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MEDICINE AND SURGERY.

Vol. XII.

HALIFAX, NOVA SCOTIA, JUNE, 1906.

No. 5.

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The Thirty-Second Session will open on Friday, August 31st, 1900, and continue for the eight months following.

The College building is admirably suited for the purpose of medical teaching, and is in close proximity to the Victoria General Hospital, the City Alms House and Dalhousie College.

The recent enlargement and improvements at the Victoria General Hospital, have increased the clinical facilities, which are now unsurpassed, every student has ample opportunities for practical work.

The course has been carefully graded, so that the student's time is not wasted.

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(Pass Primary M. D., C. M. examination.)
- 3RD YEAR.—Surgery, Medicine, Obstetrics, Medical Jurisprudence, Clinical Surgery, Clinical Medicine, Pathology, Bacteriology, Hospital, Practical Obstetrics, Therapeutics.  
(Pass in Medical Jurisprudence, Pathology, Therapeutics.)
- 4TH YEAR.—Surgery, Medicine, Gynaecology and Diseases of Children, Ophthalmology, Clinical Medicine, Clinical Surgery, Practical Obstetrics, Hospital, Vaccination.  
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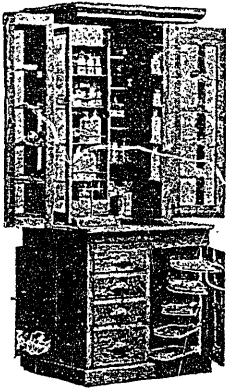
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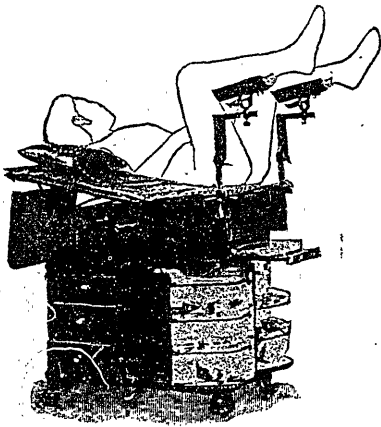


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VOL. XII.

HALIFAX, N. S., JUNE, 1900.

No. 6.

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Original Communications.

REPORT OF THREE CASES OF DOUBLE SALPINGO-  
OOPHORECTOMY.\*

By N. E. MACKAY, M. D., M. R. C. S. (Eng.), Surgeon to Victoria General Hospital,  
Prof. of Surgery, Clinical Surgery and Operative Surgery,  
Halifax Medical College.

CASE I. On October 9th, 1898, I was called to see Mrs. G. W., age thirty-four, who was suffering from severe pain in right and left inguinal regions. The pain and tenderness were more marked in the region of the left ovary. Her temperature was about 101.2, and pulse 100.

The following history was elicited:—Born at Waverley; menstruated at fifteen; married at twenty-one; had two children, youngest about ten years old; had a miscarriage five years ago; always enjoyed good health till eighteen months ago. About a year ago, after driving a distance of fourteen miles over rough roads, she had an attack similar to the present which confined her to bed for five or six weeks. For the six months immediately preceding the first attack she suffered by times from aching pains at the bottom of her stomach, but they were not at any time bad enough to consult a physician. During the first attack as well as the present, relief often followed a free discharge of pus per vaginam. Since recovery from the first attack she has been quite regular and suffered nothing unusual when unwell; but she often experienced soreness in the pelvic region after walking a long distance or working hard. Bowels fairly regular. She was fairly well nourished.

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\* Read at meeting of Maritime Medical Association, Charlottetown, July, 1899.

Examination :—Uterus of normal length and in normal position and was more or less fixed ; a hard mass in Douglas' cul-de-sac (the size of an orange) flattened from before backward and extending on a level a little below the cervix. This mass occupied chiefly the left fornix. There was a similar but smaller and softer mass in right fornix, which was very tender to the touch. Both tumors were firmly adherent to the uterus.

I treated her for the first two weeks as follows with no improvement :—Hot bichloride douches, 1 in 5000, twice a day and painted the cervix and fornices twice a week with Churchill's tincture of iodine, and inserted tampons of carbolized glycerine after each application.

Curetted the uterus on the 20th and packed it with iodoform gauze ; left packing in for twenty-four hours ; continued the hot vaginal douches twice a day for two weeks more ; no improvement. Recommended an operation with a view to removal of tubes and ovaries to which patient and her husband consented. On the 7th of November, assisted by Drs. Stewart and Archibald, I performed a double salpingo-oophorectomy. Prepared patient in usual way. Washed vagina with soap and water and douched it thoroughly with bichloride lotion, one in one thousand. On opening abdomen the ovaries, tubes, uterus and loops of small intestines were found matted together. Both the ovaries and tubes were prolapsed into Douglas' pouch and were intimately adherent to the posterior surface of the broad ligament and the pelvic wall and floor. I first separated the uterus from the intestines. This was effected with my finger and scissors. The left ovary and tube which were held firmly down in the cul-de-sac with old adhesions were lifted up with difficulty and the tube amputated close to the cornu. The ovary was also removed. The contents of this tube and ovary were thick and creamy. The adhesions binding down the right tube and ovary, however, were recent and separation was effected easily. The outer half of this tube where the pus was retained was very thin so much so that in manipulating the tube to free it from adhesions it burst and pus escaped into the pelvic cavity. Fully an ounce and a half of pus came from the tube. To prevent infection of the peritoneum the ovary and tube were packed all around with iodoform gauze. The tube was then amputated close to the cornu. All the appendages were hopelessly diseased. There was no chance to do any conservative surgery on either of them. There was very little bleeding from the sites of the de-

tached adhesions. The pelvic cavity was now washed thoroughly with warm sterilized saline solution poured from a pitcher. After drying the parts thoroughly and to establish free drainage, I made a counter opening through Douglas' pouch and after carrying a piece of gauze through it into the vagina, packed the pelvic cavity solidly with dry iodoform gauze. The vagina was also packed well with gauze. The abdominal wound was closed up in the usual way, viz.: The peritoneum with a continuous suture of catgut, the muscular and fibrous layer with interrupted sutures of catgut, and the skin with interrupted sutures of silk-worm-gut. The patient was then put to bed which had previously been made warm with hot water bags, and to overcome the shock of the operation which was considerable, hot water bags were applied to head, armpits and lower limbs and an enema of brandy and strong coffee was given at once and repeated every three hours, and hypodermic injections of strychnin, gr. 1/20, with tincture of digitalis, minims four, every two or three hours for the first twelve hours. The foot of the bed was raised eight inches. Reaction set in slowly. When she recovered from the anæsthetic she was very restless and complained of intense pain in the pelvic region. I gave her a hypodermic of morphine, gr. 1/6, and repeated it every four hours for the first twenty-four hours. She had little or no nausea from the anæsthetic. At 1 a. m., morning following operation, her temperature went up to 102.8, and pulse to 160 and weak. An ice-bag was now applied to head and abdomen. At 6 a. m. gave her 15 grs. of quinine sulphate per rectum, and ordered a cold sponge bath. Very restless during the night; slept only one hour and a quarter.

*Day report, Nov. 8th.*—Slept a little at 8.30 a. m.; at 10 a. m. temperature 100, pulse 140; discontinued the ice-bags; at 3 p. m. pulse and temperature unchanged; respirations 52; abdomen greatly distended with gas and tender on pressure. Introduced rectal tube and turned patient on her side; some flatus escaped which gave her great relief. At 6 and 9 p. m. slept a little.

*Night report.*—At 11 p. m., temperature went up again to 102.5; very distressed from distention of bowels with gas. Introduced again rectal tube higher up; considerable flatus expelled which gave her great relief. Tube left in for an hour or two. Was given three doses of calomel through night, two grains each. She was very restless the greater part of the night and slept only an hour.

*Day report, Nov. 9th.*—Abdomen greatly distended with flatus and patient very restless. She had a wild and anxious look with eyes somewhat sunken. She looked very bad. Her pulse was 160 and respirations 46, and temperature 100.4. Ordered high enema of soap suds with turpentine half ounce; bowels moved slightly; feeling sick at stomach. Repeated the enema in two hours; bowels moved a little. Patient still greatly distressed. At 5 p. m. inserted the rectal tube with good effect. Patient somewhat relieved. Rested very little through the day. Pulse, temperature and respirations unchanged.

*Night report.*—Eight o'clock, resting nicely. Slept only an hour and a quarter; was troubled very much with tympanites and nausea. Used rectal tube once, with fairly good effect; was given two grains of calomel at 11 p. m. and at 1 and 4 a. m.

*Day report, Nov. 10th.*—The calomel had good effect; rested well through the day; slept 5 hours. Pulse, 158; temperature, 100; respirations, 38. Ordered peptonized milk by the mouth for first time.

*Night report.*—Patient had a very good night; slept fully five hours. Felt quite comfortable and refreshed this morning. Patient looked very much better.

*Day report, Nov. 11th.*—Patient still keeping better; removed part of gauze packing; had slight attack of diarrhœa. Felt quite comfortable. Pulse, 138, and respirations, 32; temperature unchanged.

*Night report.*—Patient slept very well all night and felt very much better in the morning; had diarrhœa; washed rectum out with weak boracic acid lotion.

*Nov. 12th.*—Condition the same as on previous day. Diarrhœa better; slept all night; pulse down to 120.

*Nov. 13th.*—All the gauze packing in pelvic cavity removed. It was perfectly sweet; no discharge; washed vagina thoroughly with bichloride solution, 1 in 5,000. Slept all night; had slight diarrhœa through night.

*Nov. 14th.*—Patient feeling much better this morning. At 9 p. m. had a slight chill; pulse 160, temperature 102, respirations 38; had pain in lower corner of wound which looked very angry and inflamed. On removing the three lowest stitches quantities of milky fluid welled up from pelvic cavity which was perfectly odorless. A similar discharge came from vagina. Slept fairly well till 4 a. m., but was restless in her sleep.

*Nov. 15th.*—Discharge from abdominal wound contained fæcal matter, as also did discharge per vaginam. Washed both wounds thoroughly with boracic acid lotion. There was direct communication between the vaginal and abdominal wounds. Fæcal matter escaped constantly all night per vaginam and through the abdominal wound.

The case now presented a new complication. I had to deal with a fæcal fistula. This is the first case of the kind I ever had in my practice. The question now to my mind was, what best be done with the fistula? Whether to reopen the abdominal wound and try and locate the abscess, wash it out thoroughly, pack it with gauze, and stitch the wound up again, or to leave it alone? However, I decided to leave it alone and depend upon the thorough and frequent cleansing of the wound. From this date the case progressed as well as could be expected under the circumstances. Her pulse, temperature, and general condition gradually but steadily improved. She suffered intensely by times from colic and rectal tenesmus. This was especially the case after a purgative which we had to give her often, as her bowels would not move without medicine, and we would not dare to give her an enema. When she had these attacks, a knot of intestines could be felt with the hand passing down to the wound where their vermicular motion was suddenly arrested and a gush of gas issued from the opening. She then got relief. The fæcal discharge lessened gradually and on the twenty-third of December, she left the hospital well. When she was discharged, there was a small sinus at the lower angle of the wound which healed in a week or so. She now enjoys excellent health and is free from aches and pains and offensive discharges.

CASE II.—E. P., age 24, single. Was admitted into the Victoria General Hospital 23rd of June, 1899, suffering from a double pyosalpinx. She gave the following history: Menstruated at 13; was always regular, but flow usually scant; always enjoyed fairly good health till about Nov. 1898. Since then she has not felt very well, but had no occasion to consult a doctor till six weeks ago, when she was taken ill with an intense pain, of a sharp cutting character, in the region of right ovary. Sent for her physician, who examined her, and found a tumor in Douglas' cul-de-sac. For the past six months she had a yellowish discharge from the vagina. Patient rather anæmic. Examined her under an anæsthetic on the 25th. Result: Uterus of normal length and in normal position. A semi-elastic tumor, the size of a large orange, in Douglas' pouch, intimately adherent to uterus, and occupying a position

somewhat to the right of the mesial line, and an irregular mass immediately to the left of the uterus, firmer than the former, and adherent to it as well as the uterus. Both tumors were very low in Douglas' pouch. On the 26th of June, assisted by the house-surgeon, I performed a double salpingo-oophorectomy. Upon opening the abdomen, the entire pelvic contents were found adhered *en masse*. Separated intestines from the ovaries, tubes and uterus, first. The adhesions binding the ovaries and tubes to the posterior wall of the broad ligament and floor of the cul-de-sac were ill-defined and very dense, and the tubes and ovaries were exceedingly fragile, so that at every effort made to free them they burst and pus escaped. Their depth in the pelvic cavity added greatly to the difficulty of removing them. At last I had to separate them piece-meal, and portions of them had to be scraped off the peritoneum with the curette. The tubes were amputated close to the cornua of uterus. Fully three ounces of pus came from the right ovary and tube.

To prevent infection of the peritoneal cavity, the intestines were protected with sterilized gauze pads, and the ovaries and tubes were packed all around with iodoform gauze. The left tube was about the size of my index finger and free from pus. Both ovaries were completely disorganized. There was little or no oozing from the sites of adhesions. The pelvic cavity was then carefully washed with bichloride, 1 in 6,000 and afterwards thoroughly douched with normal saline solution.

To provide free drainage, an opening was made into the vagina behind the uterus, and a strip of gauze carried through it, and the pelvic cavity packed solidly with dry iodoform gauze, as in Case No. I. The abdominal wound was closed in the usual way. She suffered very little shock from the operation, but after recovering from the anæsthetic, she was very restless and complained of intense pain in the abdomen and of a good deal of nausea. She was given hypodermically, one-sixth of a grain of morphia at night, which made her rest fairly well the first night, but she did not sleep any. On the 27th, she was very sick and vomited considerably. Used the stomach tube and removed fully twenty ounces of dark, sour liquid therefrom. This gave her great relief and she slept three hours. Gave her one grain of calomel every hour till six or seven doses were taken,—no effect; gave an enema of soap suds with one ounce of turpentine, with good effect. She contracted bronchitis on the 30th, (fourth day after operation) and her tempera-

ture jumped up to 102.2, and pulse to 108. Cough very troublesome. On the 1st, of July, removed part of the gauze packing and on the third removed it all, and none was replaced. No odor from gauze packing; no discharge. Highest temperature 101.4 and pulse 103. The abdominal dressing was changed for the first time on the 7th of July. There was one stitch abscess, otherwise the wound looked well. After this convalescence was uneventful.

CASE III. Mrs. S., aged thirty-four, was admitted to Victoria General Hospital on January, 12th, 1899, with the following history: Menstruated at fourteen; was always regular; flow profuse especially since present trouble began. When seven years old swallowed a pin and since then had hæmorrhages of the lung till she was twenty-one, when she coughed it up—never had a hæmorrhage since. Was married twice; had three children. After birth of second child suffered from pains in womb and general weakness. About six years after this, patient was again married and eight months after, gave birth to an eight months child. After this confinement she was unable to leave her bed for some time. Was treated then for laceration of cervix and displacement of uterus. Improved somewhat. In January, 1897, on the advice of her physician, she went to the hospital for treatment. Examination revealed that she was suffering from a torn perineum with a tendency to rectocele; quite a marked laceration on left side of os uteri and to a less degree on the right. The uterus was curetted and the torn cervix and perineum repaired.

Two weeks after this she developed acute septic peritonitis, to which she nearly succumbed but after two months treatment she recovered sufficiently to enable her to leave the hospital on the 30th of March. She attributes her present trouble to the treatment she first received in the hospital.

From the time she left the hospital in March 1897, till she was re-admitted in January 1899, she complained of the following symptoms:—Severe pain low down in the pelvis and felt as if a lump were pressing down into the rectum. Had constant desire to make water; was troubled with constipation; under treatment with hot vaginal douches and rest, patient improved and was able to get about part of the time, but since June 1898 she experienced periods of severe pain in pelvic region followed by chills and fever and profuse perspiration. Each attack lasted three or four hours. Latterly these attacks became more frequent and retching and vomiting followed the chill. Bowels



irregular; stools more or less yellow and streaked with blood; urine thick and inclined to be bloody. Condition when re-admitted in January 1899 under Dr. Chisholm:—Hard mass in left fornix, extending behind the uterus and considerably to the right of it. Mass well down between rectum and vagina and tender to the touch. It involved the uterus, both it and the tumor being immovable. The uterus was lifted up and pushed forward toward the pubes. The cellular tissue was extensively involved. The tumor was easily felt in left inguinal region by palpitation. She was sent to hospital with a view to an operation, but at a consultation, the pelvic cellular tissue was found to be so extensively involved that it was decided to wait and try to hasten absorption of inflammatory exudate by local treatment, such as tampons of glycerin and ichthyol and hot vaginal douches. Pus had been discharged per rectum at irregular intervals the past year. Each attack was preceded by chills and fever. Patient came under my care about the 1st of May, 1899. Examined her on the 16th, and found a hard mass, tender to the touch, in the left fornix extending behind uterus and a little to the right of it. The mass was ill-defined and intimately adherent to the uterus and both very slightly movable. The tumor was much better defined now than it was when I examined patient with Dr. Chisholm in February. Uterus in normal position and practically fixed on left side, but its right side was somewhat free. The right tube was thickened and the ovary considerably enlarged and hard to the touch. The mass in right fornix was always smaller after the discharge of pus per rectum.

Performed a bilateral salpingo-oophorectomy on the 3rd of June assisted by Dr. Chisholm, in whose service the patient was, till I succeeded him on the first of May. Two or three loops of small intestines were intimately adherent to the posterior surface of uterus. These were separated without much difficulty. On holding the loops of intestines to one side no ovaries could be seen nor tubes either. They were prolapsed and turned in under the border of the broad ligament and covered over by adhesions formed between the ligament and meso-rectum, and not till I passed down one finger in front of the ligament and another behind it, did I succeed in locating the ovaries. They felt as if they were situated between the folds of the broad ligament. I then separated the adhesions between the ligament and meso-rectum and dug out the ovaries and tubes with my finger. This was not an easy task. The right ovary was as large as a good-sized orange and contained a little pus, the left about the size of a hen's egg. They were both completely disorgan-

ized. In separating the adhesions I accidentally tore the peritoneal layer of rectum to an extent of an inch which I stitched up before closing the abdominal wound. I could find no trace of a fistulous opening communicating with bowel even after injecting the rectum with about ten ounces of normal saline solution. I then made a counter opening through vagina and douched the pelvic cavity thoroughly with normal saline solution and packed it firmly with dry iodoform gauze as in cases I. and II.

Patient stood the operation well. She had a good deal of pain the first day or two, and suffered greatly from nausea and vomiting, so much so, that I had to wash out her stomach on the second day. This gave her great relief. The nausea and vomiting ceased at once. Although she rested well the first night, she only slept one hour. On the third day after operation, she was given 1 gr. of calomel every hour till her bowels moved, which occurred after the sixth dose. After this she rested well. Her pulse ranged since the operation from 80 to 110, and temperature between 99.8 and 101.6. On the 9th of June (the seventh day after operation), I removed the gauze packing and none was replaced. It was perfectly sweet and free from odor. Douched vagina with bichloride lotion, 1 in 5000, and inserted a tampon of iodoform gauze. In the evening she had a pronounced chill and her temperature went up suddenly to 104, and pulse to 110. Was ordered a cold sponge bath and 15 grains of quinine sulphate. Temperature registered the following day, 102 and pulse 108. On the 12th she had again a slight chill. There was a free discharge of milky fluid from vagina the day after packing was removed, which in a few days became purulent. The abdominal dressing was now changed for the first time. There was a slight discharge of pus from the two lowest stitches. After this her temperature gradually dropped and the further progress of the case was uneventful.

Cases II. and III. are still in the hospital, and at the present moment they are doing well. One was operated upon on the 3rd of June, the other on the 26th, so that sufficient time has not yet elapsed since the operations to enable me to say positively what the ultimate results will be, whether these patients shall be the victims of such terrible symptoms as are predicted for them by the advocates of hysterectomy, or otherwise. This much I can say, however, the indications for success are very encouraging. Case III. is sitting up and is free from pain or vaginal discharge. This was a case of acute septic infection following curet-

ting of the uterus, just such a case as might reasonably be subjected to the major operations, as the uterus in these cases is more than likely diseased. But notwithstanding this I desisted, believing that the removal of the adnexa would have a salutary effect on the diseased organ, and that atrophy of the uterus would take place sooner or later. No microscopical examination was made of the contents of the ovaries or tubes. Case II. has some discharge from the counter opening in the vagina but she has no pain nor rise of temperature. She feels well. Cases I. and II. were gonorrhœal in origin. No microscopical examination was made of the contents of the tubes or ovaries in these cases either.

One of the most important problems which arise in connection with cases of "Suppurative Diseases of the Appendages," and which has occupied the attention of leading gynæcologists, both on the continent and the United States the past eight or nine years, and which I may say is still occupying their attention is, "When in operating for septic diseases of the adnexa, it becomes necessary to remove the ovaries, is it usually advisable to remove the uterus also?" Some answer the question in the affirmative and some give a negative reply. Amongst the former may be mentioned such men as Pean (of forceps fame), Polk, Krug, Baldy, Pryor, Richelot, Sijoud, Jacobs, Henrotin and others, and amongst the latter, A. Palmer Dudley, Goffe, Noble, Wyeth, Martin, Van Hook, Landau, Pozzi, Ferguson and others. Most of these are able gynæcological surgeons whose opinion on suppurative disease of the appendages should be respected. Now when such eminent authorities arrange themselves, so to speak in two schools, advocating entirely opposite methods of treatment, it is difficult for us to know which to follow, or to lay down any definite plan of treatment. It seems to me that after all we have to be guided by the circumstance of each case and our own individual experience.

While I am on this question, it may not be out of place to look into the subject a little closer and endeavor if possible, to find out the cause of this divergence of opinion. To my mind, it is this:—Operators have found that a great majority of women who have had their ovaries and tubes removed, were cured; a small percentage, however, were not cured. Some operators started out to seek "a sure cure" for that small proportion, and in their vagaries lighted upon the happy expedient, hysterectomy; and in this operation they claim to have found a "panacea," for all the aches and pains, associated with suppurative dis-

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eases of the adnexa. They hold that an "emasculated uterus" is a useless organ; nay, "is a dirty hole" which if retained, keeps up such disagreeable symptoms as leucorrhœa, irregular discharges, profuse abnormal flow, bloody flow, and weight and dragging in pelvis. They say, remove the organ and you will get rid of all these disagreeable symptoms, and also destroy neoplasms—unless malignant—and usually remove pelvic pain and render nervous disorders, due either to the diseases or the climacture period, less. Doubtless there would be much force in their contention if they were satisfied to limit the operation to uteri actually diseased. But they are not. They say, remove the organ in every case whether it is diseased or not. This doctrine is to me unsurgical, as well as unscientific. That no healthy organ should be sacrificed needlessly is a sound surgical principle.

Dr. Martin in a paper read before the Chicago Gynæcological Society entitled "Plea against Hysterectomy when Removing the Ovaries for Septic Disease," said, "never remove the healthy uterus for the cure of a pathological condition foreign to it, remove it only for inherent disease when such disease is incurable by minor means and seriously menaces the life of the patient. Therefore I should most positively oppose the removal of the uterus in all cases, simply because the appendages of both sides are the seat of apparently incurable diseases."

"It seems to me that the same rule should govern us which governs the general surgeon in operating upon other portions of the body. The general surgeon removes no portion of the hand which he can by any possible means save. That is the ideal rule and should, I think, be applied by ever conscientious man to all portions of the body."

On the other hand, those who are opposed to indiscriminate hysterectomies in cases necessitating the removal of the ovaries and tubes, contend that they can effect practically as many cures by simpler methods, such as dilating the uterus and curetting and packing it with gauze.

Recognizing the fact that disease of the appendages usually has its origin in the interior of the uterus, it seems therefore rational to attack the original seat of the disease while removing the organs which have become affected subsequently. They claim that it is a correct practice to dilate, curette and pack the uterus with gauze before opening the abdomen, to remove the appendages, and they also claim, that if this plan was more generally adopted, it would obviate the necessity of removal of the uterus in many instances.

I fear that some of those who advocate hysterectomy in every case of bilateral ablation of the appendages for suppurative disease of the tubes, are not safe guides to follow. Indeed it is sometimes difficult to understand their position. One day they advocate, with all the energy they possess, a certain line of treatment and claim it is the treatment "par excellence," and another day they declare it is no good and advocate a very opposite treatment.

In 1893, Dr. Polk read a paper before the Obstetrical Society of New York in which he stated that he could cure ninety-nine cases out of a hundred of pyosalpinx by curetting the uterus, packing with gauze and draining. Four months afterwards he read a paper in which he advocated removal of the entire uterus for pyosalpinx. Where is the middle ground between these two papers? It seems that Polk is willing to sacrifice ninety-nine healthy uteri to run a very dangerous and doubtful chance of curing one.

Those who oppose the indiscriminate recourse to hysterectomy contend, and to my mind rightly, that the operation should be limited to the following class of cases :

1. In cases with suspicions of malignancy.
2. In cases in which the uterus is the seat of fibroids.
3. In septic cases with local deposits of pus in the uterus.

They oppose oophoro-salpingo-hysterectomy on the following grounds:

1. The operation is unscientific and unsurgical.
2. It is a mutilation, as it involves the removal of an unoffending organ.
3. Hysterectomy involves greater danger to the patient than salpingo-oophorectomy alone.
4. It destroys the equilibrium of the pelvic floor, displaces the pelvic fascia, changes the axis of and shortens the vagina, and thereby tends to produce prolapse of the abdominal viscera and the remaining pelvic organs into the vagina.
5. It unsexes the woman and destroys sexual feeling.
6. The ablation of the uterus produces a more profound impression upon the nervous system.
7. In every young woman, or such as have infantile sexual organs, the operation is said to be followed by involution of the vagina, with atresia.

My experience of bilateral ablation of the appendages for suppurative disease is confined to the three cases reported above, and of course

I cannot speak of the operation with the same authority as those who can count their cases by the score; but still the little experience I have had enables me to say that it is not at all necessary to remove the uterus in every case of double pyosalpinx. The operation of oophoro-salpingo-hysterectomy is only called for in cases in which the uterus is actually diseased. As for instance in cases following septic infection where multiple abscesses exist in the substance of the organ.

June 15th, 1900.—Cases I. and III. are enjoying excellent health. They suffer no pain and have no vaginal discharge of any kind. Both are doing household work. Case II. is in good health and is attending to her usual work as nurse. Her physician under date 7th inst., informs me that she has pelvic pains occasionally and vaginal discharges. On the whole she feels very well.

Two months ago I operated on the following case for double pyosalpinx with abscess of both ovaries:—

CASE IV.—M. McK., aged nineteen, unmarried, was admitted to the Victoria General Hospital Dec. 13, 1899, complaining of a dragging pain in the small of back and a bearing down pain in hypogastrium and dull aching pain in inguinal regions; had a child 10 months ago. Since then she has never been well. Examined under ether and found a retroverted uterus with some flexion; cervix slightly lacerated and the posterior lip eroded. Cervix was dilated and uterus curetted and nitrate of silver applied to its interior. The uterus was replaced and a pessary inserted. This did her no good. She was again examined on the 25th of Jan., 1900, but nothing new was discovered. She was discharged Feb. 6th slightly improved.

I saw her for the first time February 15th. She then complained of pain in the pelvic region, chiefly over the left ovary. Examined her without an anæsthetic and found the left tube thickened and left ovary tender and enlarged; marked retroversion of the uterus with flexion; ordered rest and vaginal douches.

Saw her again on the 10th March; condition no better; saw her the third time on the 18th and found her in a state of collapse; pulse almost imperceptible, temperature  $102\frac{1}{2}$ . She was covered over with cold and clammy perspiration; there was marked tenderness over the lower part of the abdomen which was swollen and tympanitic. She continued in this way till the 24th of March when she took a change for the better and recovered slowly.



On April 11th I performed double salpingo-oophorectomy. On opening the abdomen found the intestines, tubes, ovaries and uterus matted together. Some of the adhesions were recent, others old. Had considerable difficulty in making my way to the fundus, which was retroverted and firmly bound down to the floor of the pelvis. The tubes were full of pus and met over the uterus. They were firmly adherent to each other. Each was the size of a large sausage and full of pus. Each ovary was the size of a large orange, and loaded with pus and situated behind the broad ligament. In separating them, (tubes and ovaries), the ovaries burst and pus escaped into the pelvic cavity. Gauze packing was used to prevent general infection of peritoneal cavity. The tubes and ovaries being removed I irrigated the pelvic cavity with bichloride lotion (1 to 7,000) and afterwards with peroxide of hydrogen—1 to 1—and lastly with sterilized normal saline solution. The parts were then dried thoroughly and a counter opening made in Douglas' cul-de-sac and the pelvic cavity was drained and packed with iodoform gauze. The abdominal wound was closed in usual way. She was very weak after the operation but rallied under restorative treatment rapidly. Removed part of the gauze packing on the 18th and the whole of it on the 20th under an anæsthetic. Considerable pus came away with the dressing. Washed cavity out well with permanganate and inserted a drainage tube. Highest temperature registered up to this date was 101.8. Washed cavity well with peroxide of hydrogen on the 21st after which the discharge quickly lessened and her temperature dropped to normal and she made a rapid recovery. She was discharged well on 1st of June. She is now well and suffers little or no pain.

These are the only cases of the kind I have had in my practice so they are not picked. The results obtained are very satisfactory.

## TINEA FAVOSA.\*

By GEO. G. MELVIN, M. D., St. John, N. B.

Although, so far as I am aware, this disease is not considered by the immigration authorities of Canada sufficient cause of exclusion or quarantine, yet the recent action of the United States government with regard to it, combined with the ever-increasing importance of this city as a port of entry for transatlantic passengers, has invested the subject of favus with interest, not only to the profession, but to the public generally. I do not think it is necessary to enter upon any argument as to the wisdom of our Republican neighbors in their efforts to exclude this disease. The only cause for astonishment is that similar steps had not been taken years ago. To any one at all familiar with the population of the lower quarters of the great American cities, especially New York, their habits of life, their origin, and their continual and enormous accession of numbers from the down-trodden, ignorant, debased and servile classes of Europe, the expediency of the action will at once commend itself. Nor is this action to be characterized as a selfish one. Indeed, in its nature, it is the very reverse. Although individual cases of hardship do occur in consequence, it is the very best method that could be taken to benefit these people themselves. Human and charitable organizations, without number, are constantly endeavoring, and with a considerable degree of success, to educate, elevate, and above all, to invigorate this population. Considering no task too severe, no expenditure too great, depressed by no discouragements, the splendid charities of our American cousins only ask that the personally diseased and those liable to injuriously affect their neighbors be eliminated from that continual stream of immigration, which for four centuries has set toward the confines of the New World. To bring this matter a little nearer home, I think it would be well if our own authorities followed the example of the Great Republic in this matter, as they have in many other innovations for the betterment of mankind. I am aware that there are other places more appropriate to discuss this phase of the subject than within these walls. Here, we are supposed to be rigidly

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\* Read before the St. John Medical Society, March 7th, 1900.

scientific. We confine ourselves, as much as possible, and very rightly so, to the purely professional aspect of things. Yet, if I am not mistaken, this very step was proposed and pressed upon the attention of the United States Government by the Medical Society of the County of New York. And, further, I am quite sure there are none of us who would not strongly resent the imputation that we are so wedded to our profession as to forget the humanities, and it is with this idea that I have ventured to submit the foregoing remarks. Of course, in the nature of things, happily, no large experience can be had of favus in private practice in this city. Nor, indeed, does one see much of it in that great centre of modern civilization, London. Within a practicable distance, it is most frequently to be met with, as I have hinted, in New York, and it was in that city that I acquired the only practical knowledge that I possess on the subject. In the following remarks, whenever personal experience fails, I shall follow Crocker, who, in addition to his eminent scientific attainments, possesses a literary ability that makes reading his works a pleasure. The name signifies a honeycomb, and it is no bad description of its most typical, and perhaps, its most constant appearance. It is an affection characterized by canary-yellow cup or rather saucer-shaped discs, pierced in the centre by a hair, in the hairy regions, and common to the whole body surface, though its favorite situation is the scalp. It is due to a fairly well differentiated vegetable parasite, and is therefore contagious. Though I am informed it is common in Scotland, it is, as I have said, among the rarest of dermatological lesions in England. This is a little curious, as, again, across the Channel, in France, it is of frequent occurrence. A French authority states that over a thousand conscripts are rejected annually there, in consequence of the disease. It is, however, in Russia, in the acquired districts of Poland, in the Slavic portions of Austro-Hungary, and, perhaps, in Syria, that it is most rife. In many of these regions it is endemic, and it is from them that nearly all our cases come. The peculiar, small, concave disc, deeply seated in the epidermis, of the characteristic yellow color, is its typical beginning. The hair becomes dry and lustreless, though, as a rule, much less brittle than in tinea tonsurans. The disc usually envelopes the shaft of a single hair, but it is not until the disease has made considerable progress that the latter becomes easy to extract from its follicle. As these discs enlarge and increase in number, they coalesce, and except in color, which never quite gets rid of its yellow hue, might not be inaptly compared to solidified patches of "pancake" ice, so often seen in our rivers in the

fall, after having become circular by constant attrition. When this coalescence occurs, as is also the case with the ice, the crusts and scales become heaped up in thickened masses about the periphery of each disc. This sometimes almost makes the circular contour of the disc, and, partially losing their yellow pigment, they lay a trap for the unwary observer, who, seeing this condition, immediately thinks of psoriasis. This is the ordinary course of the disease. It may, however, attack the non-hairy regions, and even the nails. In one remarkable case, seen by Dr. Roddick in the Montreal General Hospital, and described by him, nearly the whole cutaneous surface was involved. It has also been known to attack the mucous membrane of the digestive system, in one of which instances it proved fatal. Without treatment its natural course is of almost, although not quite, interminable length. If we cannot, in strictness, apply the term "self-limited" to it, it certainly seems liable to self exhaustion. The scalp then assumes a peculiar appearance. If the disease has been extensive and intense, as, without treatment it almost invariably is, we have, as regards the hair, a condition resembling that which often happens in agriculture, in consequence of the sowing of very inferior seed. The scalp presents the appearance of a "missed" field of wheat. Absolutely bald patches are numerous, but of no great extent. Here and there over the region, are hairs, perhaps fairly healthy, but from an eighth to half an inch apart. Again, small, fairly thick tufts appear, and, if we imagine the surface of our wheat-field changed into hard, white, glistening rock, with shallow depressions scattered at intervals over it, the picture is complete of a post-favus scalp. It is undoubtedly propagated from person to person, and that this is the way the vast majority of cases arise, there can be but little question. However, indirect methods are often responsible. The domestic animals, dogs, and especially cats, are very susceptible to the contagion, as are also mice and rats. The comparatively innocent term "mange" so often applied to cutaneous diseases of the former animals, is, without doubt, often made to cover the grave disease in question. Compared, however, with many of the other local contagious diseases, the danger of infection is but small. Close and prolonged contact, infancy or youth, and gross neglect of cleanliness are almost always essential. I think it only probable that it is often contracted through abrasions of the skin. Nothing is more common among the classes in which it is endemic than pediculi capitis. This gives rise to scratching, which in turn sets up an impetigo, by means of which the achorion finds ready entrance and a

grateful soil. The incubation period is somewhat doubtful, but probably is not less than three nor greater than six weeks. The mode of ingress is almost undoubtedly the hair follicle, and it has been conjectured that two or three days neglect of washing is necessary to enable it to make a permanent and successful lodgement.

Researches within the past quarter of a century have pretty well determined the pathology of the disease. It is no longer a question that it is due to a fungus, the mycelium and spores of which can be easily detected, under proper conditions, with a lens of sufficient power. An interesting point in this connection is that observers are by no means agreed as to whether this fungus consists of a single or of several species. To the ordinary observer it would seem that the weight of evidence is in favor of a multiplicity of species, for certainly in any good specimen there is considerable divergence in the size and shape of the spores and in the length, contour and breadth of the mycelium. From analogy also we would draw the same conclusion. In *tinea tonsurans* we have certainly two varieties of fungi, at least, the *endothrix* and *ectothrix*. However, they rarely exist together in the same case, and are so distinct that an active observer will distinguish them by the clinical aspect of the lesion. Still, you will probably agree with me that, until the authorities settle this question, we can consider more profitably other points of the disease.

Although no lesion situated on the skin is more distinctive than favus when typical, yet it is capable of so masking itself, that its diagnosis, off-hand, is by no means an easy matter. Sufficient has been already said regarding this typical appearance. But when it is not so, it is liable to be confounded with *tinea tonsurans*, psoriasis, impetigo and eczema. In the first there is not the distinctive color, no loss of tissue as a rule, greater brittleness of the hair, and the individual lesions are very much larger, and less well-defined than in favus. To distinguish between the two the microscope is of little use, except to an observer with unique advantages and long practice. Both diseases present fungi, and to pronounce definitely between the trichophyton of *tinea tonsurans* and the fungi of *tinea favosa* is what no one should do without distinct confirmatory clinical evidence. Where favus has partially lost its yellow color, where the discs are crowded together in the manner already described, and where scratching and dirt have set up an impetiginous condition, it is sometimes impossible to come to a definitive conclusion.

In such cases all that can be done is to set the case aside for a week or two, arrest the impetigo, and the disease will then disclose itself.

Psoriasis is white, with crusts very much thicker, no loss of tissue, as a rule, and almost invariably present in some of its favorite locations on other parts of the body. Also, of course, the microscope would be negative. Impetigo is very liable to be associated with favus. Though the itching in the more grave disorder is often not so great as in many other cutaneous diseases, yet it is generally sufficient to give rise to considerable scratching and consequent pus-inoculation. But it glues down the hairs, pus is always present, pediculi hardly ever absent, and there is lacking any of the distinctive characteristics of favus. The microscope also, by its negative result, would serve to confirm the diagnosis.

Eczema ought not to cause much trouble. On the scalp it is almost always seborrhœic, and evidence of this condition is usually obtainable elsewhere.

It is very uncertain how long the disease lasts when left to itself. In my own somewhat limited experience I have not got a history of an active case of more than fifteen years. When contracted in youth it is extremely improbable that it will persist into middle age.

To cure it, time and much patience are required. Crocker says there are three procedures necessary, but with all due deference to that eminent man, I think we should add a fourth. I think it is quite certain that in addition to the removal of the crusts, epilation of the diseased patches, and the application of parasitocides, the first step should be the close clipping of the scalp. To keep it closely clipped is really a most difficult matter, unless the surgeon himself chooses to act the barber's part, a part—needless to say—most offensive and disagreeable. It is needless to linger upon the question of the removal of the crusts and epilation. Everyone can easily understand the utility of these operations. Indeed, unless they are conscientiously done, there will be but little efficacy in any curative application.

The list of remedies is a long one. In fact, speaking generally, the application suitable for tinea tonsurans will be useful in favus, but requiring, if possible, a more thorough application, and to be of greater strength. The paramount object is to drive the germicide into the hair-follicle, where the disease really resides. Whichever plan will best do this will quickest and most thoroughly cure the lesion. Where the disease is but recent, and the discs few, T. Colcott Fox's method in tinea tonsurans is easily applicable and I think, quite efficient. He applies

pure croton oil to the affected parts. This is severe. If pushed far enough it causes a violent inflammation of the diseased follicles, with a possible permanent scarring, but it will efficiently kill the fungus. Oleate of copper, 20 per cent. is excellent, while resorcin  $\bar{z}$ i. to  $\bar{z}$ i. has proved curative. But at best, it is but a tedious process, and even when all traces of the disease have disappeared it is necessary to hold a definite pronouncement of cure in abeyance in order to ascertain if fresh lesions do not appear.

Several minor points in connection with its management are far from being unworthy of notice. The unaffected parts of the scalp should be daily subjected to some antiseptic wash. A really germicidal soap, such as is put up by Parke, Davis & Co., is most useful for this purpose. It serves for purposes of cleanliness as well as prophylaxis. Segregation or isolation in the daytime is not absolutely necessary if proper methods are taken. One of these is to make the patient constantly wear a skull-cap of some cheap material, as paper, which can be burned each night, and a new one at once provided.

I trust that in this very imperfect sketch I have not been too didactic. I have attempted, so far as in me lies, to present it in as little a hackneyed manner as possible. If I have employed illustrations savoring of the flood and the field, it has been with the object not only to cast old ideas into new language, but to impart into a subject, in itself repulsive and disgusting, some little of the free air of heaven and of the beautiful and unchanging laws of nature.

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2. As a Treatment  
for Diabetes.

3. As a "Nerve-  
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acterized by Debility,  
Spermatorrhœa, etc.

4. As a Purgative  
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## SHALL THE SPECIALIST DIVIDE THE FEE WITH THE GENERAL PRACTITIONER?\*

By EMORY LANPHEAR, M. D., Ph. D., L. L. D., St. Louis, Mo. Formerly  
Professor of Surgery in the Kansas City Medical College and in the  
St. Louis College of Physicians and Surgeons; Gynecologist  
to St. Joseph's Sanatorium, St. Louis.

When an attorney in a county-seat has a client in danger of the penitentiary (whom he might defend successfully, but fears failure) and hence in need of the best of counsel it is customary for him to seek some eminent lawyer of a great city and request his aid. In so doing does he approach the distinguished gentleman and say: "I have a client accused of—, who is able to pay \$3,000 for his acquittal; will you take the case with me for this sum—leaving me the gratification of having done my professional duty?" By no means! He plainly states: "My patron has \$3,000 to pay for his defense; are you willing to take \$2,000 of this to join me in securing justice for him?"

Arrangements of this kind are made daily in every large city. Does anyone ever suggest that the country attorney has been guilty of a dishonorable act in thus securing his city brother to do the major part of the work for \$2,000, he retaining \$1,000 for his services? Would any doctor, sued for \$100,000, regard such a transaction as disgraceful, unethical, objectionable if thereby he were saved this sum?

But let the question be one of saving life instead of securing liberty or preventing financial loss—and how different it is!

If a country practitioner have a patient affected with recurrent appendicitis (upon whom he *might* operate with success, but fears possible failure) with a prospective fee of \$600, must he—in order to be "ethical"—write to some city surgeon to come to his help, take all of the \$600 and leave him merely the satisfaction of a duty well performed or at best the little sum of money he may receive for a few visits at starvation rates? "Upon what meat doth this our Cæsar feed that he hath grown so great?"

\*Extract from a paper read before the Missouri State Medical Society, May, 1900.

Why should not the country doctor plainly say to the specialist: "I have a patient with appendicitis who is able to pay \$600. Will you operate for \$400 and allow me \$200 for the preparation, after treatment, etc.?" What would be wrong about this? Let Drs. Robt. T. Morris, of New York, and Burnside Foster of St. Paul, who so vigorously maintain that division of the fee is unethical under any and all circumstances, point out what injustice would thereby be done to (a) the patient, (b) the attending physician or (c) the eminent surgeon. Why should we not learn a few things from the methods of our most noted lawyers, men who are above suspicion as to purity of motives? Have we not hitherto been too unmindful of the financial interests of ourselves and our professional brothers?

I insist that the payment of a "commission" for all business simply "referred" to a specialist, or for a mere consultation, is probably unethical—certainly demoralizing in tendency; but that division of the fee is perfectly honorable and right when the specialist and the general practitioner jointly share the work and the responsibility.



THE  
MARITIME MEDICAL NEWS.

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Editorial.

THE TRAINED NURSE.

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Many are the wonders which we have seen in these latter days; many the innovations; many the revolutions. In every calling and profession which engage the attention of men, change has been the rule, and a necessary step in progress. In our own profession discoveries of momentous import have led to such advance in our ideas of disease and its treatment that we are fain to believe that ours is the most progressive of all the professions. And synchronously with these discoveries, Sairy Gamp has disappeared from the sick-room, and her place has been taken by the educated, refined, earnest, devoted, trained nurse.

The trained nurse has become a positive essential. By her aid alone can our modern ideas of infection, sepsis, etc., be made practical in our work. The inborn and inbred prejudice of the average mortal against fresh air, sunlight and cleanliness in the sick-room cannot be successfully combatted unless the physician can leave there a guard who will faithfully and with intelligence follow out his instructions. Such a guard is a nurse trained to be systematic, self-reliant, tactful; with such a knowledge of the principles of disease as to give her an intelligent interest in the management of her patient, and to give "first aid" should an emergency arise.

There is, however, a quality common to nearly every trained nurse which frequently is most irritating, and sometimes is even reprehensible. Doubtless the tendency to discuss diseases and doctors in the presence of the patient is often but evidence of that enthusiasm for which the trained nurse is noted, but it is none the less objectionable. Fortunate is the physician who has not had a nurse who has discoursed learnedly to her patient upon the significance of the various symptoms presented by the patient, and the treatment which other doctors would doubtless adopt under similar circumstances.

To a certain extent the nurse is to blame for this. The gentler sex are not always past-masters in the exercise of tact and judgment. But we incline to the opinion that the training of the nurse is accountable in very great measure for this unfortunate and annoying fault. The hospital of to-day which does not have its training school is indeed a rarity. The spirit of rivalry which exists between hospitals embraces the training schools, and each school strives to outdo the others in some or other feature. In consequence the curriculum of the average training school now includes a variety of subjects which is really astounding. A smattering of knowledge in nearly every subject of the medical curriculum is imposed upon the pupil. Many schools actually give their pupils a synopsis of the symptomatology and treatment of the more common diseases. The result is what one might expect. The attempt to cram so great an amount of technical information into the understanding of the young woman who has not been suitably prepared for such a course of study, is almost certain to result in imparting that little knowledge which is a dangerous thing. Not realizing the incompleteness of her store of knowledge, and proud of her ability to rattle off some medical terms of complicated orthography, she is very apt indeed to be led into conversations in which she may not always be discreet. There is no need for making an amateur doctor out of the nurse. Much of what is taught her is not of the least practical use to her. Time and energy which might better be devoted to more useful training are acquired for a technical education which is not only useless but often actually prejudicial to the usefulness of the nurse.

Without desiring to indulge in anything which might be considered "carping criticism," we nevertheless feel that the real object of the training school is being over-reached in most of our hospitals, and we venture to protest against the prevalent habit of giving nurses instruction in the theory and practice of medicine. The duties of the nurse do not require that she should be posted in the symptomatology, pathology and treatment of disease. Let the nurse know how to maintain cleanliness and order in the sick-room, how to keep the bed neat and comfortable without unnecessarily disturbing the patient, how to administer food, medicine, enemata, baths, etc., how to prepare poultices, how to make ready for operations, how to administer massage, and how to be discreetly companionable. But why should she be stuffed with imperfect ideas of the abstrusities of medicine, and led to think herself capable of passing judgment upon the capabilities of the doctors who employ her?

## MEDICAL SOCIETY OF NOVA SCOTIA.

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Once more we wish to remind our readers of the approaching meeting at Amherst on the 4th and 5th of July. The programme promises to be one of the most interesting and profitable so far given in the history of the Society. The address by the President, Dr. Mackintosh, will be on "The Duty of the People towards the Medical Profession," after which Sir Charles Tupper will address the Society. The subject for discussion in Medicine will be "Cholera Infantum," which will be opened by Dr. Andrew Halliday, of Shubenacadie, and closed by Dr. D. A. Campbell, of Halifax. The discussion in surgery will be on "Prostatic Affections," in which Dr. James Bell, of Montreal, has kindly consented to take part. Dr. Bell will also deliver the address in surgery on "Some Observations on the Treatment of Cancer of the Breast."

The above are only a few of the interesting topics which will be discussed at the approaching meeting. Surely the majority of us can forsake practice at this quiet season and enjoy two profitable and pleasant days at Amherst.

## MARITIME MEDICAL ASSOCIATION.

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The Maritime Medical Association takes a high position in the medical world of the Maritime Provinces. Practitioners have found much pleasure and profit from the papers and discussions at the meetings of the Association. The attendance of members is not only good but generally representative and an excellent opportunity is afforded of meeting brother maritime medicals—not a small advantage in the opinion of those attending meetings.

The three centres where the Association holds its meetings in turn—Halifax, Charlottetown and St. John—are all within reasonable distance, yet each presents sufficient difference to be attractive.

This year, the annual meeting will be held in St. John on the 18th and 19th of July. A substantial programme has been prepared, consisting of papers and three discussions, while several medical men from a distance have accepted invitations to be present and take part in the proceedings. This will add interest and value to the work done; yet it has been kept steadily in view in making the arrangements that these meetings are preeminently for the participation of its own members. It is desirable that as many as possible should take part; names

and titles of papers should therefore be forwarded to the committee of arrangements or secretary as soon as possible.

The discussion in medicine will be on Arterio-Sclerosis—opened by Dr. W. H. Hattie, Superintendent of N. S. Hospital for the Insane, Halifax; followed by Drs. C. D. Murray, Halifax; S. Skinner, St. John; G. M. Campbell, Halifax; F. H. Wetmore, Hampton.

The discussion in surgery will be on Spinal Deformities—opened by Dr. E. Farrell, Halifax; followed by Drs. Wm. Christie, St. John, and N. E. McKay, Halifax.

There will also be a discussion in Gynæcology on Uterine Retro-Displacements—opened by Dr. P. Conroy, Charlottetown, followed by Drs. A. B. Atherton, Fredericton, and T. J. F. Murphy, Halifax.

Papers have been promised by Drs. John Stewart, Halifax; G. E. Armstrong, Montreal; H. D. Fritz, St. John; E. A. Kirkpatrick, Halifax; N. E. McKay, Halifax; T. D. Walker, J. H. Morrison and J. E. March, St. John.

Dr. E. W. Cushing, of Boston, will attend the meeting and take part in the discussions.

The St. John members hope to make the stay of their visitors as pleasant as lay in their power; to this end some of their energy is being directed to the adequate entertainment of the Association and its guests.

It is satisfactory to note that the indications point to an unusually large meeting.

## CANADIAN MEDICAL ASSOCIATION.

It has been suggested that the great fire at Ottawa will interfere with the success of the Canadian Medical Meeting in that City on September the 12th, 13th and 14th next, but we are glad to be in a position to state that the profession of Ottawa are working with redoubled energy, and from what one learns from all over the Dominion the profession at large intends to see that the Ottawa people are not disappointed.

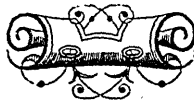
A goodly number have signified their intention of reading papers. In addition to Mr. Edmund Owen, of London, England, Dr. F. Shattuck, Professor of Clinical Medicine in Harvard, will contribute to the programme. An address in Gynæcology will be given by Dr. Wm. Gardner, of Montreal; Dr. Gerster, of New York, will read a paper on "Some Gall-stone Cases"; A. M. Hamilton, of New York, has promised a paper on "The Recognition and Management of Tabes Dorsalis"; and Nicholas Senn has also promised to be present.

### THE COGSWELL LIBRARY.

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New medical works are being constantly added to the Cogswell Library at the Halifax Medical College by the energetic committee appointed for that purpose. Any registered practitioner in Nova Scotia can obtain books on loan by complying with the regulations. The following new books have recently been added:

Text Book of Hygiene, Rohé; Goodhart's Diseases of Children; Jamieson's Skin Diseases; Von Jaksch's Clinical Diagnosis; Jacobson's Male Organs of Generation; Tirard's Albuminuria; Stevenson's Wounds in War; Brunton's Tables of Materia Medica; Introduction to Modern Therapeutics; Pharmacology; Fenwick's Diagnosis; Binz's Pharmacology; Bramwell's Anæmia; Murray's Rough Notes on Remedies; Brodbent's Diseases of the Heart; Garrod's Rheumatism; Transactions of the Obstetrical Society, 1898, vol. 40; Keith's Plea for a Simpler Life; Balfour's Diseases of the Heart; Encyclopædia of Medicine; Osler's Cerebral Palsys; Secret Nostrums; Taylor's Structure of the Nervous System; Osler's Diagnosis of Abdominal Tumors; Dana's Nervous System; Angina Pectoris; Cheyne and Burghard's Surgical Treatment; Thompson's Dietetics; Kelly's Gynæcology; Wyeth's Surgery; Jacobi's Therapeutics of Childhood.





## Society Meetings.

### SAINT JOHN MEDICAL SOCIETY.

MAY 2ND, 1900.—Dr. Scammell, President, in the chair.

A paper on "Spastic Paraplegia" was read by Dr. Skinner. A typical, well-marked case of the disease was first exhibited. The patient, a young man, developed spastic symptoms about one year ago and the condition has gradually increased.

The pathological changes found in spastic paraplegia were then fully considered, special reference being made to Golgi's method of investigation by staining nerve tissue. The cell unit and neurons were described and the course of sensory and motor impulses were traced by means of diagrams.

A history of syphilis may be obtained in the majority of cases and in the one already referred to dated back four years.

MAY 9TH.—Dr. Crawford in the chair.

A discussion on "Puerperal Eclampsia" was opened by Dr. Murray MacLaren.

Several members took part.

Dr. Melvin referred to an instance which had come under his observation of puerperal eclampsia having occurred in three members of one family, all within comparatively a few months and all fatal.

MAY 16TH.—Dr. Scammell, President, in the chair.

Dr. J. H. Morrison read a paper on "Sympathetic Ophthalmia." This paper will appear in the NEWS.

MAY 23RD.—A paper on Hæmophilia was read by Dr. W. A. Christie. He exhibited a patient suffering from well-marked symptoms of the disease. The case was that of a young man aged 30 years. Repeated hæmorrhages had occurred since childhood. He had had retinal hæmorrhage and hæmaturia, and at present there is oozing of blood from a wound in the mouth. A painful condition of the joints was a prominent feature.

Dr. Taylor, of Charlottetown, P. E. I., took part in the discussion which followed.

A case of discoloration of the skin and other symptoms suggestive of Addison's disease was reported by Dr. Morris. A post-mortem examination revealed cystic degeneration of both suprarenal bodies.

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## Liquid Peptonoids with Creosote.

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Liquid Peptonoids with Creosote is a preparation whereby the therapeutic effects of creosote can be obtained, together with the nutritive and reconstituent virtues of Liquid Peptonoids. Creosote is extensively used as a remedy to check obstinate vomiting. What better vehicle could there be than Liquid Peptonoids, which is both peptonized and peptogenic? It is also indicated in Typhoid Fever, as it furnishes both antiseptic and highly nutritive food, and an efficient antiseptic medicament in an easily digestible and assimilable form.

In the gastro-intestinal diseases of children, it also supplies both the food and the remedy, thereby fulfilling the same indications which exist in Typhoid Fever.

Each tablespoonful contains two minims of pure Beechwood Creosote and one minim of Guaiacol.

DOSE.—One to two tablespoonfuls from three to six times a day.

THE ARLINGTON CHEMICAL COMPANY,

TORONTO.

## "BOROLYPTOL"

Is a combination of highly efficient antiseptic remedies in fluid form designed for use as a lotion whenever and wherever A CLEANSING AND SWEETENING wash is required. It possesses a delightful balsamic fragrance and pleasant taste, and can be employed with great advantage

AS A CLEANSING LOTION      AS A VAGINAL DOUCHE

AS A NASAL DOUCHE      AS A MOUTH WASH

AS A FRAGRANT DENTIFRICE.

Samples sent  
on application.

The Palsade Manufacturing Co.,

88 WELLINGTON STREET West, TORONTO.

# To the Medical Profession:

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## **ABBEY'S EFFERVESCENT SALT**

is without doubt the most elegant, palatable, and efficient saline laxative and antacid within your reach.

It possesses every requisite that such a salt should have; the slight granulation enables that patient to obtain the fullest benefit of the slower development of the carbonic acid gas; its action upon the bowels is gentle, but positive, and its valuable antacid properties render its use particularly beneficial in many cases where a harsher aperient might prove deleterious.

The use of Abbey's Effervescent Salt is growing daily, and is now regarded as a standard preparation, put up in the most high-class manner, and sold through druggists only.

The preparation is manufactured in the most perfectly appointed laboratory in America, under the supervision of expert chemists, and is in every way guaranteed to meet the many requirements for which its properties render it useful.

MAY 30TH.—Annual meeting.

The election of officers resulted as follows :—

President,	-	-	-	-	DR. J. ROBERTSON MCINTOSH.
Vice “	-	-	-	-	“ W. L. ELLIS.
Secretary,	-	-	-	-	“ G. G. MELVIN.
Treasurer,	-	-	-	-	“ J. CHRISTIE.
Librarian,	-	-	-	-	“ C. OLDING.
Curator of Museum,	-	-	-	-	“ J. W. DANIEL.

The Secretary reported that during the past year 32 meetings had been held. One new member has been elected, and two vacancies were caused by death—Drs. Bruce and MacFarlane. The average attendance at meetings during the year has been 9.56. Twenty papers were read, twenty-three cases reported, nine cases exhibited, two subjects discussed, and numerous pathological and microscopical specimens shown.

The Treasurer reported that \$40 had been received during the year, and expenditure amounted to \$49.38.

The Librarian in his report stated that Dr. John Berryman had presented the Society with 148 volumes, and that there were now 336 volumes in the library. Attention was drawn to the fact that fifteen books were missing from the shelves.

The Society then adjourned its meetings for the summer months.



## Matters Personal and Impersonal.

Dr. J. F. Black has returned to the city after an absence of some months and resumed practice.

The annual graduating exercises of the Training School for Nurses in connection with the Nova Scotia Hospital for the Insane, took place at the institution on the 19th of June, and were of a very interesting character. Hon. Chas. E. Church, Commissioner of Public Works and Mines, occupied the chair, and the diplomas and prizes were presented by His Honor the Lieutenant Governor, Sir Malachi Daly, who also made an address. Dr. E. Farrell likewise gave an address, and the valedictory (on behalf of the graduating class) was read by Miss Meadows.

Diplomas were presented to Miss Elsie McHeffy, Miss Rachel Merson, Miss Lida Meadows, Miss Mary Parrott, Miss Irene Settle, Mr. Thomas Christian and Mr. Archibald McKeigan. The DeWolf Medal, for best average in all examinations during course, was awarded to Miss Settle. The Commissioner's Prize, for best average in examinations in senior year, was awarded to Miss McHeffy, who also won the Staff Prize in medical nursing. The Staff Prize for best examination in surgical nursing was awarded to Mr. McKeigan, while Miss Meadows won the Staff Prize for the best examination in the practical work of nursing. In the junior year, the first prize (Dr. Sinclair's) was won by Miss Mary McManus, the second prize (Dr. Moore's) by Miss Snook.

The death is announced of Dr. S. G. A. MacKeen, of Baddeck, C. B. Dr. MacKeen practised for many years in that town and the surrounding country. An extended obituary will appear in our next issue.

Dr. James T. Whittaker, of Cincinnati, died at his home in that city on the 5th inst. of cancer of the intestine. He was professor of medicine in the Ohio Medical College. Dr. Whittaker's contributions to the literature of medicine were numerous and valuable.

The tenth annual meeting of the American Electro-Therapeutic Association will be held at New York on September 25th, 26th and 27th. The subjects announced for set discussion are "Electricity in Gynæcology and the Present Reluctance of Gynæcologists to use Electricity," and "Electricity in Tuberculosis and the Present Modes of Treatment."

At the recent Centennial celebration of the University of New Brunswick at Fredericton, the degree of LL. D. was conferred among others on Drs. Wm. Bayard and Boyle Travers, of St. John, Principal Forrest of Dalhousie University and Professor Falconer of Pine Hill College.

The first annual meeting and banquet of the Philippine Association of Acting Assistant Surgeons, U. S. A., was held at the Paris Café last night and an excellent time was spent by all present. Six toasts were proposed by the toastmaster, Dr. Harry Morell, and were responded to as follows: "President of the U. S.," Dr. Thornberg; "The Governor-General," Dr. Howell; "The Surgeon-General," Dr. Belt; "Chief Surgeon in the Philippines," Dr. Norris; "The Press," Mr. Harris, the *Manila Times* representative; "The Ladies," Dr. Ohliger.

A short speech was made by the president, Dr. Beal, and the banquet closed by all singing "Auld lang syne."

The Association was formed on April 28th on board the U. S. A. T. Grant, on which seventeen of the members of the society came over to the Philippines to administer relief to the sick and wounded soldiers. The following doctors were elected officers of the association:—President, H. W. Beal; Vice-President, H. Morell; Corresponding Secretary, R. M. English; Recorder, H. M. Stromberger. Members—Drs. F. M. Baker, L. P. Bell, H. P. Belt, C. R. Byars, J. A. Collie, C. L. Hodgkins, L. P. Howell, G. L. Marcion, J. N. Merreck, J. L. Norris, C. R. Ohliger, J. J. Reilly, E. R. Rockbill, W. H. Spiller, S. A. Springwater, R. M. Thornburgh, E. M. Trook and C. E. Ward.

It is the intention of the association to enroll as members all the acting assistant surgeons in the Philippine Islands and hold a meeting and banquet on "Dewey day" (May 1st) every year in the future. The association has no doubt a very bright future and it is expected it will accomplish its aim.—*Manila Times*, May 4th.

(Dr. Morell who is mentioned above is a graduate of Toronto. He lately practised his profession in Slayton, Minnesota, and is a regular subscriber to the NEWS.)

## Book Reviews.

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POST-MORTEM EXAMINATIONS, METHODS AND TECHNIQUE. By John Caven, B. A., M. D., L. R. C. P., Professor of Pathology, University of Toronto Medical Faculty. Price \$1.00 net. Published by J. A. Carveth & Co., Toronto.

The proper method of performing an autopsy with full particulars is plainly and concisely given in the pages of this work. The first chapter deals with the instruments, bacteriological outfit, hands and wounds and handling the knife, while the chapters following give explicit directions for the proper examination of the body and details to guide one in doing a post-mortem thoroughly. The sixth chapter deals with criminal poisoning, and the seventh with infanticide, proof of breathing, cause of death, etc. Another valuable chapter is that on the preservation and preparation of tissues. The method of preservation with alcohol, Müller's Fluid, and formaldehyde are carefully explained and a rapid method of making sections for microscopical examination completes the chapter. Weight and measurement of organs finishes the last page of the book.

We can commend Dr. Caven's work most highly to the profession as an excellent guide for the purpose for which it was written.

## BOOKS AND PAMPHLETS.

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FRACTURES. With an appendix on the practical use of the Rontgen Rays. By Carl Beck, M. D., visiting surgeon to St. Mark's Hospital and to the New York German Poliklinik. Octavo volume of 335 pages, with 178 illustrations, beautifully bound in polished buckram. Price \$3.50 net. Published by W. B. Saunders & Co., Philadelphia.

ATLAS AND EPITOME OF SPECIAL PATHOLOGICAL HISTOLOGY. By Docent Dr. Herman Dürck, of Munich, Germany. Edited by Ludvig Hektoen, Prof. of Pathology, Rush Medical College, Chicago. Contains 158 pages of text with 62 lithographic plates in colors. Price \$3.00 net. Published by W. B. Saunders & Co., Philadelphia.

TWENTY-SECOND ANNUAL REPORT OF THE PRESBYTERIAN EYE, EAR AND THROAT CHARITY HOSPITAL OF BALTIMORE.

ANNUAL REPORT OF THE TRUSTEES OF ABERDEEN HOSPITAL, New Glasgow, N. S.

## Therapeutic Suggestions.

### LUMBAGO.—

R	Potassii iodidi .....	ʒss.
	Tinct. opii deod .....	ʒii.
	Spts. lavandulæ co .....	ʒi
	Spts. æther nit .....	ʒss.
	Aquæ distill .....	ʒxii.

M. Sig.—Two tablespoonfuls twice daily.—SIR B. BRODIE.

### FOR SWEATING FEET.—

R	Formaldehyde .....	gr. x.
	Thymol .....	gr. x.
	Zinci oxidi .....	ʒvii ss.
	Pulv. amyli .....	ʒxiii ss.

M. Sig.—Apply as a dusting powder.—*Kansas City Medical Record.*

FOR INSECT STINGS.—The *Journal des Praticiens* ascribes to Bernbeck the two following formulæ:—

1. R Flexile collodion .....
- Salicylic acid .....

M.

2. R Flexile collodion .....
- Corrosive sublimate .....

M.

For local application.

These two applications are said by the author to give excellent results, and to be preferable to ammonia as at present employed. If applied promptly after the sting, pain is allayed, and subsequent inflammation is said to be rare.—*N. Y. Medical Journal.*

CONDYLOMATA.—*Reforma Medica* gives the following:—

R	Calomel .....	30 parts.
	Boric acid .....	15 “
	Salicylic acid .....	5 “

M. Sig.—Apply the powder two or three times a day.

PAINFUL ERECTIONS.—Bavatier (*Bulletin général de thérapeutique*) gives this formula:—

R	Methyl salicylate .....	1 part.
	Liquid vaseline .....	10 parts.

M. The penis to be anointed with this liniment, covered with a thin layer of cotton and bandaged.—*N. Y. Medical Journal.*



THE INJECTION TREATMENT OF HEMORRHOIDS.—In the cases of internal hemorrhoids that are thought suited to cure by the injection methods, Dr. Tuttle, of New York, uses the following formula for making his fluid injection:—

R. Acidi carbolic	.....	ʒiiss
Acidi salicylici	.....	ʒss
Sodii boratis	.....	ʒi
Glycerini, q. s., ad	.....	ʒi

M. et ft. solution. Sig.—Injection for hemorrhoids. Of this fluid two to four minims are injected into the base of the hemorrhoid. If other injections are needed they are to be made in from three to five days.—*Jour. Am. Med. Assn.*

### WHY I USE PEPTO-MANGAN "GUDE." AN EXPERIMENTAL DEMONSTRATION\*

By WM. KRAUSS, PH. G., M. D., Memphis, Director of the Microscopic Laboratory, Memphis Medical College; Pathologist and Visiting Physician to St. Joseph's Hospital, etc., etc.

Some five years ago I wrote a paper for the *Memphis Medical Monthly*, giving a resumé of the evolution of the iron compounds, and appended a report of cases giving blood counts, etc. The manufacturers of the preparation I preferred saw fit to reproduce the case reports in their pamphlets, but said nothing about the reasons that induced me to prefer their product.

At a recent joint meeting of physicians and pharmacists I was criticised for opposing the use of ready-made compounds, while still advocating the use of Pepto-Mangan "Gude," which is a proprietary preparation. I hesitated considerably about bringing the matter up again, because I dislike to build up a reputation as an endorser, and have never in any other instance written an article endorsing a proprietary preparation.

I hope, however, to show you this evening that there is no pharmacœal preparation that meets the requirements of an ideal iron compound, and, until this is found, I intend to continue to use what has never disappointed me, and is not based upon mere faith. The work of Bunge is too well known to be now quoted, and I will only make a few experiments before you this evening and show the reasons for the faith that is in me. There may be other proprietary iron compounds, and

\* Read before the Memphis Medical Society.

doubtless there are, that will come up to the same requirements, but I see no advantage in swapping the devil for the witch.

It is not necessary to repeat all the tests with all the official iron preparations, because they are divisible into groups, all the salts of one group behaving very much alike toward the gastric and intestinal juices.

An ingenious theory recently put forward regarding the action of the mineral salts of iron is, that they decompose the substances in the intestinal tract which precipitate the *food iron* so that it may be absorbed. This is the only rational explanation of the fact that we do occasionally get results from them. On the other hand, it is far more rational to use an iron compound that can be, and is absorbed, for then we are reckoning with known quantities, instead of blundering along, giving more iron at a dose than is contained in the entire body, and incidentally deranging the digestive functions by precipitating the gastric, pancreatic and intestinal juices, and producing constipation by reason of the very astringent nature of some of the iron salts.

Beginning with the organic double salts, of which the scale salts are representatives, we notice upon the addition of this gastric juice, that a precipitate is formed; the double salt is decomposed and ferric salt remains, which is insoluble, both in gastric and intestinal juice.

The tincture of ferric chlorid will precipitate some of the gastric constituents, though most of the iron will remain in solution in the hydrochloric acid; the iron still in solution will not be absorbed, because its non-diffusibility is taken advantage of in the manufacture of *dialysed iron*, the acid passing through the animal membrane; when the iron finally reaches the intestine, the alkalin carbonates promptly precipitate it. Ferrous sulphate behaves similarly. In both instances, as you see, the very insoluble ferric oxid is finally formed. If you have ever tried to remove iron stains from your water pitcher, you have some idea how insoluble it is.

The insoluble compounds, like reduced iron, or Vallet's mass, only severe to render inert the arsenic with which they are usually prescribed; if dissolved at all in the stomach, they are re-precipitated in the intestine.

Taking now Gude's preparation, we find it soluble, not only in all these reagents, but also in a mixture of them. Potassium ferrocyanid readily gives the iron reaction, excess of ammonia will separate it, redissolving the manganese, which is then recognized by the color of its sulphide; the alkalin copper solution gives the reaction for pepton, showing that it is what the label says. It mixes with arsenious acid, forming a perfect solution, thus giving us a most useful hematopoietic agent. The soluble alkaloids are perfectly soluble in it, as is also mercuric chlorid. Being a pepton, it is readily diffusible by osmosis.

The only disturbing agent in the intestinal tract is hydrogen sulphide; this will precipitate it, but presumably, much of the iron must have been

absorbed before it encounters this gas; if not, appropriate agents should be used for its elimination.

Therapeutically, it does not nauseate, constipate, discolor the teeth, precipitate the digestive agents, nor become inert from contact with them. As to the clinical results, I need not add anything to the many reports already on record.—*Memphis Lancet*.

RELIEF FOR BRITISH-BOER WAR SUFFERERS.—The following letter from the London office of The Antikamnia Chemical Company, under date of March 2nd, 1900, will be found interesting:

*Dear Sirs:*—It was suggested to me a few days ago that I should contribute some Antikamnia to one of the Hospital Ships going out in charge of Dr. Conan Doyle and Surgeon O'Callaghan, F. R. C. S., the latter of whom is well known to me, and has a very substantial practice. I have contributed to this Hospital Ship and to the 'Maine,' equally, in your name, the following exact number of ounces, viz.: 12 dozen ounces of Antikamnia Powdered and 24 dozen ounces Five-Grain Antikamnia Tablets, in all 36 dozen ounces and I feel certain you will readily endorse what I have done. This constitutes the first introduction of Antikamnia, *in quantity*, to the Army Medical Service of Her Majesty.

February sales show nearly double the volume of sales for February, 1899. Rather a pleasant report to make, is it not? Regular monthly statement by next post.

Yours very truly,

THE ANTIKAMNIA CHEMICAL COMPANY,

Per J. M. Richards.

REPLY.

ST. LOUIS, U. S. A., March 14th, 1900.

*Dear Sir:*—In reply to your favor of March 2nd, 1900, we beg to say that the contribution of 36 dozen ounces of Antikamnia Preparations to Hospital Ships, may most agreeably be charged to account of Home Office.

We must thank you for your timely thoughtfulness in making these donations. We have, on this side also, contributed liberally to the Boer Relief Fund through the local representative, Dr. Emil Preetorius, of this city.

Glad to note your reference to increased sales, etc.

Sincerely yours,

THE ANTIKAMNIA CHEMICAL COMPANY,

Frank A. Ruf, Pres't.

SANMETTO IN ENURESIS-NOCTURNA—Dr. L. L. Gray, St. John, Mo., reports the outlines of a case of enuresis-nocturna, treated with sanmetto, several years ago. The case was that of a maid thirteen years of age, who had suffered with enuresis from infancy. She was old enough to realize her condition, and keenly felt its effects—acted as though she thought every one she met knew her troubles, and consequently she was shy, unsociable, ashamed to be seen in company, and strangers would ask if she was entirely sane. He gave her a bottle of sanmetto, told her mother to give her all assurance that it would cure her, if properly taken. A second four ounce perscription verified the truth of his statement. He says it did cure her for all time, and to-day she is a perfectly formed young lady, intelligent and sociable, the downcast countenance gone, and life is again worth living.

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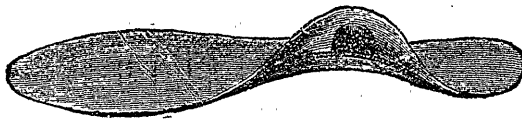
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The principal orthopedic surgeons and hospitals of England and the United States are using and endorsing these Supporters as superior to all others, owing to the vast improvement of this scientifically constructed appliance over the heavy, rigid, metallic plates formerly used.

These Supporters are highly recommended by physicians for children who often suffer from *Flat-foot*, and are treated for weak ankles when such is not the case, but in reality they are suffering from *Flat-foot*.

IN ORDERING SEND SIZE OF SHOE, OR TRACING OF FOOT IS THE BEST GUIDE.

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tive Tonic for the treatment of Consumption, Bronchitis, Scrofula, and all forms of Nervous Debility. This  
elegant preparation combines in an agreeable Aromatic Cordial, *acceptable to the most irritable con-*  
*ditions of the stomach:* Cone-Calcium, Phosphate  $\text{Ca}_3 2\text{PO}_4$ , Sodium Phosphate  $\text{Na}_2 \text{HPO}_4$ , Ferrous Phos-  
phate  $\text{Fe}_2 2\text{PO}_4$ , Trihydrogen Phosphate  $\text{H}_3\text{PO}_4$ , and the active Principals of Calisaya and Wild Cherry.

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Gestation and Lactation to promote Development, etc., and as a *physiological restorative* in Sexual De-  
bility, and all used-up conditions of the Nervous system should receive the careful attention of therapeutists.

NOTABLE PROPERTIES.—As reliable in Dyspepsia as Quinine in Ague. Secures the largest percent-  
age of benefit in Consumption and all Wasting Diseases, *by determining the perfect digestion and as-*  
*similation of food.* When using it, Cod Liver Oil may be taken without repugnance. It renders success  
possible in treating chronic diseases of Women and Children, who take it with pleasure for prolonged  
periods, a factor essential to good-will of the patient. Being a Tissue Constructive, it is the best general  
utility compound for Tonic Restorativ-purposes we have, no mischievous effects resulting from exhibiting  
it in any possible morbid condition of the system.

Phosphates being a NATURAL FOOD PRODUCT no substitute can do their work.

DOSE.—For an adult, one table-spoonful three times a day, after eating; from 7 to 12 years of age, one  
dessert-spoonful; from 2 to 7, one teaspoonful. For infants, from five to twenty drops, according to age.

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