature remains what it is, he will always play an important role in the ignorant and superstitious mind.

The world has witnessed its outburst of dancing mania, epidemic chorea, tarantulism, vision seeing, transition and so on. There is some abnormal psychological condition founded, it may be, on some strong belief. But it is highly improper, indeed absolutely wrong, to try to cure these cases by methods

that are founded on error, and often on actual fraud. One error should not be supplanted by another. Cure should be sought by natural and rational means, by improving the general health by good counsel and management, and wise encouragement.

INTEMPERANCE AND HEREDITY.

At the Brooklyn meeting of the American Association for the Study and Cure of Inebriety, held in 1888, a committee was appointed to study and report upon the heredity of inebriety. Dr. T. D. Crothers was chosen as chairman of the committee. After thirteen years investigation, the committee makes an advance and partial report.

The report deals with the histories of 1,744 cases of inebriety. Great care was taken in all cases to verify the facts. These studies have included every condition or circumstance which might be regarded as entering into the development of inebriety. It was found in the study of these cases that great care was required, as many evaded or concealed the facts about their parents or grandparents, having drunk to excess.

The heredity of intemperance is established beyond doubt by the histories of the cases given. The heredity may pass over a generation, and the intemperate habits break out with marked activity in a second or third generation. The injury caused by the use of alcohol to the cells and tissues of the nervous system, is bound to be transmitted in some form or other. It may not always be in the drink or narcotic drug habit, but in the form of some of the neuroses. There may be a combination of the drink or drug habits with some neurotic condition, as epilepsy, hysteria or insanity.

Of the 1,744 cases of inebriety reported, 1,080 cases were clearly of a hereditary nature; 390 cases of drunkenness were due to disease, injury, shock, strain and worry; 180 cases were traced to lack of food and poisoning from some trade or occupation; and eighty-five cases were due to bad surroundings, exposure, ignorance and contagion of the habit from others. In nine cases no assignable cause could be traced.

In the first and largest group there was mental instability and want of control. There would often be a period of psychical

pain and unrest which found relief in the use of spirits. The characteristics of the parents or grandparents reappeared in the descendants with remarkable similarity, beginning to drink at the same age and under the same conditions. In many instances at a certain age the drink habit disappeared and would be replaced by distinct religious emotions. This change generally came about the age of 30 to 40. It must also be borne in mind that many of the children of parents who drink are weakly, and are allowed stimulants early in life to act as a restorative. The tendency for the drinking habits to break out at the same age as in the cases of the ancestors, is quite noteworthy.

There are a certain number of the descendants of drinkers who do not take to intemperate habits, but show some distinct psychopathic state. They are often enthusiastic temperance workers, emotional preachers, excitable politicians, or act as persons on the border line of insanity. The children of such parents may revert to the drug and drink habits of an earlier generation. Criminals, tramps, and the mentally submerged usually belong to this class.

There are a certain number of the descendants of intemperate parents where the outbursts take on the epileptic characteristics. Like a bolt from the clear sky they become intemperate. There is a strong tendency to assume the cyclone and periodic features. The women descendants of such parents become drug neurotics, suffer from all sorts of ailments, and resort to faith curers and such like for relief. Some of these persons may show great sexual perversion, or may become gourmands. Again, there may be instances of remarkable endurance, the persons performing almost impossible tasks.

NOTES BY THE WAY.

Home again, after an absence of ten weeks! While I am glad, for many reasons, to be here, I must admit that I would like to have made a longer stay in certain cities I have visited. A few notes as to what I have seen and heard! I was much interested while in New York in examining some of the modern aids to teaching in obstetrics, of which we have heard much during the last few years. Clifton Edgar, of the University of the City of New York, and Robert Dickinson, of the Long Island College Hospital, appear to be doing excellent work in this direction. Edgar's life-size manikin, which has been used by Temple, of Toronto, and Moorhouse, of London, for some years, is still the favorite in New York; and, on the whole, I don't know that I have seen anything that is much better. I still, however, have a fondness for the French manikin, almost an exact copy of the original German model, which I have used during the last fourteen years. I will not now attempt to describe the great variety of models, wet and dry preparations, bony and metallic pelves, etc., which the obstetrical teachers of New York use, particularly as many of them are like those we use in Canada; but I desire to express my extreme satisfaction at the great advances that have been made during the last few years in the various colleges of that city. Fifteen years ago no single school of New York required its students even to witness a case of confinement before graduating. In those days they were far behind us in Canada, as far as their methods and requirements in obstetrics were concerned. Now, however, the New Yorkers are forging ahead, and it becomes our duty as Canadians to see to it that we do not go behind. I don't mean to say, at the time of writing, that I have any pronounced fear about our position, but the assumption of a little humility will do us no harm. I can't help thinking that we have our ebbs and flows in Canada as elsewhere. I think I know one medical college that suddenly became weak almost during the day of its greatest strength. With reference to the improved condition of things obstetrical in New York (which is not, however, confined to that city), I think it only fair to say that much credit for the same is due to the late Theophilus Parvin, of Philadelphia, and Clifton Edgar, of New York. Without going into any special details, I may say that I know of no obstetricians in the world who have a better conception of the various injuries which may occur to the pelvic floor (not the perineum) during labor, and of the proper methods of repairing the same, than those of New York. In conclusion, as to this city, I have to say, with much regret, that many of the models and preparations which have been described in the medical journals, and to

which I have already referred, are so rough and crude as to be quite disappointing. Either the teachers are too busy to properly explain their ideas to the instrument makers, or the latter are too careless in carrying out the instructions they receive. The finished style and the completeness which one finds in colleges and manufacturers' establishments of Paris is in striking contrast with some of the almost slovenly and uncleanly things which one sees in like places in New York.

Wm. Caven, John Fotheringham and I left New York on the good steamship "Minneapolis," April 20th, and, after a very pleasant passage, reached London, April 29th. Dear old London—how glad I was to see it once more—after twenty-four years. They told me I would find it much changed. Perhaps I did; but, if so, I didn't realize it to any extent. In fact, I scarcely saw the new things. The old things I can find only in London—the new things I can find much nearer home.

To commence with medical matters, I may say that I was somewhat surprised to find that no great advances had been made in the methods of obstetrical teaching during the last twenty-five years. The Londoners appear to view with something like contempt many of the manikins, models, and other appliances which are so commonly used in Germany, France, and America. Some of them freely express the opinion that persons using such artificial aids are "playing to the gallery." I fail to see how the expression is suitable; but I may say that if I at any time find the gallery filled with medical students, I am quite willing to "play" to it, to some extent, at least. Notwithstanding their modesty, however, they do use some artificial aids for demonstrating purposes; but I am not certain that they have anything newer than the Tower of London. I still think, at the same time, that they teach the science of obstetrics exceedingly well—I know of no place where they do it better; but I believe that they teach the art of obstetrics exceedingly ill—I know of no place where they do it worse. Some of them say the proper place to teach obstetrics is at the bedside. Quite right, but they don't do it there. Public opinion, unfortunately, will only permit them to indulge in such practical methods to a very limited extent. We will know what that sort of handicapping means in our fair city of Toronto.

I was very much pleased with what I saw in Queen Charlotte's Lying-in Hospital. It is about 150 years old, but its importance and pronounced success commenced about 90 years ago, when it came under Royal patronage. In 1809 His Royal Highness the Duke of Sussex became President for life, and Her Majesty Princess Charlotte became Patron. In 1850 Her Majesty Queen Victoria became Patron; in 1866 the Princess

of Wales became Vice-Patron. Now Her Majesty Queen Alexandra is Patron, and the Duchess of York is Vice-Patron.

In a general way their methods may be described as including a combination of asepsis and antiseptis, and call for no special comment. I was much interested in the completeness of their system of making routine examinations of their patients during pregnancy. The patients come at regular stated intervals to the out-door department for such examinations, which appear to be made with great care. Apart from the chance of finding a disproportion between the child and the pelvic cavity from any cause, they attach great importance to the discovery of breech presentations. Turning in such cases (generally during the eighth month) appears to have become quite a fad in London during the last few years. Without attempting to discuss the merits of such procedure, I will simply say that I think it quite right in certain cases. I would like to suggest, however, to the London, or more properly the English, teachers, that if they spent more time in demonstrating the proper methods of delivery in breech presentations, they would be doing greater service in the interests of the unborn, and would much reduce the mortality (now frightful) in breech deliveries in that country.

I was very anxious to get some definite knowledge as to the success of the "London Medical Graduates College and Polyclinic" (why did they burden it with such an awful name?), and naturally expected to learn a good deal about it from some of our Canadian graduates, of whom there are about twenty-five in London. Strange to say, I couldn't find one who appeared to know much about it, nor one who was attending it. Two had evidently made a big effort to attend it faithfully, but had given up the attempt, and were irreverent enough to say that it was "no good." Yet I learned from English sources that it is the cheapest thing of the sort in London, is rendered eminently respectable by such men as Sir Wm. Broadbent, Mr. Jonathan Hutchison, and others, is lauded and encouraged by such men as the leader of the House of Commons, and other celebrities, and is patronized by a fairly large number of English graduates. I understand the course consists of one out-door clinic a day, a lecture on some special subject twice a week, and a clinical lecture once a fortnight. I wonder how it would do to shorten the title and extend the "menoo" a bit? I have a great respect for English physicians and surgeons, but I can't help thinking that in some respects they are terribly slow and positively stupid. For many long years the world was saying that London should do more in the way of utilizing its magnificent clinical material. The poor, drowsy old city at last awakened, put on new vigor, and after years of toil, and

almost an un-English amount of advertising, has only managed to bring into existence this poor, miserable, beggarly little Polyclinic.

Caven and I left London and Fotheringham, May 15th, and reached Paris the same evening. I found here that the teachers, compared with those of London, go to the other extreme, and even during their didactic lectures employ an almost bewildering variety of charts, models, preparations, phantoms, manikins, etc. A visit to Tramond's shop near the University Medical College was a revelation to me. I never before had seen anything like such a variety of obstetrical wax models and pelves of all sorts. I also paid a couple of visits to the shop of the celebrated instrument maker, Matthieu, where I saw much that greatly interested me. As I have before intimated, his latest manikin pleased me more than any I had previously seen.

The system of teaching, so far as I could learn its character, appears to me to be admirable in many respects. The students have to take a regular course of instruction and then pass a rigid examination before they are admitted to the clinics, where they take a practical course (acting as assistants) for three months, during about half of which they are internes. During these three months they do no work outside of obstetrics. The chances for graduates (home or foreign) are not so good; but there are certain private courses which they may take, and in which they can do various kinds of practical work under competent guidance on payment of about four dollars an hour.

Pinard and Budin—in fact all, or nearly all, Parisian obstetricians still use the Tarnier forceps, and as a general rule adhere to the French custom of applying the blades in the transverse diameter of the head. Some, however, make certain exceptions to this rule, as, for instance, in cases where the head lies transversely across the pelvic inlet, when they apply the forceps in the oblique diameter (see Ratchinsky's paper, "Obstetrics," October, 1900). In examining for the fetal heart-sounds they use a special stethoscope with a broad bell, which, when pressing on the abdomen, pushes away the liquor amnii, thus rendering the sounds more distinct. They use quite freely the anti-streptococcus and anti-staphylococcus serum in actual or suspected septicemia; and some go so far as to use it as a prophylactic in women who have been examined after the rupture of the membranes before admission to the lying-in rooms. While we were in Paris there was an epidemic of diphtheria, and a proclamation was issued by the Mayor urging physicians to use anti-diphtheritic serum in all suspected cases.

After leaving Paris we went to Switzerland, where we spent a week very pleasantly. We enjoyed our stay of four days in beautiful, quiet, restful Lucerne. I can now fully understand

why English and English-speaking people love Switzerland, but I will not undertake to explain why. I would, however, advise those who wish to visit that charming country to go during the latter part of May or early in June, when they will see things at their best before the usual summer rush. After a couple of days in Zurich we went through the Black Forest to Bingen; thence down the Rhine to Cologne; thence to Brussels, Antwerp and Rotterdam; thence to London by way of Harwich.

When we returned to London we found Fotheringham still at work. Dwyer had started for home. Orr had arrived. Spence had returned from some country town, where he had been doing *locum tenens* work. He expected to go to Paris some time in June. Badgerow was hard at work, and expected he would stay in London for some time longer. Clingan was spending a good portion of his time at Chelsea, working under Bland, Sutton and Giles. Perry Goldsmith was working hard at his specialty, and had the good fortune to secure the warm friendship of Dundas Grant, who will shortly publish a work on "Diseases of the Ear, Nose and Throat." Hackney, Boyd, Young, Bell, Jones, Graham and Beatty were all hard at work. I found that quite a number of Canadians were spending their time mostly at University College. We were exceedingly glad to see so many of "the boys," and to find them all doing well. I had occasion to meet some of the London doctors, and was treated with very great kindness, especially by Wharton Hood, Dundas Grant and Easton. I was pleased to learn that Hood was likely to publish a second book in the near future. In it he will describe his methods of treating stiff joints, and will probably have something to say about the "bone-setters" of England, whose violent "smash-ups" have now happily become obsolete. On a certain occasion I was anesthetized, and I was surprised to find that Easton, the anesthetist, was married to a daughter of our old friend, W. H. Howland, whose death some years ago we so much deplored. Her relatives are still in evidence in Toronto, her uncle being our present mayor, and her brother one of our T. G. Hospital internes during the past year. Caven and I had the pleasure of spending a very pleasant evening with Dr. and Mrs. Easton at Dr. Hood's house.

Of course we heard a great deal about the South African war, and learned much about the warm feeling which the ordinary Englishman has to-day for Canadians. I think there is no doubt that England has learned many lessons from that war, and that she has become in consequence, more democratic (for which, in a general way, I am sorry). I heard of the occurrence of many rather amusing episodes in connection with this same war. A student of the London University told me of one. We

have heard much in Canada about the delirium which seized London when news of the relief of Mafeking arrived. On that evening the students of London University marched in a body through the streets. At their head were most of their Professors, including Lord Kelvin, Sir Norman Lockyer, Professor Perry and others. Lockyer, probably the oldest of the Professors, well known as the Astronomer Royal of England, took the leading part. At every opportunity, especially in passing a monument, he would climb as high as possible and address the students, making patriotic remarks, and at the same time begging them to be orderly and quiet. Then off they would start again—the orator waving a Union Jack and making more noise than any of the students. One of the results of the war has been the establishment of numerous rifle clubs throughout England. Dr. Conan Doyle has organized one of these. In an interview with Captain Trevor (see *Strand Magazine* for July). He says “the men of the club are drawn from all classes, and things are run on democratic lines. We have a Professor of Oxford side by side with a cabman or a mason in his corduroys. At a boxing day competition a publican and a non-conformist clergyman were shooting off their finals at the last range. The publican won.” I’m not sure that we will ever have exactly that sort of thing in Canada, but I can easily fancy that it would be very interesting to see—for instance—Lem Felcher and the Rev. Dr. Potts shooting off their finals at the Mimico ranges.

Some of my friends will be interested in hearing that we saw some good cricket in London. I don’t know that it is generally understood that Bill Caven is a regular sport, and dearly loves to watch a good game. John Fotheringham, on the other hand, is sadly deficient as to his knowledge of cricket; so Bill and I left John doing diseases of the nervous system, while we did the noble game. We were delighted to see our old friend, Dr. W. G. Grace, in good form. As usual, he always goes in first, and the appearance of the big, clumsy-looking giant is always the signal for a rousing English cheer. When he commences to bat you cease to see anything clumsy. They call him the old man now, and it is rather sad to think that as an active cricketer he can’t last much longer. We also saw Prince Ranjitsinhji, who still plays in his own inimitable style, but was unable to put in an appearance during the month of May on account of illness. Huge scoring is still in evidence, and much fine bowling is done, but poor fielding is not uncommon. The number of missed catches during the early part of the season was deplorably large. One might think from the tone of the British press that fielding is a lost art in England; but if he got a chance to see Yorkshire in the field, he would discover

that such is not the case. However, I may say that this same Yorkshire excels in three rather important points, *i.e.*, fielding, bowling, and batting. We saw the match between Yorkshire and Middlesex at Lords, which drew an attendance of from eight to ten thousand on each of the three days. Yorkshire, however, won easily, with eight (I think) wickets to spare. We saw the match between South Africa and M.C.C., which was a fairly close one. The S.A. team fielded well, bowled fairly well, but were rather weak at the bat. We saw Jessop twice. He is the most dashing, and the most popular bat in England. They tell rather a good story in connection with a match between Authors and Artists. Conan Doyle was bowling, and one of the Artists got out, first ball. To the spectators it seemed easy enough, and a friend asked the unlucky Artist, "What was the matter with that ball?" He replied, "I don't know. I didn't see it." "Why, how's that?" he was asked. He then got rather indignant, and said, "See here, how could you expect a fellow to play against a great big beggar like that, with a pink shirt and an olive-green background?"

When one comes back after a trip abroad, he is apt to think of the condition of things at home. My general feeling in reference to things medical in Canada is one of satisfaction. I have an opinion—perhaps more pronounced than ever before—that the rank and file of our profession in this country will compare favorably with physicians in any part of the world. As to our own city of Toronto, I should not, perhaps, say much, especially as some outsiders, not uncharitably disposed, think we have a fair share of vanity and conceit. These, however, are not very bad commodities, and I only hope we will never have any worse characteristics. I hope I may be pardoned when I say that I feel proud of the physicians and surgeons of this city, and believe that, all things considered, they are the best Toronto has ever known. We have been talking for some years about post-graduate courses. We have plenty of teaching ability, and a fair amount of clinical material at our disposal. How would it do to stop talking, and go to work?

A. H. WRIGHT.

TORONTO, July 1st, 1901.

ONTARIO MEDICAL COUNCIL.

Toronto, June 11th, 1901.

The Medical Council met this day, and all the members present excepting Dr. Henry, who shortly after took his seat. The usual routine of business was gone through with, the retiring President, Dr. Britton, delivering his annual address, which was very interesting, he having paid very close attention to the working of the Act throughout the year, and made the statement regarding the annual fee that 1825 members of the College had paid all arrears up to that time. We learn now, however, that up to date 1940 have paid up all arrears. The Doctor, in his annual statement, called the attention of the members of the College throughout the province to the fact that the protection given the profession was owing to the Medical Act itself being in existence and in practical working order, and that if it were not for that, medical men throughout the province would have from one thousand to one thousand two hundred more men to compete with than they have at the present time, as the applications for information as to what it is necessary to do to qualify in the Province of Ontario are received in great numbers throughout the year, so that the very fact of prosecutions of quacks throughout the province is not the only protection that the practitioners are afforded under the Act.

The proceedings of the Council were marked with more harmony than any previous meeting for some years, and the work of the committee was completed at an early date. Dr. Roddick addressed the Council at some length on "Interprovincial and Dominion Registration," and conferred with the committee of the Council on the subject. The report of the committee to the Council endorsed the general principles of Dr. Roddick's Act, but there are many portions of minor detail which will take some time to work out. The general feeling of the Council was much in favor of the Dominion Act, with a view of trying to create a wider field for the practise of medicine.

Dr. Brock and Dr. Emory, the President and Vice-President of the Council, respectively, for this year, gave very great satisfaction in their work, and all the old officers of the Council were reappointed, with the exception that Mr. Christopher Robinson, K.C., takes the late B. B. Osler's place, and Dr. J. C. Patton becomes auditor in the stead of Dr. Carlyle, deceased. The Council adjourned on Saturday, the 15th, after pretty constant work for five days.

The candidates who served their country in South Africa were granted the examinations they had thus missed by being away, the Medical Council following out the spirit of the other

licensed institutions in Canada by granting these requests. There are little or no changes in the curriculum of the College for the ensuing year, it remaining much as last year. Also the Board of Examiners remains the same, with the exception of two, who have been replaced by other members, as they had served a long time on the Board, and the Council seem to desire to adhere to an unwritten law that three years should be the limit of service on the Board of Examiners. This has not been carried out to the letter, but it is the intention to comply with the idea as nearly as possible for the future.

We also find that the number of practitioners in the province now are looked upon to be about 2,200 who are in active practise. This is somewhat of a falling off in the medical population, but is borne out by the canvassers of some of the medical directories who have been travelling through Canada this last summer.

It is announced that the dates of the next meeting of the Mississippi Valley Medical Association have been changed from the 10th, 11th, and 12th of September to the 12th, 13th, and 14th of September. This change has been made necessary because the dates first selected conflicted with another large Association meeting at the same place.

The meeting is to be held at the Hotel Victory, Put-in-Bay Island, Lake Erie, O., and the low rate of one cent a mile for the round trip will be in effect for the meeting. Tickets will be on sale as late as September 12th, good returning without extension until September 15th. By depositing tickets with the joint agents at Cleveland, and paying 50 cents, the date can be extended until October 8th. This gives members an opportunity of visiting the Pan-American Exposition at Buffalo, to which very low rates by rail and water will be in effect from Cleveland.

Full information as to rates can be obtained by addressing the Secretary, Dr. Henry E. Tulley, No. 111 West Kentucky Street, Louisville, Ky. Members of the profession are cordially invited to attend this meeting.

Those desiring to read papers should notify the Secretary at an early date.

Personals.

Dr. G. S. Burt, of Severn Bridge, Muskoka, went to Scotland early in June.

Dr. A. McPhedran, of Toronto, is going to Europe for a two months' holiday.

Dr. John T. Fotheringham, of Toronto, sailed from London for New York, July 6th.

Dr. Geo. A. Bingham, of Toronto, has gone to England, where he will remain for some weeks.

Drs. A. H. Wright and W. P. Caven have returned from Europe, and resumed their practice July 1st.

Dr. George Clingan has returned to his home in Manitoba. On his journey from England, he remained a few days in Toronto.

Dr. Robert J. Dwyer has returned to Toronto after spending a year at post-graduate work in the hospitals of Great Britain and Germany.

Dr. B. E. Hawke, of Stratford, has removed to this city and has located at 31 Carlton Street. He will confine his practice to diseases of children.

Dr. William Lewis Yeomans (Toronto University), of Bucyrus, Ohio, was married, June 18th, to Miss Selina B. Morison, of Chicago. Congratulations.

Dr. D. W. Montgomery, Professor of Dermatology, California University, spent a fortnight in Toronto last month, visiting his family and many friends.

Dr. A. H. Perfect, of Toronto Junction, and Dr. S. M. Hay, of Toronto, returned to their respective homes, July 1st, after visiting Johns Hopkins Hospital, Baltimore.

Dr. A. T. Stanton, one of the resident physicians of the Toronto General Hospital last year, has been appointed surgeon to the C.P.R. steamer "Empress of China."

Dr. Maclellan, a graduate of Queen's University, Kingston, who has been working in London, England, during the last ten years, has come to Toronto to practice his specialty, diseases of the eye, ear, throat and nose.

Dr. Crawford Scadding has returned to his home in Toronto after spending a couple of months in England.

Dr. Arthur W. Mayburry, 253 Spadina Avenue, who has recently returned to town will in future confine his attention to the diseases of the nose, throat, heart and lungs.

Dr. Pickard (Victoria University), of Virginia City, Nevada paid a brief visit to this city last month. His friends were delighted to see him looking so youthful and prosperous.

Drs. W. C. Barber and W. Thistle, of Toronto, and Dr. J. M. Forster, of Kingston, started on a cruise in a steam yacht, going down through the Bay of Quinte and up the Rideau Canal.

Dr. J. Algernon Temple has been at Lake Simcoe having a short holiday. Excepting a slight weakness in his right arm, he has quite recovered from the effects of his recent runaway accident.

Dr. Jas. F. W. Ross, of Toronto, went away for a ten days' cruise in the "Oriole," June 27th. He and his party spent the greater portion of their holiday in Henderson's Bay, south of Kingston.

Dr. W. J. Greig, of Toronto, left his home, July 8th, for a four weeks' trip. He expected to go by Chicago and Salt Lake City to San Francisco, thence to Victoria, and back to Toronto by the C.P.R.

Book Reviews.

A Text Book of Practical Medicine. By WILLIAM GILMAN THOMSON, M.D., Professor of Medicine in the Cornell University Medical College, New York; Physician to the Presbyterian and Bellevue Hospitals, New York. Lea Brothers & Co., New York and Philadelphia: 1900.

This new work on practical medicine is eminently a student's text book, and arranged with such system that the reader can with ease grasp the subject before him. The free use of bold type in appropriate places is no small aid to the student in reading to advantage.

Dr. Thomson's long years of experience as a teacher and writer have enabled him to present a work in which are blended personal clinical observations and a knowledge of medical literature. Treatment receives more consideration than is the rule. The author assumes that the reader has for his aim a knowledge of curative medicine and the character of the book is moulded by that assumption. There are seventy-nine engravings illustrating to a great extent cases in the practice of the writer of the book.

A Text Book of Gynecology. Edited by CHARLES A. L. REED, A.M., M.D., President of the American Medical Association, 1900-1901; Gynecologist and Clinical Lecturer on Surgical Diseases of Women at the Cincinnati Hospital; Fellow of the American Association of Obstetricians and Gynecologists; Fellow of the British Gynecological Society; Corresponding Member of the National Academy of Medicine Peru, etc. Illustrated by R. J. Hopkins. 900 pages, 16 mo.: 356 illustrations. D. Appleton & Co., New York: 1901.

In this work the material on certain subjects is contributed by more than one writer, the contributions being collaborated by the editor, so that in many important instances one has the advantage of the views of several persons given by themselves on the same subject. The list of contributors embraces the names of American, English, Scotch and Canadian practitioners. It is too long to be given in full. The Canadians who have taken part in the work are J. F. W. Ross, of Toronto, and Wyatt G. Johnston, of Montreal. The work is very comprehensive and at the end contains some chapters on diseases of the rectum and anus. We observe that there are still some writers who are unable to see the superiority of the clamp and cauterizing operation for hemorrhoids and speak of its being unsafe. We are glad to be able to support the view of the editor. We have seen a large series of clamp and cauterizing operations and not one fatal result.

Selections.

SURGICAL HINTS.

Never use peroxide of hydrogen in any sinus or cavity in which there is a possibility of insufficient drainage. Unless the peroxide has a perfectly free exit it may do harm by forcing septic matter into tissues hitherto uninfected.

When there is no retention of urine, and yet no instrument can be passed, it is sometimes well to pass a catheter as far as it will go, and then leave it in position for many hours. After some time it may be found to go through easily enough.

In children and young people complaining of pains about the joints or limbs, never be satisfied with anything but a searching examination. It will not do to lightly make a diagnosis of rheumatism, for both osteo-myelitis and certain malignant tumors may thereby be overlooked.

There is no more valuable improvement in surgery than the fast spreading employment of the vaginal route for much of our intra-pelvic work. Yet the surgeon unfamiliar with it should stick to suprapubic operations until actual work on the cadaver has given him familiarity with vaginal operations. These are easy to learn and perform, but the danger is great in unfamiliar hands.—*International Journal of Surgery.*

Test for a Trace of Albumin.

Praun (*Deut. Med. Woch.*) gives a neat method for determining the slightest trace of albumin in urine. He filters a few cubic centimeters of urine into a test-tube, then adds a few drops of the reagent (he uses a saturated solution of sulphosalicylic acid), and gently mixes them; then filters more urine into the test-tube, allowing the filtrate to run down the sides of the tube until there is a good layer above the mixture. In this way the slightest cloudiness in the under layer can be determined by comparison with the upper layer. Having both fluids in the same container affords a better method for comparison than any other means.—*Medical Age.*

Acute Formalin-Poisoning.

J. Kleuber (*Munch. Med. Woch.*) was recently called to a patient who had by mistake swallowed several ounces of commercial formalin. The man was unconscious, there was marked pallor and cold, clammy perspiration, the respirations were in-

creased, there were rales over the lungs, the temperature, pulse and the various reflexes were normal, and there was neither paralysis nor vomiting. The most prominent feature was the coma, it being impossible to arouse the patient. The next morning the patient awoke several times, but soon fell back into his somnolent condition and anuria set in. At last, toward evening, the coma disappeared, the patient acted as if intoxicated, had some headache, conjunctivitis and the buccal mucosa was reddened. The next morning he was restored to health. Throughout the illness formic acid could be detected in the urine.—*Med. News.*

The Employment of Heat as a Therapeutic and Diagnostic Measure.

Many pages have been written on the therapeutic value of the local application of dry heat or moist heat in the treatment of various painful and inflammatory processes. It is a familiar fact to many practitioners that soaking a sprained ankle in very hot water will often do much toward relieving the pain and allaying inflammation and swelling, and that the use of repeated very hot vaginal douches will often relieve pelvic pain due to congestion or spasm. So, too, irrigation of the external auditory canal with very hot water is not only a pain relieving, but a curative measure in cases of inflammation of the middle ear. The other external and internal uses of hot water are exceedingly numerous.

The object here, however, says the editor of the *Therapeutic Gazette*, is to call attention to a proposition recently advanced by Lewin, of Berlin. He claims that by the use of the local application of heat we can make a diagnosis as to whether an acute inflammatory process has gone on to suppuration—as, for example, in a case of appendicitis. He asserts that if pus has not yet formed, the application of heat will be a comfort to the patient; whereas, on the other hand, if pus is present, it will so increase and exacerbate the pain that a diagnosis of the presence of this material can be made with assurance. He states, as an example, that in cases of swelling of the knee, associated with rheumatism or otherwise, we not infrequently are able to give great relief if the knee is put at rest with a fixation splint, and heat is actively employed. If by any chance pus is present the pain is augmented and becomes intolerable. Lewin states that he has employed heat for this purpose in a sufficient number of cases to make him feel confident that he cannot be mistaken in regard to this point, and he cites ten cases of appendicitis in which the heat was applied for two hours by means of hot compresses, and without the use of internal pain relievers. Eight of these received this treatment with a good deal of relief,

but the remaining two showed marked increase in pain. Of the eight cases all went on to cure in the space of from five days to three weeks, while, on the contrary, the two which suffered an increase in pain after the application of heat required the administration of opium for the relief of pain, and both of them died.

The experience of Sphor, of Frankfort-on-the-Main, is also quoted. In fifteen cases of appendicitis, which had hot applications without internal treatment, very similar results were obtained. So, too, in three cases of perimetritis, two were relieved by the application of heat and recovery promptly took place; while in the third patient the pain was greatly increased, and later on a large quantity of pus was discharged by the vagina.

If further investigations show that this method of diagnosis is at all accurate, it is so simple in its application that it cannot fail to prove of value.—*The Dietetic and Hygienic Gazette*.

A Case of Pneumococcic Peritonitis—(Reported at the February Meeting of the Belgian Society.)

Mme. A. H., aged 29 years, was married in 1894. Personal and family history were both good. The present attack began suddenly fifteen days ago, without any premonitory symptoms. On rising from bed, the woman was seized with violent pains in the stomach and back, and an intense chill, followed by elevated temperature. This was accompanied by abundant vomiting, at first bilious, afterwards porraceous in character. There was also uterine hemorrhage, with a profuse and fetid diarrhea. After eight days, the urgent symptoms improved slightly, but swelling of the abdomen set in. The umbilicus was protruded, reddened, and inflamed. At the laparotomy, made two days after her admission to the hospital (December, 1900), there escaped from the belly a flood of greenish, creamy pus, with abundant false fibrinous membranes. The immense pocket forming the walls of the abscess, and comprising the pelvis and the abdominal cavity as far as the umbilicus, was covered with false membranes. Nowhere could we discover the starting point of the inflammation. The cavity was fully irrigated with the physiological solution, and perfectly cleansed. After opening Douglas' cul-de-sac, in order to draw the pus cavity from below, we closed the abdomen by a deeper and a superficial row of sutures. The microscopic examination of the pus revealed the presence of the encapsulated pneumococcus of Frankel. A culture of this on gelatine was negative. On the contrary, the injection of the pus behind the ear of a strong rabbit brought on an acute septicemia, and the death of the animal in twenty-four hours.

During the first few days after the laparotomy there was a marked improvement of the symptoms. The temperature fell; the pulse became better; the strength and the general condition were perceptibly re-established. Beginning on the second day, the abdominal cavity was irrigated daily through the opening in the Douglas' cul-de-sac. At this time examination of the chest revealed the existence of a double bronco-pneumonia. On the tenth day, a profuse diarrhea again set in, and the condition of the patient became notably worse. During the night the abdominal wound opened at its upper end, and there flowed from it abundant blackish fecal matter. From this time the patient's symptoms were rapidly aggravated; delirium and want of appetite appeared; the temperature rose; the pulse quickened. Death took place on the sixteenth day after the operation.

It is only recently that the infectious nature of pneumonia has been admitted. We can distinguish, chemically at least, four different types of pneumonia. These are (*a*) pneumonia caused by Frankel's pneumococcus; (*b*) pneumonia due to Friedlander's pneumo-bacillus; (*c*) staphylococcic pneumonia; and (*d*) streptococcic pneumonia (Whitla). To these types we must add many varieties resulting from the association of these different pathogenic agents (King). The pneumococcus is represented by a characteristic microbe, of elongated form, elliptical, surrounded by a clear, transparent zone or capsule (Panc). From the biological point of view, the pneumococcus is developed neither below 24° nor above 42°. Gelatine is not suitable for its culture—we must use other media, such as bouillon. Certain animals, as well as man, are very susceptible to pneumococcic infection. The reactions following inoculation differ according to the susceptibility of the organism attacked, the virulence of the infecting agent, and the point of entrance of the microbe. In severe cases, when death takes place after a short time by pneumococcic infection, we find the germ in the blood, the spleen, the viscera, the peritoneum, the bone-marrow, etc. When, on the contrary, under the influence of certain causes, the inoculation has been insufficient to cause death, it is affirmed that the animals surviving have become insusceptible to a further inoculation. Resting on this established fact, we have for some years made efforts at vaccination, both preventive and curative, which, although not yet absolutely conclusive, are none the less very encouraging in their results.—Translated from *Annales de la Société Belge de Chirurgie* by HARLEY SMITH.

(To be Continued.)

Miscellaneous.

THE DAY'S DEMAND.

God give us men! A time like this demands
Strong minds, great hearts, true faith and willing hands,
Men whom the lust for office does not kill ;
Men whom the spoils of office cannot buy ;
Men who possess opinions and a will ;
Men who have honor ; men who will not lie ;
Men who can stand before a demagogue
And damn his treacherous flatteries without winking ;
Tall men, sun-crowned, who live above the fog
In public duty and in private thinking.
For while the rabble, with their thumb-worn creeds,
Their large professions and their little deeds,
Mingle in selfish strife, lo ! freedom weeps ;
Wrong rules the land, and waiting justice sleeps.

—J. G. HOLLAND, in *Dietetic and Hygienic Gazette*.

Accidents after Adenoid Operations.

C. E. Holmes reports two cases in which the curette used for the removal of adenoids broke off just at the beginning of the sharpened portion of the loop. In one case the piece was removed without incident. In the other it was swallowed, but proper diet prevented any untoward consequences, and the piece was passed in the stools three days later.—*The Laryngoscope*.

Curettagé of the Uterus.

The very popularity of this operation is a source of danger, for the gynecological proclivities of many general practitioners are apt to blind them to the risks associated with this procedure when carried out carelessly and without due regard to antiseptic precautions. We have heard of instances in which the uterus has been curetted in the consulting room without previous sterilization of the vagina, the patient being then allowed to drive or walk home. Even when carefully performed, curettagé of the uterus is not unfrequently followed by troublesome and possibly dangerous peri-uterine inflammation, and when done by the inexperienced or careless, it becomes positively dangerous. That it is a valuable method of treatment in certain conditions of the uterine mucosa cannot be denied, but the facility with which it can be done, after a fashion, by anyone, is calculated to lead to its abuse.—*Med. Press and Circular*.