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NOTICES

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THE SASKATCHEWAN MEDICAL JOURNAL

VOL. 1.

OCTOBER, 1909

No 4.

Original Memoirs

*THE PREVENTION OF SOME MALADIES OF THE FIFTH DECADE

JOHN McCRAE M.B., M.R.C.P. (Lond.), Etc.

Assistant Physician to the Royal Victoria, and Attending Physician to the Alexandra Hospital, Montreal; Lecturer in Medicine and in Pathology, McGill University
Montreal; Professor of Pathology in the University of Vermont.

Mr. Chairman and Gentleman:—

I need not tell you that I am flattered by the opportunity of coming here to address you this afternoon, nor need I emphasize the fact that I am deeply anxious to justify my presence here by giving you something that will repay your time. If I fail, I promise you it will not be because I am not anxious to succeed.

My subject may seem to you an obscure one; but it means that I am dealing with those common and difficult diseases which are insidious in their onset, which may be really arterial or renal or cardiac or all three together, which are the outcome primarily of hard work, of stress and of strain, which attack the busy man when he is busiest: they constitute many cases of so-called "break-down"—or perhaps "break-up" expresses it

*Read before the Sask. Med. Assn. at Saskatoon, July 7th, 1909.

better,—which though associated with neurasthenia and neuroses are essentially very different. Had I called this arteriosclerosis I might have frightened you with the prospect of a hackneyed subject; had I referred to these as early manifestations of nephritis I would have failed to include many cases; had I referred to them as neuroses I would have been misleading,—of the three I think arteriosclerosis would have been the least error.

Before speaking more particularly of signs and symptoms, I want to give a text for my discourse. It is the business or professional man of forty-five who slaps his chest and tells you "he never was better in his life, hasn't had to see a doctor for twenty years, works hard, eats well, plays golf, and takes his three or four whiskies and sodas, or leaves them alone if he chooses." To begin with, this man too often never reaches the profession, unless perhaps at an insurance examination. But this is a man whose real interest it is to be overhauled by his physician as often as by his dentist. In China the doctor is paid, I have heard, only so long as the patient keeps his health, and this is one class of case in which the system might with advantage be introduced in Canada. When you get a man who is wise enough to take stock of himself as he takes stock of his business, you are not to merely ask a few questions, pat him on the shoulder, tell him he is as good a man as he ever was, that you wish you were half as hearty. No. You are to strip him to the skin, go over him from top to toe, look for the visible or the palpable artery, get the half-inch increased heart-dulness, the thudding impulse, the accentuated second sound, the increased blood-pressure, if you possess an instrument, the casts that may lurk in the centrifugated urine, even if there be no albumen; dilate his pupils, find a tortuous retinal artery—or find none of these things. Then you may begin to think of patting him on the shoulder and telling him he is all right. But don't do it quite yet. Enquire into his diet. Everybody says we eat too much, but very few think of eating less: by the time one is forty he does well to think of this and he does better still if he puts into practice the moral to be deduced.

Tell your patient that if the boiler is old he had better not carry on 225 lbs. steam pressure any longer, but had better pull the fire a bit. Of this more anon.

You will gather that the maladies of the fifth decade to which reference is made in the title are (1) various results of arterial degeneration, (2) early nephritis, (3) certain cardiac diseases depending primarily upon the state of the vessels, such as myocarditis, manifested by dilatation or arrhythmia or pain, (4) perhaps gout and often obesity. The point which I wish particularly to impress is that these maladies, diverse as they are, have no symptom or sign in common, but the one point on which oftener than any other they unite, is that frequently the blood-pressure is habitually raised and the instrumental observation of the compressibility of the arteries may enable us to take the right direction in their treatment. It would be foolish to insist that the blood-pressure machine is a mathematically accurate instrument, or that its application to medicine is an epoch-making step; but it is a very useful help to our work, and has this advantage, that while it sometimes fails to give the clue, it rarely or never cries wolf when there is no wolf. Since estimation of blood-pressure is so important to the subject, it may be well to deal shortly with the bearing of heightened pressure upon the body.

I would like to be able to tell you something of the pathology of the breaking-up process. Is there a toxin of old age? In one sense, yes. We speak of strain and stress, but these things contribute to the damage rather than cause it. Let me digress for a moment. A cell perfectly fed, perfectly cleared of its excretion, can perform its maximum of work; but let its food supply lessen below the fixed requirement, or let it fail to rid itself of its excretion, and the cell-power is reduced, be it ever so little: if the maximum of work be yet demanded of it, it can do it, but only at a price, viz., degeneration. This is the state of affairs in the human body. Hard work, mental or physical, means metabolic wear and tear: this in turn means increased output of excretion: this excretion has to be handled by the bowel, the kidney, the skin, the breath, the saliva and

so on. Let one of these fail and the others are overworked; the overwork means damage to the overworked organs, and presently failure in their ability to excrete—and the body fluids carry a slightly increased percentage of toxicity. In addition, most of the bodies to which we refer are overfed. This means yet more toxicity. This toxicity—we have no idea of the chemical composition of the toxin—means that every heart muscle cell, every muscular or elastic fibre in every artery is not only less well nourished, but is, to a slight degree it is true, also poisoned. Then degeneration in heart muscle or in arterial and capillary wall means lowered power to do the required work: if nervous stimuli are still able to get out of damaged tissue the same work as before, it is constantly at a higher price—and the diminished excretion cumulates. Since we are referring to every capillary in the body, the damage is gradual, because universal; but at last it shows itself in some locality—with one a “sluggish” liver; with another a broken Charcot’s artery; if it were not for these “weakest links” the chain might remain unbroken for a long time.

Imperfect excretion then means toxicity—auto-intoxication is our usual word. We are familiar with the dire effects of certain quickly-produced toxins, although we cannot analyze them at all: for example, the toxin of eclampsia, of acute yellow atrophy of the liver, of superficial burns, of uraemia, of acidosis in diabetes and acidosis apart from diabetes, these are intoxications as evident as the intoxications of ptomaines or of the well-known bacterial injections. In each of these “home-made” intoxications there is manufactured in the body a large dose of a substance of unknown nature and composition, which poisons organs as definitely as does a chemical poison. The poison of uraemia is probably totally different chemically from that of diabetic coma, and both totally different from that which ordinarily causes slow degeneration of arteries, but the resemblance is there, and the difference one of degree and speed. The body fluids outside the vessels are laden with this mild toxin, the vessels are carrying it; where it is strong enough to contract arteriole-walls these contract, and as a result blood-

pressure is raised behind this area; the heart is worked harder on this account, and the vascular damage has begun. The early symptoms must be dealt with in various groups, cerebral, general; local, cardiac, spinal; abdominal, renal; and so on, and each will be merely outlined, especially as reference is here made only to the symptoms that are early and therefore obscure.

The evidence offered by the patient at times points not to arterial disease, but to essential renal disease, but this is often merely that the arterial change manifests itself earliest in the kidneys: there has long been recognized a "pre-albuminuric" stage of nephritis—and if any symptom can guide us to its recognition, it will be some symptom that points to arterial change, for the obscure toxins that bring about renal change have been equally or more potent to affect the arteries, arterioles or capillaries. It is conceivable that one man starts life with hereditarily poor arteries, another with good arteries but poor kidneys, a third with good arteries, good kidneys, but poor brain cells: if the same toxin in the same amount were to circulate during the same time in these three men, it seems reasonable to suppose that one would show arterial, the second renal, and the third cerebral disturbance first of all: and many a man dies of the vessel-kidney-heart combination, of whom we cannot say that he died of any one disease. We more frequently compromise and say that he "broke-up generally." My whole idea is to get at the earliest possible recognition of this combination or of any part of it, although in so doing I may seem liable to the charge of laying nearly all ills at the door of the toxin-affected artery. This may not be so far from the truth after all, when one considers how much of our bodies is made up of serum (body-fluid we name it); and how absolutely universal are the channels of all kinds and sizes that conduct it.

When one speaks of toxin substances that cause arterial change, we revert to the well-known agents that cause it: such are lead, syphilis and gout; lead we know as a definite chemical substance, the toxin of syphilis we can understand, because we have so definite a parallel in the bacterial diseases, and in gout, we suppose that the body is the victim of "the end products

of proteid metabolism"; or if not the end-products, then the products that are formed half-way to complete metabolism. Gout we have known for a long time as a cause of arterial degeneration; and this is but another way of saying that hearty eaters and drinkers are prone to this degeneration, even if in the process of its production, we cannot recognize the particular symptoms and signs which are familiar to us as gout. Fothergill was fond of the phrase, "The Protean forms of Gout," and pointed out that there were many signs which said "gout" to him, which did not do so to the average physician. It is these latent gout signs or premonitory signs of gout that are here referred to, but you are asked to count them under the head of "early arterial" disease rather than the term "gout." You will recognize throughout the man who lives too well, and Fothergill, like many physicians of his time, spent much energy in finding which wine would do the least harm, and what form of meat was best to forbid, leaving a fair latitude, probably too wide a latitude in the quantity consumed. The question of drink the patient understands; the question of food is what he needs to be told. Here lies the success of quack methods which add to austerity of diet some foolish trick, such as wading through wet grass while the morning dew is on it. The patients scarcely note the ascetic diet, the early rising, implying early going to bed, and the lay mind fastens upon the trick that is exploited by the learned quack.

Recalling to you that this toxic state may show itself in a great many different ways, we shall deal with these various manifestations in classes, taking up first the one which is most obscure,—the cerebral symptoms.

There is a series of symptoms that are very indefinite, such as headache, dizziness (as when one laces his shoe), irritability, lapses of memory, sensory disturbances in the extremities, and many similar slight departures from absolute well-being. How very likely one is to say that such things mean an over-worked state of the nervous system, and that the subject of them needs a rest. Remember that the neurasthenic in the strict sense of the word offers just exactly such symptoms, and

if he is not examined carefully, you may begin to "build-up" his nervous system when you should "pull down" his arterial system. Neither you nor the patient can afford to make any such mistake as that. A slow pulse may excite suspicion on examination. I would be the last to counsel a necessarily serious view of such symptoms, but my point is that an estimation of blood-pressure may be a most useful help at this point to a complete physical examination. It seems to be a very valuable thing to know for the patient's sake the earliest period at which his blood-pressure is habitually raised. Degenerations in cerebral arteries producing inelasticity tend, one may suppose, to pass on to the cerebral tissue, unmodified, hyperemias and anæmias, which may be entirely transitory. Spasm of the vessels may occur with consequent anæmia. Yet these temporary anæmias and hyperemias, and at times consequent œdemas are very quickly reflected in the delicate functions of the part, producing the slight symptoms to which reference has been made; if less transitory they may cause aphasia or pareses, or even epileptiform or apoplectiform seizures; this statement is made without reference to the thromboses or ruptures which accompany more extreme grades of vascular degeneration. At a very early stage in the disease, the patient or his friends may realize his "loss of grip," and his inability to handle business affairs with his usual insight; here it is very necessary that the physician be not entirely led away by the idea that the patient is neurasthenic; it is a "pointer" worth remembering—a handwriting on the wall for us. "Look for arterial disease in the neurasthenic." The symptoms referable to arterial change are specially apt to come on after some crisis of business, or some exciting effort: when men "never lift up their heads again" after some family or business trouble, it is often arterial disease till then latent, which does the work. Paralyzes or asphacis attacks quickly recovered from are in the absence of syphilis, almost certain to be arteriosclerotic in source. So much for the cerebral manifestations of early arterial change, dealt with first because as a group they are

probably the earliest indications in the most delicate part of the mechanism.

Equal to these in uncertainty and even more insidious are certain general symptoms which depend upon lowered perfection of nutrition—when a middle aged man suffers in a most indeterminate way from mere lack of well-being: he tires easily, may occasionally look anæmic or even cachectic, loses weight, while his tissues become flabby. Your attention which has been directed to carcinoma, pernicious anæmia and what not, finds no particular resting place, and is driven back by exclusion to the supposition that he is not as young as he once was. Here again, if a heightened blood tension be found, you have a definite road to follow.

The cardiac results which are especially due to vascular change are fairly well known, and of a wide range. Changes in the heart itself go hand-in-hand with arterial change [and inasmuch as the heart is part of the circulatory system, it is but right that the heart itself should claim the attention, and these are rightly considered with cardiac diseases proper]: whether a cause or an effect, hypertrophy of the left ventricle is well known to be a frequent accompaniment of vascular disease; most definitely of all, angina pectoris with its obscure pathology is likely a vessel disease rather than a heart disease. Unfortunately, by the time angina pectoris develops the disease has probably progressed beyond preventive measures, and has reached the stage when palliation is all that may be hoped, but early in the disease mark the thumping apex beat and the accentuated second sound. Spinal implication by arterial disease is fairly rare, and well defined cases where no cerebral implication exists are so rare that they may be passed over. Likewise it must be remembered that there is an abdominal form of arterial disease which produces symptoms, although as Janeway showed there may be no general increase of blood pressure. It has been called angina abdominalis, and is evidenced by pain, a sense of weight or pressure in the pit of the stomach, occasionally tenderness in the epigastrium, pain after eating, vomiting and pain in the back. There may even

be hæmatemesis, and the failure of treatment for gastric ulcer may finally lead one to the diagnosis. Perutz pointed out that dizziness and sweating after meals may be the chief symptoms; the pain is evidently felt in the mesenteric plexus. It must be granted that only a long process of exclusion could finally bring one to a diagnosis of vascular disease, and even then one would do well to be cautious.

Finally, or almost finally, there are the evidences of vascular disease in the extremities, producing, it may be, dry gangrene, or Raynaud's disease in its differing degrees or intermittent claudication—forms of disease interesting in themselves, but beyond the scope of the present paper. Finally, absolutely finally, there is the renal type of disease, which is admittedly common. One should not attempt to differentiate between degeneration of the arterial system with the resulting renal changes and what we call early chronic nephritis: for our purposes they are sufficiently alike to consider them altogether. Here the middle aged patient may have been referred by his insurance examiner for a trace of albumen; it is easy enough when puffiness or œdema appears, or transient blindness or the early symptoms of blindness, but there are cases in which the kidneys are probably a main point of attack where there is nothing to be found in the urine.

There is a further connection to be satisfied between arterial change and obesity; one cannot say more than that the deficient carrying-out of oxidation processes which is characteristic of the tissues of the obese is accompanied by deficient toxin-excretion, and these cases often become the subjects of arterial or renal disease the while they are developing their obesity: the apparent discomforts of obesity are often but the real discomforts of early arterial or renal incapacity.

It may seem that I have described a bewildering lot of symptoms, cerebral, general, cardiac, abdominal, local and renal, and it must be granted that they are so: yet I contend that a top-to-toe examination may reveal the true state of affairs; if one finds any one distinct symptom or sign which points to arterial degeneration, keep it well in mind for the time when

other more acute diseases may be excluded; and finally, take the blood pressure.

It cannot be claimed that the blood pressure is always visibly raised in these states, but I believe it generally is. I further believe that the instruments devised are extremely useful for this purpose, and at this moment I am personally extremely sceptical of the power of the finger to discern this. Again, let me digress. Blood-pressure, the quality we seek to discern, is not merely power, nor yet merely volume, but a combination of both related to the distensibility of the wall. This tension is measured in a workable degree by the instruments for measuring compressibility, and, as far as my own experience goes, often cannot be measured by the finger.

The principle of the apparatus is to compress the arm or the radial artery to the point at which the pulse disappears: the instruments with which I am familiar are the Riva-Rocci, its modification by Oliver and Janeway and the Von Basch. The requirements are simple: the original Riva-Rocci had a narrow arm band, and an arrangement of tubes by which one inflated the band and at the same time drove the same air-pressure into the mercury manometer, which raised the column of mercury in the properly graduated tube. *This instrument, as used at the Johns Hopkins Hospital used to cost \$2 or \$3; the most important modification was the instrument with a broadened arm band, five or six inches wide, most clinicians declare that the broad arm band is necessary, but I do not know why; it certainly goes with an increased cost of the instrument, and the ordinary Janeway instrument now costs \$11 to \$14; this is readily portable, and for several years I have not seen one of the simpler machines. The Von Basch is much more readily portable, consisting as it does of a bulb, about one-half inch diameter, six inches of tubing and a dial-machine of the size of a large watch: the bulb is pressed on the upper part of the radial, until the pulse is obliterated below it, and the indicating needle on the dial meantime registers the pressure required to do this. The whole box can be carried in a pocket. Either instrument can be used without baring

*A description of this instrument is given on page 128.

the arm, and a reading takes only a minute or two minutes to do.

When a mercury stands about 120-130 mm. the healthy pulse is compressed. I am not prepared to explain the physics of the blood-pressure; this instrument does not measure blood-pressure by compressibility: the blood pressure inside the artery is not actually 130 or 160 or 200 mm. of mercury, but these figures give us a standard of comparison which seems to work just as if they did, and the artery that requires 160 or 190 mm. to compress it, has apparently a pressure relatively raised. The compressibility of a vessel seems to be a good indicator of what we mean when we say "blood-pressure."

It will be gathered from what has been said about "blood-pressure" that if we agree that blood-pressure is the degree of distension of a vessel wall relative to the amount of blood in the vessel, that this instrument does not really measure "blood-pressure"; yet it is scarcely the less useful on that account. The real physical blood-pressure of a normal man is 90 to 120 mm. of mercury, and the normal man's "compressibility" is about the same figure; but violent exercise raises a healthy man's blood-pressure (in the true sense) about 20 mm. beyond which the heart is in danger of extreme distension; yet in many cases of damaged vessels and heart the instrument records 280 mm. of Hg., and there is good authority for the statement that it is utterly impossible for the actual blood-pressure to rise to anything like this degree. In other words, an instrumental pressure of say 300 mm. would prove to be really say 140 or 150. One must then interpret a reading thus: "If the instrument says the patient's blood-pressure so called is 280, the true blood-pressure while not anything like this is probably dangerously raised; low but abnormal readings mean thickened artery walls, and with normal 130, a reading of 150 would probably mean the difference between disease and health: whereas in a chronic case, a difference of 20, say between 200 and 220, might not be appreciable to either patient or physician by any symptom or sign. The method by which the instrument can be used to indicate "diastolic" or minimum and

systolic or maximum pressure scarcely concerns us here. It seems, then, that the hæmomanometer is a valuable adjunct to the physician; that its findings have been misinterpreted or rather misnamed, need not throw it out of court. The moral of Russell's additions to our knowledge on the subject is that a vessel which is incompressible indicates the need for treatment: that the incompressibility may be lessened, greatly in some arteries, slightly in others that are organically affected, but to the great advantage of the patient in all.

Not all cases that present early change in the arteries show a heightened blood pressure—and these symptoms referred to above may exist with a reading that is perfectly normal, but not ordinarily so. Should there be a combination of early arterial change and renal disease the blood pressure is almost certain to be raised; if renal, cardiac and arterial change coexist one may declare that the raised blood pressure is a certainty. Yet, on the contrary, diseases such as diabetes and leucæmia have been known to possess a normal or low blood pressure when coexisting with arterial change. The whole question becomes reduced to this—there are certain individuals with early arterial change whose radials or temporals may be but slightly or not palpable, with unimportant cerebral symptoms such as occasional headache or vertigo who on routine examination by the manometer show a heightened “compressibility” (called “blood-pressure”). In the majority of cases this sign is to be depended on, although its absence does not negative the existence of arterial change. Because it is easy of application, its routine use should be adopted.

Having had suspicion aroused by a high blood-pressure reading, it is necessary to search carefully for casts, and, of course, for albumen. The finding of one or the other strengthens the position greatly. A good deal of controversy has existed upon definitions of arteriosclerosis in its various phases, but it is generally agreed that when the radial, brachial, temporal or femoral artery is palpably thickened, it is a symptom worthy of note. Some consider that a thickened artery is a rigid artery, but Russell points out that an organically thickened

artery can yet contract and expand very readily, provided the calcification in its walls be not extreme, and thus a thickened artery may not be as diseased as it seems, for it may be in a condition of what he calls hypertonus. A vessel which does not show any organic change may also be in a condition of contraction, and Russell considers that one may learn to recognize with the finger most, if not all, of these cases. This contraction may be kept up for a long time and may stimulate organic disease; nor is it an entirely innocuous affair, for with its long continuance the vessel intima does begin to thicken and the media to degenerate, whether this hypertonus be the cause or not. This condition of affairs occurs in the vessels largely by reason of the irritation caused by toxic substances in the blood, and it was a very early physiological observation that certain chemicals, such as digitalis and ergot did this very thing, while we are apt to consider the size of a vessel is dependent on the vaso-motor fibres of the sympathetic nervous system, we are not entirely correct, for this very contraction and dilation can be brought about by substances in the contained blood. Now, it has been demonstrated that in an artery contracted, the pressure is not raised, but the pressure is raised somewhere between this area and the heart, so that for our purposes we may reason thus: An artery that is observed to be thickened may be organically affected, or may be merely hypertonic; in either case, there is a raised blood-pressure somewhere short of this area, in the aorta or elsewhere: the hæmomaniometer or blood-pressure machine gives us a clue to this raised pressure, the indication to lower blood pressure exists equally in both conditions, the chief difference between the hypertonic and the organically changed artery seems to be that the prognosis is much the more favorable in the former.

Having determined the fact that the "blood-pressure" is heightened, suspecting that arterial degeneration has begun, what is to be done? It may seem that the measures to be proposed lack definiteness, but if they do it is your fault in not insisting on their adoption. They are roughly (1) less to do; (2) less to eat; (3) less to drink. If in doubt as to the adop-

tion of any measure, use common sense, and some such rule as this: Anything that will cause the patient extra-heart-beats is bad; anything that spares them is good, provided he do not become so restful as to impair his excretory powers, in other words he must take enough exercise.

(1) *Less Work.* Here is a chance for a sermon on what our strenuous life means to us, and nowhere, I suspect, has this a more direct application than in this busy West. Honest mental work, dishonest mental work, alias worry, speculation, the need to get rich—all this is what your patient has to drop, for he probably cannot do things by halves; if he thinks your price is too steep, it is not for you to set the price lower, but for him to refuse it; it is his life that is at stake, not yours. Should he elect to discard your advice, he may surprise you by the length of time he lasts, but he shortens his life, and you can do no more for him than your best. He need not be an invalid, and may even work at something less exacting than before, but in some way or other he has got to spare himself heartbeats.

(2) *Less to Eat.* This you will observe is the second unpleasant prescription. You may take it for granted that he eats too much, and before you can speak rationally you must know what he really does eat—then set him bounds, definitely, as to quantity, quality, and so on. The foods good for him are the foods that entail least work in excretion, that have least purin-bodies in end result—and you can think out a diet for him precisely similar to what you would prescribe for a case with chronic nephritis, until the acute symptoms, which he may have, disappear, he had better hover between milk diet and starvation; when he comes back to his regular health, restrict bulky foods, and restrict the drinking of much fluid with food; forbid the taking of much fluid at one time, because this keeps the vessels distended, although you may allow an abundance of fluid taken in small quantity.

(3) *Less to Drink.* This means that he must leave alcohol alone. I do not think there is any form of alcohol which will not do him harm, and the more alcohol the more harm. This

is the third unpleasant prescription. As to tobacco, the physician's judgment on the individual case must come in, because tobacco does not perceptibly quicken every beat, although it does most. At least I think it is the pleasant vice that can be most safely left to him.

All this is a very serious deprivation to the man who works and lives well, but it is good sense and you cannot alter the facts. Don't apologize for it: it is his business and his disease, his to take or his to leave. Ordinarily, you will be supported by his great bettermen even after a short period of this regime.

Excretion. It is desirable to have the bowels free—in most cases, freer than before, whatever may have been his custom. This will be best done by using a purgative water, or calomel as often as necessary. The skin, too, must be kept stimulated, probably best by occasional hot baths in addition to whatever form of bath is his custom.

Medicinal. The treatment of these latent diseases is not to give but to take away, and in an ordinary case a careful regimen is all that is necessary; should definite high blood-pressure exist, it is well to give sodium nitrite grs. 3 over considerable periods, or constantly increased doses of nitroglycerine or liquor trinitrini for a couple of weeks at a time. A tolerance is very quickly established for this drug and the ordinary dose of gr. 1-100 after it has been given for a day or two might as well be thrown away. If you doubt this, take a patient who has been getting the drug, and give him one minimum of liquor trinitrini at a time to see how long it will be before you flush his face.

Potassium iodide is perhaps the most generally popular of all drugs with a regimen for the purpose of lowering blood-pressure; some say the potassium does good, some the iodine, and some say it does no good. It is well worth a trial.

For a high blood-pressure with premonitory signs do not hesitate to order rest in bed. If ordered, see that it is rest as complete as possible.

For the physician of such a patient there are a few useful pieces of advice:

- (1) Get a full history, not only of his medical past but of his habits in every regard.
- (2) Make a top-to toe bare skin examination.
- (3) A blood-pressure estimation.
- (4) A case of advanced arterial change may not have a complaint. If you discover it accidentally, your duty is as plain as under other circumstances.
- (5) Look at his temporal, radial, brachial, femoral. If you are competent look at his retinal arteries.
Look for a strong apex beat, an accentuated second.
- (6) In a middle aged person loss of weight may be the only sign of arteriosclerosis.
- (7) Beware of a diagnosis of neurasthenia in the middle aged.

A DESCRIPTION OF THE RIVA ROCCI SPHYGMOMANOMETER

An apparatus for estimating arterial blood pressure or pulse force, modified by
Dr. Henry W. Cook of the Johns Hopkins Hospital, Baltimore, Md.

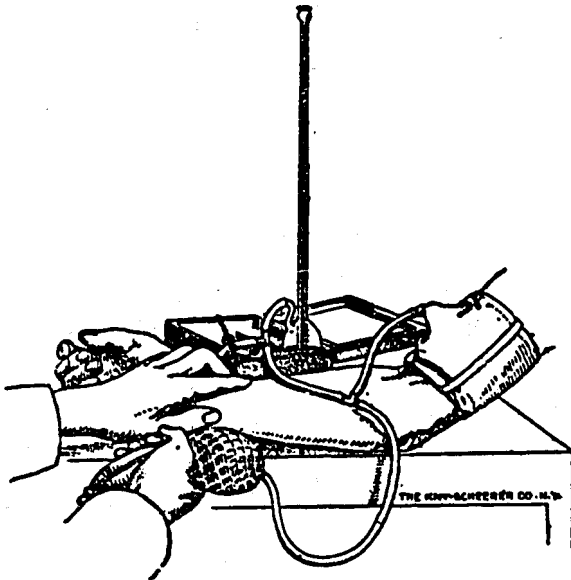
The most valuable indication derived from palpating the pulse is an estimate of arterial tension, and the value of such estimates is in direct proportion to their accuracy.

A knowledge of actual, numerically determined pulse tension is of speech value in the diagnosis of many morbid conditions where variations from the normal are characteristic; for example, in apoplexy, traumatic brain compression, surgical or traumatic shock, nephritis, cardiac diseases, aneurism, lead poisoning, concealed hæmorrhages, uræmia, etc.

Also in the treatment of conditions where correction of an existing pulse tension is aimed at, under which are included all the conditions just mentioned above, and in addition the large class of toxic cases in which depression of the vaso motor system is a prominent feature and calls for stimulation. In these cases it is specially important to be able to follow accurately variations

in pulse force and to meet such variations with proper therapeutic measures:

A closed system of air connects a rubber bulb held by operator, a rubber band placed around arm or leg of patient and a mercury manometer. By the law of gases, equal pressure is transmitted to every point throughout the air system. When the pressure is raised by the operator to such a point that the pulse of the patient distal to the constricting band is obliterated,



Riva-Rocci's Sphygmomanometer, modified by
Cook, Johns Hopkins Hospital

the height of the mercury column in the manometer is equivalent to the maximum arterial blood pressure.

Any one at all trained in pulse palpation can make an accurate reading at the first trial, an estimation taking from fifteen to thirty seconds. The arm-piece is placed around the patient's upper arm, midway between elbow and shoulder, and adjusted to fit. The operator, with one hand, increases the pressure by squeezing the hand bulb, and with the other hand, palpates the patient's radial at the wrist, the height of mercury

column is noted, and it is then allowed to drop slowly until the pulse returns. This manoeuvre is repeated without letting the air out, and by merely squeezing and releasing the reservoir bulb. The point above which the pulse is obliterated and below which it returns is the reading of maximum arterial blood pressure. A determination within two or three millimetres should be considered satisfactory.

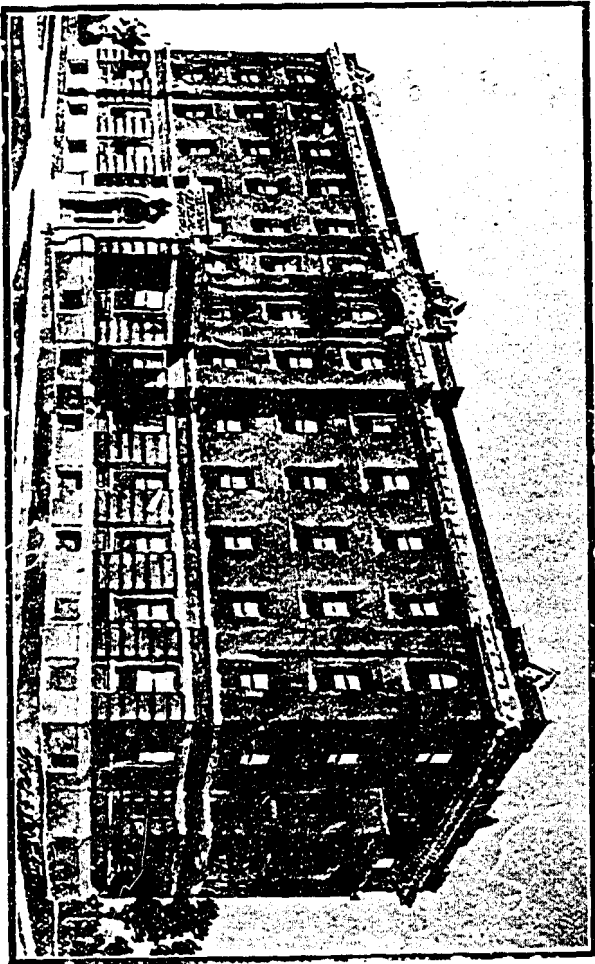
A reading of mean arterial blood pressure may be made with this instrument, as described by Professor Gumprecht, by finding the point when the greatest excursion of the mercury column occurs during cardiac systole after clamping off the tube leading to the reservoir bulb.

The normal maximum blood pressure averages when lying at rest:

For children of 1 to 3 years...	85 to 95 mm.
For children over 3 years.....	95 to 110 mm.
For adult females.....	115 to 125 mm.
For adult males.....	125 to 135 mm.

The mean arterial pressure is about three-quarters of the maximum.

The above description and illustration was furnished by the courtesy of The Kny-Sheerer Co., New York City.



REGINA'S NEW HOSPITAL.

REGINA GENERAL HOSPITAL

Storey and Van Egmond, Architects, Regina and Saskatoon

DESCRIPTION OF BUILDING

When the city of Regina decided to build a new hospital all the local architects of Regina were invited to submit plans in competition. This was done but no plan was accepted by the city. The city then engaged Mr. Sturm, of Chicago, to prepare plans and specifications. After these plans and specifications were received they were found not to comply with local conditions and requirements, and Storey and Van Egmond, architects, of Regina, were engaged by the city to prepare new plans and specifications which were accepted and in accordance with which the building is being built.

The Building.

The building is being erected by Messrs. Snyder Bros. at a cost of \$100,00.00 from plans and specifications prepared by Messrs. Storey and Van Egmond, architects, and under their supervision.

The building will be 146 feet long and 46 feet wide, four stories and basement.

Layout.

Basement. In the basement are provided the following: general waiting room, registration office, dispensary, three examination rooms, observation room, laboratory, drug stores, kitchen stores, lavatories and baths, locker room, carpenter room, morgue, fan room, elevator room, boiler room and coal room. There is a main entrance to the general waiting room. Directly opposite waiting room are situated main stairs and elevator. Service stairs separate from main stairs. Ambulance entrance at rear direct to elevator and tradesmen's entrance direct to service stairs. Separate entrance to morgue.

Ground Floor. On the main floor are provided the following: entrance lobby with stairs leading to basement and main floor; administration department consisting of secretary's offices, reception room, examination room with private lavatory, internes room, library, study, matron's rooms with private bath room, and medical superintendent's rooms with private bath room; maternity department, consisting of a general obstetrical ward, two private wards, infant ward, laboratory, toilet and bath room, service room, diet kitchen and service stairs.

First Floor. On the first floor are provided the following: two medical wards, two typhoid wards, two pneumonia wards, five semi-private wards, two toilet rooms and bath rooms, two service rooms, linen and chart room, diet kitchen, service stairs, main stairs and elevator. This floor is laid out so that the men's department is on one side and women's department on the other side with separate service rooms, lavatories, etc.

Second Floor. On the second floor are provided 18 private wards with separate closets, some of these wards can be utilized as semi-private wards in emergency. As in the floor below each wing is provided with separate lavatories, service rooms, etc., in order that one side can be for women and the other side for men. Diet kitchen, linen and chart room, etc., also provided on this floor.

Third Floor. On the third floor one wing is devoted to the operating department, consisting of one large operating room, with student's balcony above, one small operating room, sterilizing room, supply room, anasthetic room, instrument room, nurses' room, doctors' room with lavatory, shower bath, etc., laboratory, two recovery wards, obstetrical delivery room and service room. On this floor are also provided two surgical wards with toilet rooms, service rooms, etc., and one private surgical ward. In the opposite wing to the above there are provided the main kitchen, special diet room, kitchen stores, help dining room, nurses' dining room and doctors' dining room.

In General. The main entrance is in the centre of the building and opposite the entrance is situated the main stairs.

Next to the main stairs is the elevator with landing at ambulance entrance, and extending from basement up to roof in order that patients may be taken up to roof if desired. The service stairs also extends up to roof. Each service room is to be provided with work table, bed pan rack and flower sink, broom closet, sterilizer, slop sink and shelving. Each diet kitchen is to be provided with double deck table, sink, two dumb waiters from main kitchen, cupboards, refrigerator, gas stove connection and steam table connection. In the store rooms are provided two large refrigerators with three compartments in each. At the south end of the building on each floor is a balcony with iron fire escape stairway.

Construction. The building is fireproof except for the windows. The floors are of reinforced concrete and partitions either of solid brick or metal stud and metal lath. The roof is of reinforced concrete with a suspended ceiling of metal strapping and metal lath. The exterior walls are of solid brick and stone, and there are two interior walls of brick running the entire length of building. Both stairways and elevator are enclosed by solid brick walls. The finished floor in wards and rooms is to be of white maple; the corridor, lavatories, operating room, etc., will have a patent monolithic flooring with colored border. The use of trim and all woodwork where possible has been eliminated throughout, the plaster being rounded into all frames and a small cove base being used throughout. All angles throughout are to be rounded. Corridor walls, operating room walls, lavatory walls, stair walls and railings are to be finished in Keene's cement, marked off to represent tile and enamelled. All doors and other woodwork in the administration part is to be of birch with mahogany finish, and all other woodwork throughout is to be white enamelled. All walls and ceilings of operating and sterilizing rooms also to be enamelled. Stairs to be in reinforced concrete with monolithic patent treads and risers. At the elevator landing on each floor are provided automatic fusible link fireproof doors. The exterior will be executed in red pressed brick and Tyndall stone.

A complete fan system of ventilation has been provided, the fresh air being drawn in over heating coils and ejected into every ward, and the foul air ejected above roof. Pullman automatic sash ventilators have also been provided. The building will be heated by a low pressure steam system with two return tubular units and the Powers automatic system of temperature regulation by thermostats and compressed air.

The contract calls for the building to be finished by December, 1910, and the walls are now at ground floor level.

THE SASKATCHEWAN MEDICAL JOURNAL

Published by the University Press,
Regina, Canada.

HARRY MORELL, M.D., C.M., *Chairman of Publication Committee*

All communications relating to this publication should be sent to the
Saskatchewan Medical Journal, Regina, Saskatchewan, Canada.

Box 1106.

Editorial Notes

We have before us the report of the provincial bacteriologist for the past year, and it presents some interesting and comprehensive statistics. The first thought on glancing over the pages is the immense amount of work done in this institution, not only in amount but in variety of examinations made.

Report
of
Provincial
Laboratory

For instance, we find 270 specimens of the following materials were submitted and expert opinion given. They comprise: water, milk, cream, butter, bluestone, formalin, clay, sand, cement, coal, bread, meat, sewage, liquors, gopher poison, minerals and miscellaneous. Among the miscellaneous articles examined were: gasoline, sugar, stock foods, linseed oil, medicine, dynamite, coffee and syrup.

Next mentioned in the report is drainage and sewage disposal, specimens coming from the cities of Regina and Moose Jaw. Bacteriological examinations are now taken up, and in this department 817 analyses were made. Summarised as follows:

Water	112
Milk	38
Cream	8
Sewage	4
Tuberculous sputa.....	291
Diphtheria cultures.....	364
	<hr/>
Total.....	817

In examinations which are classed as pathological, 431 have been grouped, made up of these:

Tumours	155
Blood counts	15
Widal reactions (typhoid).....	51
Stomach washings.....	24
Urine analyses.....	159
Medical jurisprudence and toxicology....	16
Post mortems.....	1
Rabies	6
Glanders	4
	<hr/>
Total.....	431

The report is now continued, showing that in this laboratory grain tests were made, of which there were 1,513 specimens submitted. Other materials, as wines and liquors were sent to the institution by inspectors of the Liquor License Branch for percentage of alcohol. The report concludes with a meteorological table, giving the maximum and minimum temperature recorded throughout the year at Regina.

The time of the Director of the laboratory is encroached upon at certain intervals in the year by lecturing at farmers' institutes at outside places in the province; and at other times he is called upon to make post-mortems for coroners, and give evidence before coroners and other courts. As acting Registrar of the College of Physicians and Surgeons he has a multitude of duties to perform, being also the Secretary-Treasurer of the

Saskatchewan Medical Association, this latter position, however, does not take up any time, except at certain intervals during the year.

We have discussed freely the amount of work done, but there is another phase of this question which presents itself, we refer to the quality of scientific medicine, which has to do with the medical men of the province. We ask this question, does the laboratory give to the general practitioner at large, throughout the province an efficient and satisfactory service? and have these medical men confidence in the opinion of the reports given? Many enquiries have been made, and the general opinion is that the work is inefficient; many send all their specimens to Winnipeg, as no reliance can be placed on examinations of specimens submitted to this laboratory. How could this be otherwise when it is known that the qualified laboratory workers in this institution is limited to one, and this one is the Director.

The profession does not want and will not accept examinations made nor opinions given by unqualified persons. Granting that the Director has an extra large capacity for work, it would seem impossible for him to criticise and prove but a small proportion of the examinations made.

If we are correct in our contentions that the provincial laboratory is overworked, a change should be made; the medical profession demands it. A serious condition of affairs exists, and we must be assured that all work done is accurate. Much depends on a question of this sort; for instance, an opinion given in a diphtheria swab, think what amount of expense and confinement in quarantine a wrong examination and report would cause, and *vice versa*.

The medical men want a laboratory of their own; they demand and are entitled to consideration. The Agricultural Department, we have no doubt, requires work done, but surely there is enough work for this department to maintain a separate and distinct institution, the same as we should have. The medical laboratory should be revised and equipped so as to furnish examinations of materials which are

An Efficient
Medical
Laboratory
required

known to have direct relation to public health gratuitously. Whether or not this public laboratory should give opinions on tumors, urine, blood and other materials, which has a relationship only to private diagnostic work, is not clear to us, but that would largely depend on the matter of financial aid.

In closing, we wish to point out that in the opinion of many of the members of the profession, an entirely new laboratory of the College of Physicians and Surgeons of Saskatchewan, who, by the way, have about \$25,000 to their credit in the bank. Why not use some of this for the good of the professional men who contributed to this fund?

It should be carefully noted that we do not desire in any way to hamper the provincial laboratory officials, but we contend that the arrangements at this institution are wrong in principle, in system, and in personnel. This laboratory should set the example to the general practitioner and inspire him to better scientific work.

* * *

In our April number the question of Inter-provincial registration and Reciprocity between the Western Provinces was commented upon and discussed.

Since that time this vital issue was taken up by the different medical councils and medical associations, and it cannot be said that no advance has been made towards some solution. At Brandon at the meeting of the Manitoba Medical Association on June 22nd, the following resolution was carried unanimously:

"That this association is in favour of and will support the following scheme of registration, viz.: that the four Western

Inter-
Provincial
Registration

Provinces, Manitoba, Saskatchewan, Alberta and British Columbia, shall join together and form a federation that shall have power and authority through a federated board to provide and regulate the conditions which any person wishing to register in any of the provinces must comply with before being entitled to register, and that early steps be taken by the College of Physicians and Surgeons of Manitoba in conjunction with

the College of Physicians and Surgeons of the other provinces concerned to mature this arrangement, and that if British Columbia refuses to come in, we endeavor to secure affiliation between Manitoba, Saskatchewan and Alberta.

The above resolution was passed also by the Alberta and Saskatchewan Medical Associations at their annual meetings. At Vancouver on the fifteenth of July, a meeting was held and the outcome was that the profession and medical council of British Columbia could not see their way clear to support the resolution. It was held that reciprocity between the western provinces only would be of very doubtful benefit, but as to Dominion registration, that was another matter; they were committed to that policy, and would support the "Roddick" bill, which contemplated inter-provincial registration between all the provinces of Canada. It was to be regretted that the British Columbia council took that stand, as the only way to see the complete consummation of the measure was if the western provinces presented a united front to the measure, the east would have followed in its wake, but it was thought wise before steps were taken to give a final answer, to appoint delegates to meet at Banff at a later date.

During the latter part of September the various delegates from all parts of the western provinces met at Banff, for the purpose of arriving at some conclusion as to formulate a policy whereby one standard would be created, and the conditions of qualification be so high, that one passing this examination would be recognized by the conjoint board and be entitled to practice in any one, or all of the provinces who are party to this agreement.

The details will still have to be gone over carefully, but "coming events cast their shadows before them," and now that the way has been made, it will not be difficult to prophesy that we will have a Dominion registration within a reasonable time; even now Ontario is not unwilling to become another link in the chain.

College of Physicians and Surgeons

The first meeting of the College of Physicians and Surgeons of Saskatchewan met at Regina on the 29th of July. This meeting, which was the first held under the new law which separated this body from the old College of Physicians and Surgeons of the North-West Territories, comprising the Provinces of Alberta and Saskatchewan. The council remained in session two days, working out a policy to be followed during the present year, and formulating rules regarding standard of examinations.

The following members were present: District No. 1, Dr. Stanley Miller, of Battleford; No. 2, Dr. A. MacG. Young, of Saskatoon; No. 3, Dr. J. F. Irving, of Yorkton; No. 4, Dr. A. E. Kelly, of Swift Current; No. 5, Dr. W. A. Thomson, Regina; No. 6, Dr. H. Eaglesham, Weyburn; No. 7, Dr. Argue, Grenfell.

The following officers were elected in addition to an executive committee of three: Pres., Dr. W. A. Thomson, of Regina; vice-pres., Dr. A. W. MacG. Young, of Saskatoon; acting registrar, Dr. G. A. Charlton.

As a registrar is not a member of the council, and as there were some applications received for the post, it was thought wise to appoint the present incumbent to hold office until the first of the year, as most members were unfamiliar with this work, and the acting registrar should be "allowed to finish his work."

A large amount of business was transacted, including the fixing of August 24th as the date of the next examination, to be held in Regina.

At yesterday morning's session Dr. Milroy, of Winnipeg, who is on his way home from the coast, addressed the council in support of the idea of inter-provincial registration. It is expected that this question will be discussed at the meeting of

the Canadian Medical Association to be held in Winnipeg in August, to which Drs. Thomson and Argue were appointed as delegates by the council.

At Regina on September the twenty-second a special meeting of the council was held to consider the results of the board of examiners who conducted the recent examinations. The board investigated an unauthorized date given out whereby a number of candidates visited Regina for the purpose of examination and were put under expense; these naturally resented such treatment.

The following candidates declared to have passed: J. Hamelin, Montmartre; G. A. Harvie, Regina; J. C. S. Brown, Brandon; J. D. Windell, Spokane; H. B. Woods, Elstow; R. J. Gordon, Harris; H. E. Montgomery, Nokomis; A. H. C. Smith, Whitewood; R. J. Barrett, Osage; A. E. B. Denovan, Morse; D. A. Henderson, Landis; W. W. Tryerman, Milestone; M. Nikle, Weyburn; V. C. Francis, Adanac; C. G. Cox, Buchanan; C. D. Hewitt, Antler; E. T. French, Oxbow; A. J. Leach, Togo; W. D. Dixson, Penkill and J. L. Campbell.

The following delegates were selected to represent the Saskatchewan Medical College at a meeting of the medical men of the four western provinces to be held at Banff on September 28th, when the question of interprovincial registration will be taken up. Dr. Thomson, Regina, president; Dr. A. MacG. Young, Saskatoon, vice-president; Dr. A. E. Kelly, Swift Current.

News Items

The Manitoba Medical Association at the annual meeting at Brandon in June elected the following officers: Dr. Harvey Smith, Winnipeg, president; Dr. Hicks, Griswold, first vice-president; Dr. J. Matheson, Brandon, second vice-president; Dr. J. Halpenny, Winnipeg, hon. secretary; Dr. Rorke, Winnipeg, hon. treasurer; Dr. Wright, Oak Lake, Dr. Keel, Portage la Prairie, Dr. Ross, Selkirk, Dr. Speckles, Pilot Mound, Dr. Harrington, Daupin, executive committee.

Lord Lister, of England, the famous surgeon, who forty years ago first announced to the world his marvelous antiseptic treatment, which has saved the lives of hosts of patients, lately celebrated the eighty-second anniversary of his birthday, and received congratulations from all parts of the world. He has had many honours conferred upon him, and was appointed surgeon to the king in 1901. He is a Quaker, as were his parents before him.

Book Reviews

COMMON DISORDERS AND DISEASES OF CHILDHOOD, by G. F. Still, M.A., M.D., F.R.C.P., Professor of Children's Diseases, King's College, London, etc., Oxford Medical Publications, London. D. T. McAinsh & Co., Toronto. Price \$4.50.

This is a new book of seven hundred and one pages, with numerous illustrations.

One, on looking at this work, will be attracted with the "freshness of it." The author has not simply compiled this volume from other books on the subject, but has instilled into its pages his own extensive experience, or as the "Lancet" (London) says, "the material is mainly drawn from Dr. Still's

own large experience, and is therefore particularly valuable as being first-hand information, not mere 'warmed-up' statements of others, as text-books too often are."

Other opinions as to the originality of the contents are given by "The Canadian Practitioner," which says: "No book has appeared this year that excels this new work of Still's. Written in a lucid and readable style, the author has given his own opinions and observations, which makes the book very valuable, in striking contrast to the volumes which appear on this side of the Atlantic, compiled chiefly by means of the scissors and glue pot. Every subject considered is treated in a thoroughly scientific manner by a man who is a teacher, and who has the faculty of making things clear."

We cannot but speak of the general make-up of this book, as in our opinion it is ideal for a publication of this class. For instance, the size, binding, paper used and impress could not be improved upon.

INTERNATIONAL CLINICS. Quarterly. Vol I. Nineteenth Series. These clinics are illustrated clinical lectures and especially prepared original articles on all subjects of medical and surgical science by leading members of the Medical Profession throughout the world. Edited by W. T. Longcepe, M.D., Philadelphia.

This number contains colored plates and over three hundred pages of text. Some particularly good articles are included in this volume, as Conditions Modifying Operative Work, by A. David Willmouth Louisville, Ky.; Suppuration in Appendicitis, by E. M. Corner, London; A Case of Acute Yellow Atrophy of the Liver in Pregnancy, by Robert Jardine, Glasgow, and many other interesting lectures and addresses. J. B. Lippincott Company, Philadelphia, London and Montreal.

International Clinics. Vol II. Nineteenth Series. This number has four colored plates with over three hundred pages. A specially good monograph on Congenital Idiopathic Dilatation of the Colon, by Daniel, F.R.C.S., London. This article contains a classical description of the disease, with cases and double page skiagrams and photographs. Other splendid

articles are contributed by authorities and teachers. Philadelphia, London and Montreal. J. B. Lippincott Company.

APPENDICITIS AND OTHER DISEASES OF THE VERIFORM APPENDIX. By *Howard A. Kelly, M.D.* With 215 original illustrations, some in colors, and three lithographic plates. Philadelphia, London and Montreal: J. B. Lippincott Company, 1909.

If this and no other work had emanated from the brain and pen of Dr. Howard A. Kelly, the volume before us would have stamped the one who prepared it as the foremost authority of this subject. Four years ago, H. A. Kelly in conjunction with E. Hurdon, brought out a larger book, which at that time was the most comprehensive volume on the appendix which was ever published on this subject, and now, within four years, this, as may be called a second edition, has appeared.

The "Record," New York, in a review says "The author has attempted to make this edition of more practical value to the general surgeon, yet it should be read by everyone who is today practising medicine. The chapters on clinical history, leucocytosis, and treatment before and after operation, will prove of great value to the practitioner who never touches the scalpel.

The first chapter contains a history of this disease and well shows the great part played by the American surgeons in clearing up the real nature of the many conditions formerly grouped under the term "idiopathic peritonitis." The anatomy and pathology and the appendix and the different locations of the organ in the abdomen are made clear by numerous illustrations and by diagrams picturing the embryological development.

The chapter on treatment previous to operation is addressed particularly to the practitioner who has no surgeon at hand, yet a list of aphorisms contained in it should appeal to the surgeon as well. One of the most imperative of them is "never give purgatives in appendicitis."

The operative technique is given minutely and as the illustrations are extremely plain and lucid, there is left nothing

that would deter one from undertaking an unfamiliar procedure.

The colored plates which are drawn by Brodel, Horn & Becker are life-like, and the illustrations, which there are over two hundred, can only be described as wonderful. Brodel's work is so well known to the medical profession that it requires no praise from us, but we may be allowed to mention one, Fig. 74, "encysted peritonitis surrounding the tip of the appendix." This, according to our view point is superb. This volume is well worthy of the author and teacher who prepared it and the bookmakers who published it.

We strongly advise any medical man who has not a copy to place one on his desk.

HARRY MORELL.

BOOKS RECEIVED

A HANDBOOK OF MEDICAL DIAGNOSIS. For the use of practitioners and students. By *J. C. Wilson, A.M., M.D.*, Professor of the Practice of Medicine and Clinical Medicine in the Jefferson Medical College, etc., etc., Philadelphia. 408 text illustrations and 14 full page plates. Philadelphia, London and Montreal. J. B. Lippincott Company.

This is an absolutely new work, just from the press, and a full review will appear later.

THE EDINBURGH STEREOSCOPIC ATLAS OF ANATOMY. Edited by *David Waterston, M.A., M.D., F.R.S.E.*, and *Edward Burnet, B.A., B.Sc., M.D.* Issued under the auspices of the Department of Anatomy of the University of Edinburgh by Professor D. J. Cunningham, M.D., LL.D. A new edition in five sections. This consists of two hundred and fifty stereoscopic dissections together with descriptive and explanatory text, embracing the anatomy of the entire human body. Toronto, Canada: T. J. Ford & Company, 303 Church street.

Correspondence

Melfort, July 16, 1909.

Mr. Editor:—

I beg to offer some criticism of a case reported in your last Journal by Dr. Croll, of Saskatoon, on extra uterine gestation, more particularly as to the treatment.

During the past year I operated on two cases in the Melfort Hospital. These cases were both similar, almost in every respect, to that reported by Dr. Croll, viz., reglit tubal and rupturing into the pelvis beneath the pelvic fascia. I attacked the trouble through the vaginal route, and after making the incision with my finger introduced into the wound and pressure with the other hand over the abdomen. It is surprising how readily the clots and membrane can be scooped out.

I then packed with iodoform gauze. One case I irrigated with thierh sol first owing to fouted oder from clots and membrane and after drying as well as possible, packed with gauge. Both cases made a good recovery. In a case which has ruptured into the pelvis outside the peritoneum, I don't approve peritoneal infection, heaminar and an unsightly sear. If the rupture takes place into the peritonium then laparotomy is the right procedure (and that mighty quickly too). Vaginal route is the only justifiable operation when rupture into pelvis, it is so readily done, easy access, so completely under control, and above all outside the peritoneum.—Yours,

L. C. SPENCE,

Answers to Correspondents

W. C. K., Swift Current, Sask.—You will have to apply to the Registrar C. of P. & S. Sask., Regina, for examination and also pay the usual registration fee of \$50.00.

E. A. W. D., Seattle, Washington, U.S.—Apply to the Registrar C. of P. & S. Sask., Regina. We believe you will be allowed to write on the one subject failed in.

A. McC., Gloucester, Mass., U.S.—See advice given to W. C. K. above.

W. J. R., Virginia, U.S.—Write to Registrar C. of P. & S. Sask., Regina, for a copy of the "Medical Practice Act." The registration fee is \$50.00.

Notice

Forty-third annual meeting at Toronto, June 1st, 2nd, 3rd and 4th, 1910, Canadian Medical Association. February 1st, 1910, has been set as the time limit for submitting papers for the next annual meeting. Abstracts of all papers are to be in the hands of the general secretary by April 1st so as to provide for printing and posting same.

GEORGE ELLIOTT,

General Secretary,

Toronto.

Whatever be the accepted views of the pathology and etiology of hay fever, there is little difference of opinion concerning its importance and the severity of its symptoms. An agent that is capable of controlling the catarrhal inflammation, allaying the violent paroxysms of sneezing and the abundant lacrimation, cutting short the asthmatic attack when it becomes a part of the clinical ensemble and, finally, sustaining the heart and thus preventing the great depression that usually accompanies or follows the attack—in short, an agent that is capable of meeting the principal indications—must prove invaluable in the treatment of this by no means tractable disease.

In the opinion of many physicians, the most serviceable agent is Adrenalin. While not a specific in the strict meaning of the word, Adrenalin meets the condition very effectually and secures for the patient a positive degree of comfort. It controls catarrhal inflammations as perhaps no other astringent can. It allays violent paroxysms of sneezing and profuse lacrimation by branching the turbinal tissues and soothing the irritation to the nasal mucosa which gives rise to those symptoms. It reduces the severity of the asthmatic seizure, in many instances affording complete and lasting relief.

There are four forms in which Adrenalin is very successfully used in the treatment of hay fever: Solution Adrenalin Chloride, Adrenalin Inhalent, Adrenalin Ointment, and Adrenalin and Chlorotone Ointment. The solution, first mentioned, should be diluted with four to ten times its volume of physiological salt solution and sprayed into the nares and pharynx. The inhalent is used in the same manner, except that it requires no dilution. The ointments are supplied in collapsible tubes with elongated nozzles, which render administration very simple and easy.

It is perhaps pertinent to mention in this connection that Messrs. Parker, Davis & Co. have issued a very useful booklet on the subject of hay fever containing practical chapters on the disease, indications for treatment, preventive measures, etc. Physicians will do well to write for this pamphlet, addressing the company at Walkerville, Ont., or at branch—378 St. Paul St., Montreal, Que.

After All

You're the butt of many a joke,

Doctor-man;

We hand you many a poke,

Doctor-man;

But when we're feeling ill

We're not satisfied until

We've partaken of your pill,

Doctor-man.

That your ignorance is great,

Doctor-man,

We very freely state,

Doctor-man.

But when the microbes on us land,

And the germs have us unmanned,

We'd have you close at hand,

Doctor-man.

We meet your bill with squalls,

Doctor-man;

Charge you with needless calls,

Doctor-man;

But if baby's taken sick,

Or Marjorie or Dick,

We forget it mighty quick,

Doctor-man.

So, in spite of all our slams,

Doctor-man,

And our funny epigrams,

Doctor-man,

And though frequently we doubt you,

And say mean things about you;

We can hardly do without you.

Doctor-man.

—Exchange