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The SUMMER SESSION for 1889 will commence on Monday, April 29th, and continue until July 5th

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The **SPRING SESSION** consists of recitations, clinical lectures and exercises, and didactic lectures on special subjects. This session begins about the middle of March and continues until the middle of June. During this Session, daily recitations in all the departments are held by a corps of Examiners appointed by the Faculty.

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The Collegiate Courses of this School are a Winter Session, extending from the 1st of October to the end of March, and a Summer Session from the end of the first week in April to end of the first week in July.

The fifty-seventh session will commence on the 1st of October, and will be continued until the end of the following March; this will be followed by a Summer Session, commencing about the middle of April and ending the first week in July.

Founded in 1824, and organized as a Faculty of McGill University in 1829, this School has enjoyed, in an unusual degree, the confidence of the profession throughout Canada and the neighbouring States.

One of the distinctive features in the teaching of this School, and the one to which its prosperity is largely due, is the prominence given to Clinical Instruction. Based on the Edinaburgh model, it is chiefly Bed-side, and the Student personally investigates the cases under the supervision of special Professors of Clinical Medicine and Surgery.

The Primary subjects are now all taught practically as well as theoretically. For the department of Anatomy, besides a commodious and well-lighted dissecting-room, there is a special anatomical museum and a bone-room. The other branches are also provided with large laboratories for practical courses. There is a Physiological Laboratory, well stocked with modern apparatus; a Histological Laboratory, supplied with thirty-five microscopes; a Pharmacological Laboratory; a large Chemical Laboratory, capable of accommodating 76 students at work at a time.

Besides these, there is a Pathological Laboratory, well adapted for its special work, and associated with it are two "culture" rooms, in which the various forms of Bacteria are cultivated and experiments on Bacteriology carried on.

Recently extensive additions were made to the building and the old one entirely remodelled, so that besides the Laboratories, there are two large lecture-rooms capable of seating 300 students each, also a demonstrating-room for a smaller number. There is also a Library of over 10,000 volumes and a museum, as well as Reading-rooms for the students.

In the recent improvements that were made, the comfort of the students was also kept in view.

#### MATRICULATION.

Students from Ontario and Quebec are advised to pass the Matriculation Examination of the Medical Councils of their respective Provinces before entering upon their studies. Students from the United States and Maritime Provinces, unless they can produce a certificate of having passed a recognized Matriculation Examination, must present themselves for the Examination of the University, on the first Friday of October, or the last Friday of March.

#### HOSPITALS.

The Montreal General Hospital has an average number of 150 patients in the wards, the majority of whom are affected with diseases of an acute character. The shipping and large manufactories contribute a great many examples of accidents and surgical cases. In the Out-Door Department there is a daily attendance of between 75 and 100 patients, which affords excellent instruction in minor surgery, routine medical practice, venereal diseases, and the diseases of children. Clinical clerkships and dresserships can be obtained on application to the members of the Hospital staff.

#### REQUIREMENTS FOR DEGREE.

Every candidate must be 21 years of age, have studied medicine during *four* six months' Winter Sessions, and *one* three months' Summer Session, one Session being at this School, and must pass the necessary examinations,

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Please mention THE MARITIME MEDICAL NEWS.

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A JOURNAL OF MEDICINE, SURGERY AND OBSTETRICS.

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### A LECTURE ON GENERAL PARESIS, DELIVERED AT THE HALIFAX MEDICAL COLLEGE, APRIL, 1890.

BY GEO. L. SINCLAIR, M. D.,

*Assistant Superintendent Hospital for Insane.*

GENTLEMEN,—There is a form of mental disease with which, it seems to me, the general practitioner is particularly unfamiliar, viz, what in this country is usually spoken of as GENERAL PARESIS; it is also sometimes referred to as *general paralysis of the insane* and *progressive paralysis of the insane*.

It is a very characteristic mental malady, is apt to run a distinct course and have but the one termination, viz, death.

I said the general practitioner was unfamiliar with it, and I make this assertion upon the strength of our experience at Mount Hope. I cannot recall now any single case in which the committing certificate recognized the fact that the patient was laboring under paresis, and I can several, in which a diagnosis of acute mania was made and the relatives of the patient told that as he was in good health, was not old, and the violent symptoms were recent, that the probabilities of recovery at any early date were good; a correct prognosis had the case been one of simple acute mania, but not at all so if maniacal symptoms were only part and parcel of a distinct disease—paresis. Knowing of this; during your visit to the Hospital on Saturday last, I took particular care to point out to you the cases of general paralysis and, as far as possible, to show you patients who were in the stages of the disease as we generally see it clinically.

Perhaps, after all, it is not remarkable that physicians do not recognize this affection; for while we have no reason to doubt that it has existed almost from the history of medicine, it is only since 1826 that it has been accorded a distinct place in our nomenclature.

In that year M. Calmeil gave a complete account of it. Previous to this other observers, both French and German, had been struck with some of the more prominent symptoms and had referred to them. For instance, Bayle in 1822 noted that the mental disturbance and paralysis were synchronous and due to chronic inflammation of the arachnoid, but as I said, to Calmeil the credit of being the first to fully describe the condition, is usually awarded. It is a specially fatal malarial and destroys many valuable lives yearly, the victims usually being men in the very prime of life.

Who then are specially liable to this disease? According to Sankey, we have first, males of the lower class; second, males of the upper class; third, females of the lower classes, and fourth, females of the upper classes. I am not sure that our statistics would bear this tabulation out. Here at any rate the majority of cases have occurred among males of the upper class. I have seen among females only one case of which I was sure, and one other doubtful one. The affection is rare before 30 years of age, most common about 40 years, and at 70 is unknown. The victims are often in their prime of intellectual and physical development, are free from a nervous strain, but as a rule have "enjoyed" life, and lived hard—have gone to excess in the use of their mental and physical powers, have been consumers of animal food, usually of stimulants, and also may have indulged in sexual excesses. About this latter statement I shall say more when we come to treatment; it is usually given as an exciting cause of paresis, but it is a difficult matter to say just how much is cause and how much effect.

#### SYMPTOMS.

It is usual to speak of a stage of *incubation*, a *stage of acute mania* and that of *chronic mania*,

*lapsing into dementia* with utter prostration of mind and body.

I am not personally familiar with the symptoms in the early part of the first stage—this portion of the drama is usually enacted at home. It is only when its tendency to run into the second stage appears that the patient is committed to our care. Still, I have heard the story so often from the relatives and friends of patients, that I can give you a fair account of the symptoms of this period of incubation. You remember the first patient to whom I called your attention in the wards, or rather the one who first called your attention to himself. The history I received from his wife was something like this.

Her husband is 42 years of age. He has been engaged in mercantile pursuits at which he has worked very hard and with only moderate success; of late he has had special difficulty in keeping the "wolf from the door." He uses tobacco to excess; before his marriage he was a free drinker; since, he has entirely reformed and manifested great interest in religion, having become a church member and regular attendant. Of course from her I could gain no information as to there being venereal taint, but I have no reason to suspect that he ever had syphilis.

The first change which she noticed, was that after an unusually hard "spell" of work, involving late hours, and hurried meals, he complained of great fatigue and headache. He did not sleep well and she thought he was more talkative than usual. He hinted vaguely that he expected soon to be very rich—he had some schemes on hand which upon completion would make him a millionaire. He had previously been a very nervous man and particularly easy going. He next displayed unusual irritability, speaking sharply to her and correcting his children with unwonted severity for very trivial offences. He surprised her greatly one day by presenting her with a diamond ring, she knew he could not afford it and told him so, he became very angry and repeated his assertion about speedily being known as a wealthy man. He began to buy and send home useless and expensive articles, talked in a very exaggerated manner, gave orders of a most contradictory character, and became enraged because they were not instantly obeyed. She became alarmed and suggested to him that he was not well and had better see his medical man, but he laughed her to scorn, and said he was never better, that he was the strongest man in town, and could out-walk, out-jump and out-run any other man.

His sleep left him now almost entirely. He walked about the room for hours keeping every one else awake—roused the family at very early hours, and peremptorily ordered them down stairs to begin work. He punished one of his children unmercifully—neglected all of his ordinary duties, became untidy in dress, and at table was so unmannerly that the family could not tolerate him. He spilt his food upon his clothes, crammed his mouth full, and loaded his plate with everything within reach, and ate with his fingers. His language became loud, vulgar and profane. He

boasted of his conquests among the fair sex and before his children made most obscene suggestions, finally when she expostulated with him he struck her, produced a revolver and threatened to shoot her. This alarmed her, she then called in her medical man, who advised his removal here. The certificates were made out and a policeman called in to prevent trouble. Strongly protesting, he was driven here in charge of the policeman and handed over to us for care. When he saw me he called me by name, said he was not ill, that he was never better, that he would yield to the force of circumstances, but he intended to sue the men who had signed the warrant and would recover large damages from them, and the medical man who certified that he was insane. He went quietly to the ward, and within an hour sent me a paper announcing that he had changed his name, that he was a great religious philanthropist and a very wealthy man—furnishing a schedule of his properties and putting *his* values upon them. He was on the eve of a great speculation and he sent me the figures to show how certain he was to make a large sum of money. He then gave me his medical history, ending by requesting me to send him some opening medicine as he was costive.

Now I want to draw your attention to the fact that in all of the delusions which the patient has manifested, there are two peculiarities: one is their extravagant character, as shown by his assertion of wealth and great physical and mental power—he was going to write a wonderful book, showing how every one could acquire wealth, and the other was the changeableness of the delusions when they affected his own personality. These two symptoms are almost characteristic of paresis. An ordinary lunatic is tenacious of his opinions and defends his assertions and assumptions—a paretic rarely does. While the general idea of his individual greatness remains, his inconsistencies in particulars is very marked.

Well, our friend the next day said he had slept splendidly—he had been quiet all night—and was in rather a good humor. He was inclined to "boss" his fellow-patients, but had "accepted the situation" fairly well. He was very prone to launch out into his extravagant schemes and was very self-assertive. I noticed that his pupils were not the same size, and when he began to speak his lips trembled as if he was going to burst into tears, when his tongue protruded it also trembled and it seemed to me he spoke "thick." I asked him to say "infallibility" and "constitutionality" he blurred his words very much, and when he was requested to rhyme, "Round the rugged rock the ragged rascal ran," he could not complete the sentence in an intelligible manner. He recognized this himself and became annoyed with me for asking him to try.

His face was flushed and also his conjunctiva and his pulse was over 100 per minute. His temperature was 99.5.

All cases admitted here do not present the same symptoms. I have seen them exhibit great violence and resist being taken to the ward, at other times they will protest and plead against it, declaring there is nothing the matter, that they were never better in their lives, and they rapidly pass into threats—they will sue everybody—will appeal to the Queen, will obtain the help of the fleet and garrison and so secure their release. Generally their outbursts of



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" Mastic.....½ grain. | M. ft. one pill.

Lady Webster Dinner Pills This is an excellent combination Officially designated as Aloes and Mastic, U. S. P. We take very great pleasure in asking physicians to prescribe them more liberally, as they are very excellent as an aperient for persons of full habit or gouty tendency when given in doses of one pill after dinner.

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(Dr. Fothergill.)

R—Pulv. Ipecac.....½ gr. | Strychnine.... .1-20 gr.  
Pulv. Pip Nig.....1½ gr. | Ext. Gentian.....1 gr.

The above combination is one of Dr. Fothergill's recipes for indigestion, and has been found very serviceable in some forms of Dyspepsia it may be necessary to give a few doses, say one pill three times a day, of Warner's Pil Anticonstipation.

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ONE GRAIN IN EACH.

The dose of Iodide of Iron Pills is from one to two at meal times; is recommended and successfully used in the treatment of Pulmonary Phthisis or Consumption, Anamia and Chlorosis, Caries and Scrofulous Abscesses, Loss of Appetite, Dyspepsia, etc.

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With this important fact in view, we have devoted special study to Iodide of Iron in pillular form, and we are warranted in announcing that WARNER & CO'S IODIDE OF IRON PILLS meet all requirements, being the most perfect preparation of the kind.

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R—Ext. Sumbul... .1 gr. | Ferri Sulph. Ext.....1 gr.  
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"I use this pill for nervous and hysterical women who need building up." This pill is used with advantage in neurasthenic conditions in conjunction with Warner & Co's Biomo-Soda, one or two pills taken three times a day

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Proto-carb. of Iron, 3 Grains. Dose, 1 to 3 Pills.

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Ferri Sulph. Fe SO<sub>4</sub> 1 | Ferri Carb. Fe Co<sub>3</sub>  
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## Pil. Chalybeate Comp.

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Same as Pil. Chalybeate ½ gr. Ext. Nux Vomica added to each Pill to increase the tonic effect. Dose, 1 to 3 Pills.

## Pil. Digestiva.

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A VALUABLE AID TO DIGESTION.

R—Pepsin Conc't... .1 gr. | Gingerine.....1-16 gr.  
Pv. Nux. Vom. .... ¼ gr. | Sulphur..... ¼ gr.

IN EACH PILL.

This combination is very useful in relieving various forms of Dyspepsia and Indigestion, and will afford permanent benefit in cases of enfeebled digestion, where the gastric juices are not properly secreted. As a dinner pill, Pil. Digestiva is unequalled and may be taken in doses of a single pill either before or after eating.

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(WM. R. WARNER & CO.)

EACH PILL CONTAINS.

Sulphite Soda.....1 gr.  
Salicylic Acid.....1 gr.  
Ext. Nux Vomica..... ¼ gr.

Dose, 1 to 3 Pills.

Pil. Antiseptic is prescribed with great advantage in cases of Dyspepsia attended with acid stomach and enfeebled digestion, following excessive indulgence in eating or drinking. It is used with advantage in Rheumatism.

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Sulphite Soda.....1 gr.  
Salicylic Acid.....1 gr.  
Ext. Nux Vomica..... ¼ gr.  
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Dose:— $\text{ʒi}$ , containing 5 grs. Pepsin, after each meal with an Aperient Pill taken occasionally.

This preparation contains in an agreeable form the nature and assimilative principles of the digestive fluid of the stomach, comprising **Pancreatic, Pepsin, Lactic and Muriatic Acids**. The best means of re-establishing digestion in enfeebled stomachs, where the power to assimilate and digest food is impaired, is to administer principles capable of communicating the elements necessary to convert food into nutriment.

The value of **Liquor Pancreopepsine** in this connection has been fully established, and we can recommend it with confidence to the profession as superior to pepsin alone. It aids in digesting animal and vegetable cooked food, fatty and amylaceous substance, and may be employed in all cases where from prolonged sickness or other causes, the alimentary processes are not in their normal condition.

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This preparation combines in a pleasant and agreeable form:—Salicylic Acid, Cimicifugæ, Gelsemium, Sodii Bi-Carb., and Potass. Iodid., so combined as to be more prompt and effective in the treatment of this class of diseases than either of the ingredients when administered alone.

This remedy can be given without any of the unpleasant results which so often follow the giving of Salicylic Acid and Salicylate of Sodium, viz.: gastric and intestinal irritation, nausea, delirium, deafness, nervous irritability, restlessness, and rapid respiration; on the contrary, it gives prompt relief from pain, and quiets the nerves without the aid of opiates.

Elixir Salicylic Acid Comp. has been extensively used in private practice for several years with almost unvarying success and with better results than any other mode of treatment yet suggested.

It is a matter of great satisfaction to us to be able to place before the medical profession a remedy so effectual in the cure of one of the most stubborn classes of disease.

The dose is from a teaspoonful to a desertspoonful, and increased as necessary to meet the requirements of the case.

Each teaspoonful contains five grains of Salicylic Acid.

Elixir Salicylic Acid Comp. is put up in 12-oz. square bottles, and may be obtained from Druggists everywhere

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(WM. R. WARNER & CO.)

## ALTERATIVE, RESOLVENT, APERIENT, TONIC.

COMPOSITION:—Phytolacca Decandra, Stylingia Sylvatica, Lappa Major, Corydalis Formosa,  $\text{ãã}$  grs. vi., Xanthoxylum Fraxineum, Potassii Iodidum, Cascara Sagrada,  $\text{ãã}$  grs. ij., in each desertspoonful.

**Syr. Phytolacca Comp.**, the Composition of which has been given to the profession, has been known and used by Physicians, myself and others of my acquaintance, and found superior to other alterative compounds now in use. It has been used with great success in the treatment of Lupus, Herpes, Psoriasis, Acne, Glandular Enlargements, Strumous Affections, Granular Conjunctivitis, and Eczema. As a remedy for Syphilitic Diseases of the Skin and Mucous Membranes, it has proved to be especially valuable in my hands in a large number of cases where all the usual remedies had failed to improve their condition, and when **Syr. Phytolacca Comp.** was administered the improvement was very prompt and satisfactory.

It will be seen that **Syr. Phytolacca Comp.** contains the best alterative remedies now in use, and that they are so combined as to make a permanent and agreeable preparation that can be administered to children or persons with the most delicate stomach.

I usually prescribe it in doses of a teaspoonful, which may be increased to a tablespoonful four times a day, the frequency of the dose to be diminished if bowels become too active.

CHARLES W. BROWN, M. D.

# ELIXIR CASCARA SAGRADA.

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Used as a Remedy in Habitual Constipation, and as a Tonic in Stomachic Debility.

Med. Prop.—Mildly Laxative, Anti-Rheumatic. Dose— $\text{ʒi}$  to  $\text{ʒij}$ .

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objections will not be of long duration and in a day or two you will find them apparently reconciled, or even engaged in planning reforms in the management—promoting the members of the staff and dispensing gifts on paper and cheques without stint to the officials around them.

The patient evidently regards himself as a superior person and speaks to and of his fellow-patients in a condescending and patronizing way.

Such patients are at times very violent. Remember, they are frequently strong, active men and they imagine themselves stronger than they really are. They will attack attendants and are utterly regardless of consequences.

All this time then delusions of the grandiose type are present, and they are more absurd than those of the ordinary maniac,—for instance, a man labouring under ordinary insanity may consider himself very wealthy, or that he is a Duke or some titled personage, but a parietic is the richest man who ever lived—he is thinking of buying the whole place, demolishing it at once and rebuilding on a much more elegant scale. He is a Prince, a Duke, a Marquis all at once, and he is going to be married to a dozen people at one and the same time. He gets up immense excursion parties to which all the crowned heads of Europe are coming, and he wants you. It won't cost you a cent—he will pay all expenses and give you the best eating and drinking. He will not argue as to the truth or possibility of the truth of his preposterous assertions, but expects you to believe them on his own statement and seems to feel pity for you if you do not.

These patients are liable to epileptiform seizures—the attacks may be of the “grand mal,” or the “petit mal” type. They are apparently not preceded by an “aura” and the tongue is not injured. They are sometimes very severe and continue for hours. Paralysis does not appear increased after this.

Sleep is often fairly good, although it is as frequently bad, and a patient may be very noisy and also extremely dirty in his habits. They are also at times most destructive. I have seen them tear up every article in the room and decorate themselves in the most fantastic way with the pieces, imagining they are uniformed to represent the historical personage whom they for the present claim to be. If expostulated with, they declare they can afford to pay for their spree and offer you a cheque at once. At times again, they will smear themselves and the room with fæces and urine.

Their appetite is usually voracious and their mode of eating most objectionable—cramming quantities into the mouth and spilling everything about the floor and table.

Frequently they evince strong kleptomaniac propensities, will steal anything from anybody—stuff themselves out with the stolen article and seem surprised when they are made to restore it. Indeed a propensity to steal is at times early manifested; before they are suspected of being insane. We have had at least two cases sent to us, one from the police station and the other from jail, who had been arrested for pilfering in the most open manner. Toward the end of this second stage there may be noticed some slight change in the gait, an unsteadiness on the feet and a somewhat slow and deliberate way of walking.

After the above symptoms have lasted from a few weeks to some months, a change occurs, and either the patient gets better—shown by his giving up his delusions and apparently realizing that he has been wrong in his mind, or, and this is by far the more common change, he passes into a state of

increasing dementia. Progress is characteristic of the disease, and the change is most apt to be for the worse.

In this third stage the patient loses all evidence of mind and his physical powers ultimately succumb. The change is gradual. The articulation gets more indistinct, the gait more uncertain, the general activity less. Frequently the patient, who has become very fat in the early stage, now begins to get thin, and ultimately becomes positively emaciated. He is also sometimes very good-natured. He still has his grandiose ideas, his wealth is not lessened, his powers are not decreased, but he does not volunteer the delusions; you get them by asking questions. He is frequently desirous of leaving the Hospital to look after his properties, but can be persuaded that he cannot go to-day. He gets more helpless. His fingers are all thumbs and his clothing is untidy from his inability to button his garments. He sometimes persists in unbuttoning every article of clothing and stripping himself nude. He will sit in one position and grind his teeth for hours, making a very distinct and disagreeable noise.

His powers of progression continue to fail, and at last he is practically helpless. The muscles of mastication and deglutition become involved and he is liable to choke from impaction of food in the pharynx. Epileptoid seizures may occur and it is fortunate if the patient is carried off in one rather than to linger on through this stage. Speech is very indistinct and unintelligible. Yet if asked how he is, even now he will stammer out “first rate.” Control of the bladder is lost, you may have retentive or involuntary passing of urine. The bowels are not under control and the patient is as helpless and dirty as an infant in arms.

Finally, he can sit up no longer and he is put to bed—there he lies like a log. He has to be kept clean, fed, changed and cared for like a baby. Bed sores form and extend—the slightest pressure seems to cause one, and they show little tendency to heal. Frequently the whole back is involved and the mass of sloughing flesh makes a smell which renders the ward unendurable. At last a merciful diarrhoea sets in, the emaciation continues and ends in death—a blessed release and relief to patient and all about him.

You may remember that in the wards of the Hospital I particularly directed your attention to the cases of paresis. You recollect the first patient who came forward. He addressed you and told you he was only here on a visit, that he was going to establish a Sanitarium for 1000 patients, wanted me as one of the medical staff at a handsome salary, and that he also volunteered the statement that he was then planning a speculation by which he was safe to make some thousands of dollars. This man exhibited very perfectly the condition to which the French apply the term *bien être*. He is generally very happy, full of his own importance, laughs at the idea that he is insane, and appears to regard his being here at all as a remarkable evidence of the ignorance of our profession. If you had been near enough to him you could have also seen the muscular twitching which preceded his speaking and have seen the inequality of pupil. The books sometimes speak of irregularity of pupil. I think inequality is the correct word to use.

The second case was the old man sitting near the idiot boy. He is in the latter part of the second stage—the acute maniacal symptoms are all gone and he is gradually passing into the state of dementia. He still has grandiose ideas, thinks he is quite well and is happy and contented. His gait is beginning to be ataxic.

The third case was one more advanced in this stage.

He is very ataxic, and is also aphasic. You noticed that he was still fat. His appetite is good and he evidently assimilates what he eats; before very long he will probably begin to waste, become more ataxic, then bed-ridden and then will come the end—death. Now, even, he has lost control of the sphincters and is very unclean—passing his urine and feces involuntarily. He has grandiose ideas too. He will tell you he can walk a mile in five minutes—that he weighs millions of pounds and is worth millions of dollars, everything with him is in the superlative degree, and he seems to derive much pleasure from his misconception of the real state of affairs.

(To be Continued.)

### LEPROSY IN NEW BRUNSWICK.

*Paper read before the New Brunswick Medical Society,  
July, 1889.*

BY MURRAY MACLAREN, M. D., M. R. C. S.

THE recent occurrence of a few cases of Leprosy in England and Ireland together with the death of Father Damien, a Belgian priest, who for sixteen years labored diligently among the Lepers on Molokai, one of the Sandwich Islands, where in 1885 he himself contracted the disease of which he died during this present year, have assisted in bringing this malady again into prominence, and at the present time in Great Britain the aetiology and contagion of Leprosy and the proper method to be adopted in eradicating the disease are being actively discussed.

The enormous number of Lepers widely distributed over the world, 250,000 in India alone, shows the great necessity for the fullest possible inquiry into the pathology of Leprosy so that fuller and more exact knowledge may lead to the diminution and possibly extinction of this terrible and wide-spread disease.

The history of Leprosy or Elephantiasis Graecorum in New Brunswick, with which I propose dealing, as it has existed and does now exist, though to a much less degree than in other countries may well therefore be a subject of interest to the members of this society.

*Locality.*—Leprosy in this province rarely comes under the observation of many of us, as it is confined to quite a definite area which is not readily accessible, and the Lepers, at present wholly French, move about but little and sooner or later resort to the Lazaretto.

The affected district is that portion of the north-east coast of the province, bordering on the Bay of Chaleur, the Gulf of Saint Lawrence and the mouth of the Miramichi River and embraces, in the county of Gloucester, the parishes of Shippegan, Caraquette, Inkerman (Pokemoude) and Saumarez (Tracadie) and in the county of Northumberland the parishes of Alnwick (Tabusintac and Niguac).

This district is in length about 45 miles and in breadth, from the coast inland only a few miles. Within this area all cases with a few exceptions have arisen, these exceptions being referable to this locality which is entirely rural and borders on the sea coast or near it.

The country is undulating, well supplied with good water, free from malaria and generally fairly well suited for agriculture. The soil varies from clay to sand. There are numerous rivers and streams and an abundant supply of fish. In summer the temperature is warm and in winter severely cold. The district resembles closely the large

remaining part of the northern and eastern coast of the province, which is also peopled by French and where no Leprosy exists.

*Population.*—This part of the province was settled in the latter part of the 18th century by the French who came from various parts of Canada. The present population is French or largely French, that is in proportion of nine to one. At present Leprosy is confined to this race. A few Scotch, English and Irish have suffered from this disease but none of the Indians as far as known. In 1840 the population of Shippegan, Caraquette, Inkerman, Saumarez and Alnwick collectively was a little over 5,500 and in 1881, 13,428.

The occupations of this people are mainly farming, fishing and lumbering. They are much given to social intercourse and intermarry freely. Their houses are generally small, food not very good and on the whole they are in rather poor circumstances.

*History.*—The presence of this disease in New Brunswick was first brought under the notice of the provincial government, by the grand jury at Bathurst, in January 1844, about 28 years after its first appearance. The jury drew attention to the fact "That a loathsome and frightful disease has existed in Tracadie in this county for some years past, pronounced by eminent physicians to be Leprosy, that it principally if not altogether prevails among the poorer classes, who are unable to procure for themselves medical advice, care or attention and are left to the mercy of their neighbors in their affliction. The people, however, alarmed at the disease, generally shun the afflicted and have hitherto been in the habit of confining, in some instances, the Lepers in a log enclosure constructed for the purpose and handing his food to him through an opening in the logs until he can no longer receive it when of course he dies. A practice most revolting to humanity and discreditable to the country in which it is permitted.

We have now learned with regret, that this distemper is spreading itself over that part of the country and that there are about twenty (20) cases at present in Tracadie and vicinity."

The following is Mr. H. W. Baldwin's report sent the Lieutenant Governor in March 1844:

"Sir.—About three years since some of the principal inhabitants of Tracadie, in this county, represented to me that a strange disease had made its appearance there some years before, that it appeared incurable, that it was then confined to one or two families, but that great apprehension existed lest it should spread its ravages and that it might be found necessary to assess the parish for the support of the sick; as the people, for the most part being very poor and the exacting of a money tax would be grievously felt by them, I therefore recommended them to relieve the afflicted to the extent of their power by voluntary contributions of such necessaries as they had, to be dispensed by the overseers of the poor, upon a hope that the disease might decline and finally in a year or two disappear. Upon this recommendation they have acted, up to this present period, no public grant nor local assessment having ever been supplied towards the relief of these people. The hope that the distemper would decline, however, has been disappointed. In my subsequent visits to that part of my Bailiwick I have been advised that this disease was spreading and the fear of the people for the safety of their families increasing, that relief could no longer be afforded to the extent the afflicted required

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This caution is also very necessary when buying BEEF, IRON and WINE, in smaller quantities than the original bottle, as we know other inferior makes are often substituted for our genuine article.

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Our many years experience as practical pharmacutists, thorough knowledge of the character and properties of each drug, together with appliances for manufacturing (which for completeness and economy of working, cannot be excelled), enable us to produce a line of Fluid Extracts of unsurpassed purity, activity and reliability. We ask for them the most careful and critical examination and comparison, claiming, as we do, their superiority over almost all other similar preparations in the market. We feel confident our claims will be sustained by any unprejudiced and experienced druggist.

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They are put up in cylindrical tubes, convenient for carrying in hypodermic or pocket cases, each tube containing twenty tablets, ten tubes, or two hundred tablets, in a case.

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## NOTICES OF MEDICAL JOURNALS:

*From the Lancet Analytical Records.*—"Fellows' Syrup contains the hypophosphites of iron, quinine, strychnia, manganese, lime and potash—the strychnia amounting in a dose of one drachm to one sixty-fourth of a grain. The preparation therefore includes a number of powerful nervine tonics. The reaction of the preparation is practically neutral—an advantage in many cases where the acid solutions of quinine and iron are objectionable or inadmissible. The compound is skilfully prepared, and the difficulties of keeping the remedies which it contains in solution, and in a form in which they are not liable to change, have been very successfully overcome."

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## SPECIFIC EFFECTS AND INSTRUCTIONS FOR USE.

TO STIMULATE THE APPETITE.—Take half the Tonic Dose, as directed, in very cold (not iced) water, fifteen minutes before eating.

TO STIMULATE DIGESTION AND ASSIMILATION.—Take the remaining half of the Tonic Dose, during meal time in water.

TO INCREASE RAPIDLY IN WEIGHT.—Take the Tonic Dose as directed, and adopt the free use of new milk in addition to the regular food.

TO SUSTAIN MENTAL EXERTION.—Mix two teaspoonfuls in a tumblerful of cold water, and drink small quantities occasionally during the hours of intellectual work.

TO GIVE POWER TO THE VOCAL CHORDS.—Take the Tonic Dose fifteen minutes before singing and lecturing.

Where *mucous expectoration* is difficult, the Tonic Dose repeated every two hours will effect its removal with very little effort.

TO PREVENT RECURRENCE OF NIGHT SWEATS.—Take the Tonic Dose at each meal and at bed-time. The contractile power is imparted to the nerves, which are connected with the sweat glands.

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FOR CONVALESCENCE from Typhoid and other low Fevers, and Debility from residence in hot and malarial localities, employ the Tonic Dose.

TO STRENGTHEN AND DEVELOP NURSING INFANTS.—Let the mother take the Tonic Dose as directed, with the food.

TO PROMOTE SLEEP.—Take the Tonic Dose before eating. This applies particularly to sufferers from shortness of breath.

NOTE.—In prescribing please give prominence to the name *Fellows*, thus:

Syr: Hypophos: Fellows.

and avoid disappointment

Please Mention THE MARITIME MEDICAL NEWS.

"and that the intercourse unavoidably maintained between the diseased and their families, the want of a separate building or hospital for their accommodation has a tendency to introduce the distemper into all the houses in the settlement. Under these circumstances, Mr. Young, of Tracadie, being at Bathurst tending court as a grand juror and having consulted me again on the subject, I advised him to lay the case before the grand jury, as one that now involved the safety of the public health, not only in this county but in the adjoining counties, he did so and the presentment of the grand jury was forwarded to the executive.

"The above statement comprises all the steps that have been taken in reference to this disease in this county, but the distemper having found its way to Northumberland, the Board of Health of that county directed the medical gentleman to visit and give report on the nature of the disease, which report was forwarded to the executive."

Mr. Baldwin further reported that there had been seven deaths from Leprosy, and that there existed 13 cases in Gloucester and about 10 in Northumberland, the whole within a circuit of 20 miles.

A commission of physicians composed of Doctors A. Key, J. B. Tolderoy, C. H. Skene and Robert Gordon reported in April of the same year that 5 deaths had occurred outside the affected district, all these were English speaking people, two of whom had resided in Tracadie and one had associated with the other three who became Lepers.

The commission strongly advocated the erection of a Lazaretto.

All reports and accounts agree that the first known case was that of a French woman, Ursule Bénéoit née Landré. Her paternal grandfather came from St. Malo, Normandy, where Leprosy is said to have existed but there is no history of Leprosy in either of her parents families. Ursule was born in Caraquette and on her marriage came to Tracadie. She became Leprous between 1815 and 1818 and died in 1828; her husband and her two sisters subsequently became diseased. These were a few of the early cases and the disease gradually spread from this date.

On July 19th, 1844, a Lazaretto was opened on Sheldrake Island which is situated at the mouth of the Miramichi river. It is 30 acres in area and 8 miles distant from Chatham. This position was chosen as it was a healthy district and the Lepers could be completely isolated. Dr. Kay was placed in charge and he reported in Feb. 1845 that 20 cases had been admitted.

The institution, however, proved unpopular with the Leper, who were treated as prisoners, the building being surrounded by a high picket fence and the patients locked up at night. They therefore became restive and disobedient and occasional desertions took place to the mainland by means of rafts and otherwise. The deserters were pursued and force was necessary to compel those found to return, others remained concealed in the woods. The Hospital was destroyed by fire in October 1845, and the Lepers were suspected of being the cause.

Doctors W. Wilson and Robert Bayard made a lengthy report to the government in July 1847, (Dr. Bayard afterwards contributed a paper similar to his report to the "Lancets" of September 1st and 8th 1849). They reported as strongly against contagion and in favor of heredity in the disease as the former medical report of Key, Gordon, Skene and Tolderoy had pronounced the opposite view.

In 1851 there were 37 cases in the Lazaretto which was

surrounded by a high fence and guards employed to look after the Lepers and prevent communication with the outsiders. Dr. Charles La Bellois attended the patients, about 1849 as he pronounced the disease to be Syphilis and claimed to be able to cure it. This of course ended in failure. In 1852 the buildings were destroyed by fire and re-erected the following year. In 1854, Dr. Gordon was the medical attendant and in 1861, Dr. Nicholson took charge followed in 1865 by Dr. A. C. Smith who still holds the position. In 1868 a community of nuns from the Hotel Dieu, Montreal, most unselfishly took charge of the nursing of the sick; a house adjoining the Lazaretto has been built for them. The Lepers are much better attended to than formerly and the work is done faithfully and cheerfully under the superioress, Mother Saint Jean.

In 1880 the Dominion government took over the control of the Lazaretto; the annual expenditure is the small sum of \$3,200, (increased to a slight extent during 1890). The building is wooden, of two stories, rather small and low. The females occupy the upper and the males the lower part. The high fence is abolished and the Lepers resort fairly willingly to the Lazaretto. The success of this is largely due to the influence of their priest, Father Babineau who takes a strong and active interest in their welfare. The patients have plenty of freedom being allowed to move about the grounds of the Lazaretto (11 acres in extent) to garden, fish, etc., and are contented.

(To be concluded.)

#### NOTES ON TWO CASES OF BACTERURIA.

*Read before the Cape Breton Medical Association,*

BY H. E. KENDALL, M. D., Sydney, C. B.

*Case 1.*—Mrs. A., act. 52, married, 4 children, physique spare, countenance sallow, temperament nervous. Had been troubled for 6 or 7 years with occasional attacks characterized by frequent and painful micturition, accompanied by chills and severe colicky pains in the hypogastric region. These pains were cramp like and ran down the legs and up the sides and back. Being called to her on the occasion of one of these attacks about 9 months ago I treated her with the ordinary palliatives and took a specimen of the urine home for examination. It presented the following characteristics:

Very pale and slightly turbid.

Faintly or normally acid.

Sp. Grav. 1015

A trace of albumen.

The microscope revealed no casts or pus on repeated examination. The turbidity was found to be caused by epithelium from the bladder, urethra and possibly from the pelvis of the kidneys which epithelium had not suffered much degeneration before being thrown off. Besides this the urine swarmed with bacteria in the form of streptococci. Besides this form there was another form which is not often seen I think and which I saw once before in Belle-Vue Hospital, the case being one which had been for two weeks, unsuccessfully treated as cystitis. The segments in this last form were not more than  $\frac{1}{4}$  to 1-10 the size of those of the aforementioned species. In fact it is difficult to delineate them clearly without a glass magnifying 800 diameters. Occasionally in the chain a segment appeared larger than the rest looking like knots in the rope.

The movement was wavy and slow. There was a tendency to aggregate in intertwined clusters. Prof. Roberts of Manchester, Eng., describes something like this and also gives the appropriate treatment—salicylate of sodium gr. x x ter. i. d. This was accordingly followed and for three days the symptoms rapidly abated. Contrary to directions the medicine was discontinued at the end of that time when the symptoms re-appeared. The same treatment again caused them to disappear and for 9 months the patient has been comparatively well, the only persisting symptom being a somewhat abnormal frequency of micturition.

*Case 2.*—Mrs. M., aet. 35, married, 5 children, a pretty ruddy and strong but over-worked woman. Had suffered for some 6 weeks from very frequent and painful micturition; she had been treated with the ordinary cystic sedatives, &c. Urine on examination showed the following characteristics:

Clear, pale.  
Faintly acid.  
Sp. Grav. 1018.  
No albumen or casts.

A small sediment of epithelium mostly from urethra. The first mentioned strepto-cocci were abundant. The salicylate of sodium caused an entire disappearance of the symptoms. This was nearly two years ago and there has been no re-appearance.

This latter is plainly a case of primary bacteruria. The epithelial sediment was insignificant. The first is not so clear but I have reason to think that the cystitis which existed at the time of my visit was secondary. In both cases the urine was acid and did not readily decompose, in fact the latter specimen remained on my table for over two weeks without signs of decomposition. In neither case had a catheter ever been introduced. As regards albumen, in one case there was a trace, in the other none. In three others in which I diagnosed bacteruria but was not able to follow them up, there was no albumen.

### SURGICAL CASES IN PRACTICE.

1. *Case of acute intestinal obstruction; death within 22 hours immediately before intended operation.*
2. *Strangulated femoral hernia in a woman; operation; recovery.*
3. *Diphtheritic laryngeal obstruction; laryngotomy; recovery.*

BY ARTHUR MORROW, M. B.

#### I.—ACUTE INTESTINAL OBSTRUCTION.

ON Jan. 27th. (6 a. m.), I was called to see Mr. W., a well built man of about 30 years. I found him in agonizing cramp which involved not only the abdominal walls and intestinal canal but also the legs. The abdominal wall would at times become intensely hard and his legs doubled up. The abdomen was very tympanitic. His countenance betokened extreme distress and anxiety. He vomited at short intervals chiefly bile.

I obtained the following history,—About 2½ years ago in Gibraltar (he was attached to the Engineer corps), he had suffered from a rather bad attack of abdominal cramps, which was relieved after the

successful use of an enema. Since then he had enjoyed good health up to the time of the present attack, having had very little trouble with his bowels. The day before I saw him he had eaten heartily of beef and pork, had with his dinner drunk more freely than usual of beer and had then lain down to nap on the sofa. In the course of the evening he began to have cramp like pains which increased in severity, and about midnight became associated with vomiting. He had had a most distressing night and when I saw him at 6 a. m., begged for something to relieve the muscular cramps which he said he could not stand. I injected Atropine and Morphine hypodermically and gave him a dose of castor oil. When he was somewhat relieved I left him. Four hours later I saw him again, and again felt bound to relieve his pain by a hypodermic injection. I gave an enema of Turpentine, Soap and water with little effect in removing fœces and none as affecting the pain. I began seriously to suspect intestinal obstruction and my suspicion became a positive diagnosis when about the middle of the afternoon the vomited matter began to have a foecal odour. It seemed clearly a case of intestinal obstruction somewhere high up in the canal—high up because of the rapid course of the symptoms. Soon after 6 p. m. I called in Dr. Lindsay for consultation, who agreed that an early operation offered the only chance of recovery. The temperature had not risen to any extent throughout, but the pulse was fast getting increasingly unsatisfactory. A most obvious circumstance at this point was the dyspnoea caused apparently mechanically by the extreme tympanitis which interfered with the play of the diaphragm. For this reason we attempted to lessen the tympanitic distension by puncturing with an aspirating needle. We carefully punctured at several points, but little gas escaped and no benefit resulted. I decided to perform laparotomy as soon as I could procure my instruments, and Dr. Lindsay kindly consented to meet me at ½ past 8 (it was now about 7:30) to assist me. When we left him the dyspnoea was so marked and so great as to lead Mr. W. to ask that the window should be raised, which will be recognized as a significant and ominous sign of a sense of impending suffocation. When I got back at about 8:20 I found that he had died a few minutes after eight.

I may say here that the *severe* cramps had not been so noticeable after about 2 p. m., and he did not vomit much during the last three or four hours, the dyspnoea, so to speak, displacing them as the most prominent feature of his distress.

*Post Mortem.*—The examination (at which Dr. Lindsay was present), revealed a most interesting and not common condition. Many prominent coils of intestine were tensely stretched with gas. Some others were empty and flaccid. There was a strong firm adhesion between the small intestine (at a point about six feet below the commencement of the duodenum) and the abdominal wall at the umbilicus. It was evidently the outcome of an infantile umbilical



hernia. The mass of tissue binding the intestine to the umbilicus surrounded the gut so as to constrict it. Above the constriction there was a large dilatation having a diameter when moderately distended of  $3\frac{1}{2}$  to 4 inches; the diameter lessening gradually to the ordinary dimensions of the bowel above, but contracting more abruptly towards the junction with the constriction. The length of the pouch was 5 to 8 inches. The lumen of the canal at the place of constriction was such as to offer resistance to the entrance of the index finger. Below the constriction the intestine was of smaller diameter than normal, empty and flaccid, and compared with the part above presented a somewhat atrophied appearance. Leading out from the pouch like dilatation which had the general shape of the stomach, was a secondary pouch or recess, or sac, which communicated with the primary dilatation by a small orifice which would barely admit the little finger. This secondary pouch was about the size of an egg. Lastly, the tensely stretched tympanitic bowel above the constriction in finding accommodation had become sharply bent upon itself at the point of constriction, this sharp flexion probably determining the acute obstruction.

*Remarks.*—The establishment of the constriction took place no doubt in infancy. Gradually there developed a tendency to accumulation of intestinal contents above the constriction, though this tendency may have been a recent one (within the last several years.) As a result a pouch like dilatation formed and probably was gradually increasing above the constriction. The constriction was not so great as to offer any absolute obstruction to the passage of the contents of the bowel in the state of semi-liquefaction in which they would be in that locality. Some degree of hypertrophy of the bowel extended for some distance (feet) above the constriction. The secondary pouch was probably the remains of the original hernia. The injudicious dinner (a large amount of pork, beer, &c.) it may be supposed produced indigestion and tympanitis. The tympanitis increased so much that at some time the distended bowel in its movements for accommodation (the active force being the gas accumulation and expansion) became acutely bent in the manner in which it was found.

The course of the case was very rapid, so much so that had we operated it would have been within 24 hours of the commencement of the symptoms. This even would have been unusually soon for laparotomy. But undoubtedly the case was unusual, the obstruction being unusually high up, and the course of the case to a fatal termination was necessarily speedy. And if such cases are to be rescued, operation must be early, corresponding to the circumstances. Had the operation been attempted in *this* case, as it happens, it is evident the condition of affairs would be embarrassing and difficult to be surmounted. The limited laparotomy incision below the umbilicus would only at best have enabled the operator (after failing to find the obstruction anywhere within possible sight) to feel an

attachment between intestine and abdominal wall at umbilicus. To free the intestine from its very close attachment with the knife would have been about as difficult and risky as to attempt to free it without the knife. If on failing to find the obstruction one proceeded to enlarge the abdominal incision upwards, it would then have been comparatively easy to wound the adherent intestines. On the other hand, if relieved it would have meant only a partial and probably temporary relief from a condition which must constitute a serious and constant menace to life.

When I refer to the difficulty of completing a successful operation in this case I mean in view of an unfamiliarity with the uncommon conditions. In meeting with a similar case after having seen or read of the condition, one would be to some extent forewarned and so forearmed. The case seems to me to be one in every sense worthy and useful to be recorded.

## II.—STRANGULATED FEMORAL HERNIA.

MRS. S., widow; age 66; had had a large family. I saw her first on Friday, Dec. 27th, (6 p. m.) I found her (a spare woman) in periodic, cramp like, distressing pain; abdomen tympanitic; cramps had come on about 2 p. m. She had had similar attacks before. The bowels had moved the last day or two and she had a scanty passage the same morning. With previous attacks had sometimes vomited; in general was apt to be constipated. Pulse 80, rather feeble. Temperature low. Got her into bed. Gave her a carminative mixture (no opium or atropine.) She vomited once or twice during the afternoon.

*Course.*—From the first she kept nothing down. Slept a little through the night, vomiting occasionally. Next morning I discovered an old irreducible femoral hernia of small size (walnut to egg), which she had not thought worth mentioning, as it never troubled her. At present it was very slightly tender. A hypodermic injection of atropine allayed the vomiting for some time, but this recommenced. In afternoon ordered hot turpentine fomentations and administered a copious enema of castor oil, soap and water, with indifferent result.

In the morning having got my instruments, I sought Dr. Lindsay's help and he kindly came with me, and a final attempt at taxis was made. Operation however was postponed. Next day (Sunday) matters did not change much. The vomiting continued at intervals, but without fœcal odour. The hernia though tender, was not excessively so, and the pulse still was about 80 and not unfavourable. On Monday morning the vomited matter had become fœcal, pulse 104, and neck of sac more tender. Decided to operate without delay and proceeded to do so, Dr. Lindsay giving chloroform. I transixed the skin and worked down to the sac and found the neck tightly constricted at Gimbernats ligament and the sac surrounded by many adhesions. I gradually tore down the adhesions with my finger clearing the sac all around. I then cut Gimbernats ligament, having first partly insinuated my finger between it and neck of sac as a guide. (In

this case, as I think in many, it would have been possible to detect the abnormal obturator branch had it existed, by bending the finger around Gimbernats lig. and feeling the pulsation; though not when the constriction is especially tight.) I then pulled the bowel down, found that it was also constricted by bands of inflammatory tissue, so on a director I carefully slit up the bands and freed the wall of the bowel proper and returned it. I washed and dressed the wound with carbolic oil (1 in 20), and pad of antiseptic wool.

There was no further vomiting, the next day there was a normal passage from the bowels in spite of the administration of opium which was maintained for several days. The wound healed quickly and the patient is at present well, but wearing a truss though there has been no return of the hernia.

*Remarks.*—The case contrasts with the preceding in the duration of the obstruction without relief. Not until nearly sixty hours did the vomit become fecal, indicating the seat of hernia as low down. The neck of the sac was not acutely tender till within a few hours of operation. From the time she was under the influence of chloroform there was no vomiting. There must have been considerable stamina in the patient considering the duration of the symptoms and the age of the patient (66). For nearly 70 hours the amount of food taken and retained was almost *nil*.

### III.—LARYNGOTOMY FOR DIPHTHERITIC LARYNGEAL OBSTRUCTION.

THE patient was a girl, age 13. On the fourth day of the disease (I saw her first on the third day) a croupy cough and increased dyspnoea showed that the larynx was becoming involved.

On the morning of the fifth day the laryngeal obstruction was such and the dyspnoea so great that it was evident that the only hope of averting a speedily fatal termination lay in an immediate operation.

I secured the help of Dr. Goodwin, to whom I am indebted for administering chloroform, and also for his after co-operation. At the time of operation the patient was in extreme dyspnoeic distress, and the countenance somewhat livid. The false membrane so thickly covered the swollen tonsils as to almost occlude the interval between the fauces and tongue.

The dyspnoea did not seem to be much affected by the chloroform, and having made a free incision (1 in. to 1½ in.) in the middle line the tube was ultimately inserted, after some trouble due to the plumpness of the neck and a little troublesome hemorrhage which latter made me delay opening (transversely) through the crico-thyroid membrane.

Once or twice during the operation (lengthened as mentioned on account of hemorrhage) the patient seemed to be in extremis. Immediate relief followed the introduction of the tube. At first mucus tinged with blood was coughed out through the tube. In an hour or two the mucus was pale and thin.

Now followed a trying four or five days which

were marked by periodic accumulation of mucus in and near the tube necessitating frequent removals of the tube and assistance in the dislodgment of the secretion by bent probes dressed with cotton wool, feathers and, perhaps especially, by the use, during efforts at coughing, of a strong suction syringe. The periodic accumulation of secretion was associated always, and sometimes distressingly, with dyspnoea, the usual expression of the patient at such times being "I am smothering."

On the morning after the operation a small mass of false membrane was coughed out through the tube and this was several times repeated during that and the following day, so much so that we anxiously feared extension of the diphtheritic false membrane downward into trachea and bronchi. I examined microscopically these semi-membranous shreds, and in one case found fibrillation and progressing organization.

After the third day, however, the matter coughed up was a viscid semi-purulent gelatinous mucus, the product in fact of a tracheitis and limited bronchitis. For about six days after operation no bubble of air passed through the glottis. Then there was a slight passage of air which gradually for a day or two gave rise to some awkward fits of coughing, the outcome of air through both passages, interfering with the free emission of mucus through either one.

On the 10th day after operation the tube was dispensed with and the wound quickly closed up, so that in four or five days there was a level area of granulations rapidly becoming covered by epithelium. This process was soon completed so as to leave a very slightly noticeable scar.

The diet throughout consisted chiefly of milk, but also beef tea and bovine, at intervals of three or four hours, sometimes oftener. Brandy was given constantly for 11 days at intervals of seldom more than two hours, and at times of exhaustion every hour; it was often given with the milk.

*Medicinally.*—For the first four days: Hydrarg. perchlor. (℥ gr. every three hours) and Tr. Ferri perchlor. (6 minims every two hours with about three grains of potass. chlorat.) were given faithfully. Then as signs and periods of exhaustion occurred the hydrarg. perchlorid was stopped and Tr. digitalis and Liq. Strychniae were given in frequent moderate doses with a view to preparing for and averting cardiac paralysis. I also gave for a time sodium sulphite, to combat septic poisoning.

I constructed a tent to cover the patient and into the enclosure was led steam from a bronchitis kettle. Into the kettle I put Ammon., Chlorid and Tr. Benzoin. Co., and on one or two days when the breath was foul I put in a few drops of creosote, believing that the irritation of the creosote would be less harmful than that caused by the unpurified foul secretion.

The local treatment of the throat consisted in frequent sprayings with carbolic acid in glycerine and lime water, and alternately with solutions of

papoid, (once or twice pepsin.) At present (six weeks after commencement of disease) the patient has recovered much of her color, is regaining flesh, is very well, going out and about, has her voice (regained about a week after removal of tube), and only speaks with a slightly perceptible nasal twang which is disappearing.

*Remarks.*—Probably the chief value of such a case is in counteracting a too pessimistic view of diphtheritic laryngeal obstruction which has led some to advise the abstention from operation. At the same time the undertaking is no light one because in private practice, (*i. e.*, apart from hospital advantages, including continual presence of house surgeon, trained nurses, &c.) the attention must be most unremitting and fatiguing in order to secure a successful termination. In this case for several days if myself or a substitute had been out of reach for an hour or two, the patient might have died of suffocation from blocking of the passage, entanglement of the tough mucus at the laryngeal wound, &c. The age, intelligence and previous health and condition of the patient were much in her favor.

It would seem as if, in diphtheria, mucus poured out anywhere is more coagulable than ordinary mucus. I am of the opinion that the semi-membranous shreds coughed up in this case, and not distinguishable from certain stages of false membrane, really consisted (with one or two exceptions) of coagulated mucus produced by the tracheitis set up partly by the presence of the tube, and that they were not detached pieces of false membrane proper that had extended from the larynx above. I chose laryngotomy because the parts were large enough to make it perfectly feasible, and as a simpler operation than tracheotomy. Intubation would not I believe, have wholly relieved the dyspnoea on account of the great blocking of the fauces, *i. e.*, supposing that the insertion of a tube could have been satisfactorily accomplished in spite of the faucial blocking.

Swallowing was difficult and painful, sometimes extremely so. Apparently the space of the fauces may be so nearly obliterated as not to permit of the passive passage of a sufficient amount of air, and yet may, aided by the active movements of swallowing, allow the passage of liquids.

In this case on Sunday the respiratory obstruction seemed to be largely faucial, partly laryngeal; on Monday (day of operation), there was evidently almost complete laryngeal obstruction.

#### AN ANOMALY.

Dr. McKay, of P. E. Island, reports the following, and asks our readers to say if they have found anything similar:

Presuming that all anomalous cases are of interest to the profession, I report that in the course of my obstetrical practice last year, I met a primipara, where the young mother was safely delivered of a son. I found the umbilical cord attached to the upper border of what resembled a tumor in the child, over the region of the bladder, about the

size of a hen's egg cut in two, and covered with very delicate mucous membrane. The point where the cord was attached was four inches below where the umbilicus should be. This apparent tumour is no doubt the bladder inverted or thrown out, and is now being gradually and slowly covered with integument. There is also entire absence of a penis or anything approaching to one, and no urethra where we should expect to find one. Scrotum is normal, and one testicle is found, otherwise the child is well formed. I was first at a loss to know how the child should urinate, but after a time urine was seen to issue from two small openings of a fistulous appearance at the inferior border of the apparent tumor. There are now clearly seen two urethrae one inch above the pubes, of half-an-inch in length, of usual size, leading into the bladder, and one-and-a-half inches apart. There is no sphincter and urine continually drops, but when our boy presses hardly, two good streams are thrown out. He is always wet, but does very well with a lint pad and vaseline. Our "boy" is now nine months old, is quite healthy, has teeth, will very soon walk, and is doing exceedingly well.

#### THE CARTWRIGHT LECTURES ON VITAL AND MEDICAL STATISTICS.

*Delivered before the Alumni Association of the College of Physicians and Surgeons, New York, Nov. 14th, 20th and 22nd, 1889.*

BY JOHN S. BILLING, M. D., LL. D., U. S. Army.

PART III.—(Continued.)

SO far as what is termed potential longevity—that is to say, the maximum duration of life possible in an individual of the race—is concerned, there is no evidence that this has changed for at least two thousand years, being for man generally taken as a hundred years. You will remember the scriptural declaration that the years of a man "are three score years and ten, and if by reason of strength they be four score years, yet is their strength labor and sorrow"; notwithstanding, there are sufficient records to prove that even in those days the potential longevity of man was as great as it is at present.

But when we come to the average longevity and expectation of life at birth there is sufficient evidence to indicate that it has increased; but whether this is due to the preservation of more infant lives for a few years, although they may still die before the productive period is reached, or to an increase of the number of those who live into and share the working period of life, is still uncertain, for this question can only be settled by comparative life tables, and I have already explained that we have no reliable tables that are much over fifty years old.

The most important contributions to our knowledge of the increase in the duration of life in recent years is contained in a paper on the decline in the English death-rate, by Noel Humphreys, published in the *Journal of the Statistical Society* in 1883; and in a report by Dr. William Ogle in a supplement to the *Forty-fifth Annual Report of the Registrar-General of England*, published in 1885.

The conclusions as based upon English life tables, comparing periods from 1838 to 1854, and from 1871 to 1880, are as follows:

The mean after-lifetime of a male at birth was for the first period 35.91 years, for the second 41.35, showing an average gain of nearly a year and a half. The mean after-

lifetime continues longer in the second period than in the first for each year of life until the nineteenth. At the close of the nineteenth year the expectation of life was exactly the same in each period—viz., 40.17 years. From that time onward the after lifetime is shorter in the recent period than in the older one; that is to say, the individual male in England lives on an average a shorter time after he is nineteen years old than he did forty years ago; but the number of males out of equal numbers at the start who survive to live these shorter lives is very much greater than it was formerly, so that the aggregate life of the whole is considerably increased. The gain is greater in females than in males. Thus, in the first period the expectations of life in females was 41.85, while in the second period it was 44.62, being a gain of 2.77 years on an average for each female. The after-lifetime continues longer in the new period down to the completion of the forty-fifth year, when the expectation of life becomes the same—viz., 24.06.

You are all, no doubt, familiar with what is known as the Malthusian theory, which is, essentially, that population is limited by the means of subsistence available, that population increases in a geometrical proportion, while the means of subsistence do not increase in a faster ratio than arithmetical progression; that, therefore, the growth of population is checked by want of means of subsistence, and, therefore, that the increase of mankind may be considered as the chief source of misery, which misery, together with moral restraint to a limited extent, and vice, check the superior growth of population, keeping it at a level with the means of subsistence.

If this doctrine be applied to the lower animals or to an extremely savage and ignorant set of men, it is very nearly correct; for in this case the term "means of subsistence" applies almost exclusively to the natural produce of the earth. As soon, however, as man applies his intelligence to the increase of the means of subsistence by improvements in agriculture, by manufactures, etc., it is no longer true that the means of subsistence increase in an arithmetical proportion. They may increase, and for the last fifty years have, throughout the civilized regions of the world, actually increased in a ratio more rapid than geometrical proportion and more rapid than the increase of population; and it is therefore subsequently true that "the character of every race of men is the real limit to its numbers in the world, if allowance be made for accidents of position and time."\*

The uneducated and unskilled laboring classes, who are without capital, when gathered together in large masses, tend constantly to illustrate the theory of Malthus by increasing faster than they can provide means of subsistence for themselves and their families.

But this tendency is opposed by the advance in knowledge, increase in energy, and improvement in inventions in the educated classes, who, although it may be said that they are acting only for selfish interests, are, nevertheless, led by those interests to expand the fields of agriculture, manufactures, and commerce, and thus to both increase the means of subsistence and to lessen the price thereof.

Under favorable circumstances a population is capable of doubling its number every twenty-five years. In the United States, between the years 1790 and 1860, the population doubled itself about once in twenty-three years and a half. But a portion of this increase was due to immigration.

Whether in the future a systematic attempt to maintain an equilibrium between subsistence and population will

become a practical problem of natural policy is at present a purely theoretical speculation, for it is very easy to show, as has been done by Mr. Atkinson (see papers by Atkinson in *Scribner*), that the means of subsistence at present at our command can easily be quadrupled, as the increase of the population occurs to both requires and produces such increase.

In studying the causes of disease and death in communities a very important point to be considered is the relative poverty, ease or luxury in which different parts of the population live, or the sickness and death-rate of so-called social classes.

The extreme poverty, producing inability to obtain the amount of food, clothing, and shelter requisite to preserve health, is a direct cause of high death-rates, especially in northern climates, is known to all; but the extent to which this factor of want influences the death-rates, in different countries or communities is by no means easy to determine, and thus far we have, for the most part, only data bearing indirectly on the subject. For the provident and presumably well-to-do classes we have the statistics of life-insurance companies; but these are for selected lives, which fact tends to give a low death-rate during the early years of the policy-holders, while, on the other hand, the tendency to cease paying annual dues and to give up the insurance is greater in those who are well and strong than in those who have reason to suspect that they are diseased, so that the death-rates in the greater ages are higher in the insured than in those not insured. We can also draw some inferences from the vital statistics of occupations, from tenement-house statistics, etc.; but it is very difficult to distinguish between effects of density of population, occupation, race, intemperance, uncleanly habits, and actual want of the necessaries of life.

The tendency now is to accumulate the best and the worst of the race in cities. They draw to them the most enterprising, vigorous, and prudent, whose tendency is to late marriages and few children, and thus tend, after a time, to lower the standard of the race. Where the tendency is to replace a feeble and lower race by a better one there is progress; where the tendency is the reverse there is decay. "The hope that by increased knowledge, charity, and co-operation, the feeble, sickly, and incompetent can be so cared for that they shall become strong and vigorous, is that held by most men of the present day, but there is nothing in the laws of heredity which gives any foundation for this hope."

"What is to be the outcome of this modern civilization? Its enemies are not without but within—not savage nations on its borders, but dwellers in its own cities. The general tone of modern European literature is pessimistic as to the future, filled with doubts and fears as to what the coming supreme democracy will do. In this country it is more hopeful, and looks forward to progress in improvement in the physical conditions of the race, though admitting the dangers and difficulties which this very physical improvement tends to produce." But whatever be the views of individual thinkers and writers, on one point all can agree; and that is as to the desirability of having at our command definite, positive information as to the character, amount, and sets of currents of this stream of human life in different countries and localities. An important part of such knowledge is that which relates to the composition of and changes in the population in different countries, which is the special field of vital statistics.

\* Farr, "Vital Statistics," London, 1885, p. 15.

It must be admitted that the probabilities of error are much greater in medical than in vital statistics, and this for a number of reasons. The first is that no two observers examine or interpret a disease in precisely the same way, and hence it is extremely difficult to collect a mass of observations sufficiently large to form a basis for statistical reasoning. Those who wish to be scientifically accurate in the use of such material are usually compelled to deal with a very limited number of observations, because they can not obtain a large number upon which they can fully rely.

The best data are, for the most part, those which lie in the field of surgical observation, since here the symptoms observed, the methods of relief applied, and the results obtained are tolerably definite, and there is not likely to be much difference in the methods of recording them.

The methods of medical statistics differ fundamentally from those used by the vital statistician in that they usually have no relation to the phenomena observed in the normal, healthy, living population. The physician inquires, out of a thousand cases of children or of old persons that have been treated, how many times this particular disease has been met with; or, in a given number of cases of this disease, what proportion have died. This method is in fact practically the only one which is available to the physician, but the vital statistician, if dealing with disease, well want to know the probabilities that a male between twenty and thirty years of age will contract a given disease, such as phthisis or typhoid fever, and for this purpose he wishes to know the whole number of cases observed in a given population, and the number of the population furnishing those cases, in order to establish the ratio.

The fact that in each case of sickness there are many different circumstances which combine to produce the result is not, as Louis remarks, a valid objection to the use of statistical methods for the purpose of estimating the influence and relative importance of each of these influences; it is rather an argument in favor of their employment. Counting is better than guessing, and when it gives contradictory results as applied to two groups of cases, it indicates that some circumstances have not been taken into sufficient account, and that further inquiry is necessary. In the body of the sick man, as in the test tube, like causes under like circumstances will produce like effects.

Admitting that the chances of error in medical statistics are very much greater than in those relating to vital statistics, it does not follow that they have no value. It simply increases the desirability of collecting a large number of facts before proceeding to draw any definite deductions.

In statistics in regard to therapeutics we have to take account of the various influences which the condition of the organism exerts upon the results before we can fairly estimate the action of the new and special influence which has been introduced in the shape of an action of a drug, or other mode of treatment. In any event, such statistics, even when derived from a small number of cases, serve to indicate lines of investigation and to ask questions, if they do not answer them. As Legoyt remarks, two pneumonias do not resemble two dice, each having the same number of faces and of numbers, but rather dice with an unequal number of faces and different numbers.

The greater part of our pathology and therapeutics has not been derived from statistical observation. It is not by this means that the diagnosis of small-pox, or of scarlet fever, or of rheumatism, has been worked out, or the fact that the ulceration of the intestinal glands belongs to typhoid fever, or the presence of gummy tumors to syphilis;

nor has it been by this means that the transmissibility of certain forms of disease by contagion has been proved. Whenever a necessary and logical connection between a particular cause and the resulting phenomena has been established, statistics are of little or no value in demonstrating the connection. In every case the result must follow: repetitions of such experiments give as great a degree of certainty as a thousand or more.

The chances of the occurrence of a certain event in relation to cause can only be mathematically calculated when the totality of the possible causes of the result remains the same under the different circumstances investigated. This is one of the chief reasons for the impossibility of drawing positive conclusions from medical statistics properly so-called.

The results of medical statistics will not apply to the treatment of any particular case. They can never prove that bloodletting should be employed in all cases of pneumonia, or that it should never be applied in any case of pneumonia. Even the results obtained from the most satisfactory medical statistics will only be found useful to the physician in directing his treatment in the absence of any special indications in the particular case which he has before him.

(Concluded in our next.)

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## *Hospital Practice.*

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### GENERAL PUBLIC HOSPITAL ST. JOHN.

NOTES BY F. G. ESSON, M. D., *House Surgeon.*

#### *Case I.—Rupture of intestinal wall. —*

D. C. admitted Oct. 22nd, at 10 P. M., under care of Dr. J. D. White. On admission found to have a large painful swelling in right groin extending into scrotum, and great tenderness over the whole abdomen, pulse small and weak, countenance anxious, and general condition one of great depression almost collapse, gave a history of having fallen on railway track night previously; had a scrotal hernia for several years, but it had not been down, nor had he worn a truss for six months. In the fall he received severe blow in right iliac region causing great pain and what appeared to be a return of the hernia. He was seen by two physicians a short time after the accident, and taxis was applied under ether, without effecting reduction. On admission to Hospital he referred the most of the pain to the swelling in the groin, and as his condition was so urgent he was placed under ether, slight taxis applied without result, and the sac cut down on. When this was done it was found that contents of sac could be easily returned to abdomen and there was really no strangulation. The walls of the sac were extraordinarily thick. This operation not relieving the patient's condition the wound was continued up into iliac regions and cavity of abdomen opened, when the true nature of the trouble became apparent. The abdominal cavity was found full of contents of small intestine, the peritoneum in a state of active inflammation, there was no bowel in old hernial sac, but that was also full of bowel contents and also inflamed. On careful search a rupture of the ileum about  $\frac{3}{4}$  inch long was found, this having occurred at time of fall, and being cause of symptoms. The abdominal cavity was washed out, the bowel and external wounds treated in the usual way, drainage left in. Operation had to be hurried towards the end as patient was sinking. He died 20 hours after admission.

*Notes.*—Case peculiar as offering extraordinary difficulty of diagnosis. If hernial sac had been opened, bowel contents would have flowed out and operator have certainly thought he had opened the gut, and the real rupture probably been overlooked.

*Case 2.—Double hair lip with cleft palate:—*

A. McA., 19 yrs., female, admitted under care of Dr. Wm. Christie. On admission found to have complete absence of hard and soft palate through middle line of roof of mouth, intermediate portion of alveolus projecting, and intermediate portion of lip small and attached to end of nose. Great distance between lateral portions of lip.

*Operation.*—Intermediate alveolus removed, lateral portions of lip pared and brought into apposition with hare-lip pins with difficulty and causing great tension of cheeks. Union took place readily, with small scar resulting. In a few days intermediate portion of lip attached to end of nose was cut off. Raw surface readily healed.

Patient discharged cured, as regards the hair-lip; cleft palate too extensive to operate on.

J. H. admitted to hospital February 2nd, 1890, complaining of pain in thumb, index finger, middle finger and outer side of third finger of the left hand. Pain mostly in daytime, variable in intensity, and always relieved on application of cold to hand. Nine months previously he received a bullet wound in the middle of the left upper arm at the inner edge of the biceps muscle. At this time he noticed the pain in the hand before noticing the wound. February 7th the Median nerve was cut down on at the seat of the old cicatrix, and A. nerve to the inner side of the Brachial artery was stretched. February 13th pain in hand about 'one-third' less than before operation. February 23rd patient discharged cured.

## Society Proceedings.

### ST. JOHN MEDICAL SOCIETY.

REGULAR MEETING MARCH 19TH, 1890.

Dr. Christie exhibited specimen of Ulcerative Endocarditis, with calcareous deposit on Aortic semilunar and Mitral valves, Pleuritic and pericardial adhesions. 4 oz. fluid in Pericardium.

Dr. Esson reported a case of Cerebral Meningitis. Patient admitted to hospital, with symptoms of Pneumonia. In a few days patient gradually became comatose, in which state he died.

Strong history of chronic alcoholism. P. M. exam. of brain. General exudation of sero-purulent character, in the Pia mater, over whole of convex portion of brain, more marked in the furrows between the convolutions. Some exudation of serum into the ventricles.

A communication from the Employees' Mutual Benefit Society of the I. C. Railway was considered by the Society. The subject of the communication was that the St. John Medical Society send a schedule of rates to the I. C. R. Mutual Benefit Society for the treatment of its members during illness. The Society drew up a scale of rates, considering each item individually. It was moved by Dr. Inches that Dr. Walker, on behalf of the Society, be authorized to transmit to the I. C. R. Mutual Benefit Society the schedule passed, as a basis of negotiation for the fees to be paid by the members of that Society. Carried.

F. G. Esson, *Secretary.*

### REGULAR MEETING, APRIL 2, 1890.

*Discussion on Influenza.*—Dr. Inches, in a majority of cases in the late epidemic, experienced that Coryza was not a frequent symptom. Three classes of cases were observed, (a.) Gastro-Enteric, (b.) Neurotic, (c.) Pulmonary. He observed that those who went out of doors much appeared to contract disease more frequently than those who remained indoors. Most frequent symptoms were frontal headache, dull expression about eyes, pulse seldom above 85°, temperature not often above 102°. Erythematous eruption not satisfactorily observed. Nephritis noticed in few cases. Generally some particular organ affected, Hepatitis noticed. Pulmonary symptoms most frequently observed, Capillary Bronchitis most often. In most cases 24 hours' pyrexia, followed by subsidence, and convalescence in four days to one week, if not succeeded by complication. Prevailed during the greatest cold. Fatality great from complications, but seldom from influenza itself. Treatment: Antipyrin given to great extent and very satisfactorily. Not recommended by some without additional administration of Digitalis or Brandy. Quinine not satisfactory during disease, but useful during convalescence. Sodæ Salicylatis useful, especially if any rheumatic tendency. Bromide of Ammonium with Hyoscyamus very satisfactory. Stimulants not administered. Recurrence noticed in some cases, but not so severe as original attack.

Dr. MacFarlane thought that many cases of Influenza resembled a mild form of Cerebro-Spinal Meningitis. Treatment: Quinine gr. xii., Morph. Sulph. gr.  $\frac{1}{4}$  to  $\frac{1}{2}$  every 4 hours. Later cases Antipyrin gr. x. t. i. d.

Dr. Emery gave a very vivid description of an attack occurring in himself. Morphia and Atropine for pain, Camphor, Hyoscyamus, Taraxæum for general treatment. Convalescence, three weeks. In practice used Antipyrin and Quinine favorably.

Dr. M. MacLaren.—Complications noticed were Pneumonia, Bronchitis and Pleurisy. Temperature seldom above 102°, pulse 75° to 80°, but weak. Thinks it is contagious, on account of whole families being affected, in many instances.

Dr. Esson mentioned a case where Diabetic Coma followed Influenza, in a patient suffering from Diabetes Militus. Coma occurred 24 hours after beginning of Influenza.

Dr. J. Christie reported a case where there have been four or five relapses. In his hospital patients Quinine and Pulv. Ipecac Co. have been given for chills, and Potas. Bromid, for relief of pain.

F. G. Esson, *Secretary.*

### PICTOU COUNTY MEDICAL SOCIETY.

The January meeting was held at New Glasgow on the 7th, nine members being present.

The President (Dr. McKenzie) read notes of a recent case in his practice of Placenta prævia, with convulsions and albuminuria, in which the patient is making a good recovery.

The Society met at Westville on Tuesday, April 1st, nine members being present. Dr. Kennedy read a paper on "Two cases of ovarian abscess, accompanied by peculiar symptoms," eliciting a discussion in which most of the members took part.

It was decided to hold the annual meeting in Pictou on the third Tuesday in July, and to accept the invitation of the President to dine with him.

J. STEWART, *Secretary.*



# The Maritime Medical News.

May, 1890.

EDITORS:

D. A. CAMPBELL, M. D., Halifax, N.S. J. W. DANIEL, M.D., M.R.C.S., St. John, N.B.  
 ARTHUR MORROW, M. B., " L. C. ALLISON, M. B., "  
 JAMES McLEOD, M. D., Charlottetown, P. E. I.

*Communications on matters of general and local professional interest will be gladly received from our friends everywhere.*

*Manuscript for publication must be legibly written in ink on one side only of white paper.*

*Papers of cumbrous or unnecessary length, but otherwise acceptable, will be returned for condensation.*

*All manuscripts, and literary and business correspondence, to be addressed to*

DR. MORROW,  
 ARGYLE STREET, HALIFAX.

**S**URROUNDED, as we in these Maritime Provinces are, by the ocean, it is perhaps somewhat strange that we do not oftener prescribe the sea voyage to patients who would be invigorated by it. The benefits obtained from sea travel have long been recognized, even when the form was not rendered nearly as comfortable or pleasant as it is to-day. The modern steamer and modern sailing vessel are now fitted up and victualled in such a careful, commodious and often luxurious manner, that the invalid can go to sea without that dread of roughing it and being compelled to submit to a diet of hard tack and salt pork which some years ago placed an absolute embargo on his endeavours to regain health in this way.

Lately increased attention has been given to this subject, and the effect of a long sea voyage on patients suffering from certain diseases has been carefully noted and tabulated. The influence of sea air on the ordinary traveller seems to be of a sedative and tonic nature; it is of absolute purity so far as freedom from germs is concerned, while the traces of iodine, bromine, salt, and the increase of ozone, give it a tonic and stimulating quality, and as a matter of fact the large majority of people improve in weight and health during a voyage of any length. Some of the instances recorded of increased weight are very striking, as for example where one individual gained ten pounds in crossing the Atlantic in a sailing vessel, another twenty-five pounds on a voyage to China, and another, a consumptive, between thirty and forty

pounds during a voyage from England to India *via* the Cape. The appetite increases in a most vigorous manner, while the want of much active exercise, the total absence of all the worries of business associated with land life, the presence usually of pleasant company, the abundance of sun light and pure invigorating air, all these together are, as a rule, successful in improving the health and weight of the ordinary traveller, as well as the valetudinarian who endeavours on the sea to lure back that appetite and strength which fail to come to him on shore. It is pleasing to note that consumptives, when the disease has not advanced to the stage of formation of cavities, almost invariably improve in a most gratifying manner at sea, as witness the following statistics taken from an article by Dr. J. A. Lindsay, Physician to the Royal Hospital, Belfast, and from which the writer has culled some of the ideas here presented. From extensive trials of sea voyages in treatment of consumption, of whom 72 per cent. were in the first stage of disease, 11 per cent. in second, and 16 $\frac{2}{3}$  in the third, it was found that 89 per cent. of the patients improved, 5 $\frac{1}{2}$  per cent. remained stationery, and 5 $\frac{1}{2}$  per cent. became worse. Dr. Austin Flint made trial of the sea voyage in twenty cases of consumption. Of these three ended in complete recovery; in two others there was arrest of the disease; ten others were much improved, benefitted or notably benefitted; in three the result was doubtful or not stated, and only two became worse. Only one is recorded as suffering seriously from sea sickness. Another observer saw thirty-eight cases of consumption in which the sea voyage was tried, and of these twenty-eight improved, four became stationery, three became worse, and one died. It appears to us that no other treatment of consumption can show such favorable results as those shewn in the above statement of cases.

The sea voyage is also to be recommended in cases of scrofula both of glands and joints, and in those debilitated conditions of the general and nervous system depending for their cause on intemperance, overwork or mental worry, or delayed convalescence from acute disease or surgical operations, while of those not so ill, but who would be better for change, rest and recreation, the large majority will receive more actual benefit from a trip across the ocean than can be obtained in the same time in any other manner. The subject is here only glanced at, but is of practical importance, and should not be lost sight of in advising those especially who are the victims of incipient consumption or scrofula.

OF all the plans so far adopted with a view to preventing the abuse of dispensaries and other medical charities, that of having a wage limit seems to have yielded the best results. Under this plan a single man who receives more than a certain weekly sum must pay something for medical attendance. The wage limit is of course a larger sum for a married man, and in addition so much is allowed per child. This method of selection by no means altogether precludes the possibility of unequal and indeed undesirable pressure in individual cases, chiefly because the wage that means enough and contentment to one man is associated with debt, embarrassment and unhappiness in another.

Such circumstances call for a broad and somewhat elastic interpretation of the general rule according to which medical charity should be provided for those only who receive not more than a certain equitably fixed weekly wage; the exact sum differing according to the number dependant upon the wage earner.

We shall have something further to say upon the general question of medical charity in which is included the important subject of hospital medical treatment. The number and equipment of the hospitals in most civilized countries is a credit both to their civilization and to their charity. Perhaps no service is so deserving of public and private support as a competent and adequate hospital service. But into this noble service may creep and has crept, such an indiscriminateness of charity, and so ready a dispensation of its advantages as we believe to be neither due nor morally healthful to the receivers of the charity, nor right to the public and profession who provide it. The matter has lately received much attention in the medical and even lay press of Great Britain, and no doubt after intelligent and fair discussion, we will get the true bearing of the matter.

WE invite special attention to the important notices of the meetings of various Medical Societies and Associations, the announcements of which are to be found on pages 46 and 47.

An innovation in at least the recent history of the Victoria General Hospital, is the creation of the office of superintendent. The inside staff of that institution now comprises,—a Superintendent; a senior House Surgeon; a junior House Physician; two Clinical Clerks; a Dispenser. This is certainly a large resident staff, considering the size and accommodation of the institution. Two house surgeons, with clinical clerks and a dispenser, ought to be a sufficient and competent medical staff.

## Special Notices.

We invite special attention to the subjoined letter received from the Secretary of the Nova Scotia Medical Society:

### NOVA SCOTIA MEDICAL SOCIETY.

Truro, N. S., April 18th, 1890.

The Twenty-Second Annual Meeting of the Nova Scotia Medical Society will be held at Granville Ferry, Annapolis County, on Wednesday and Thursday, July 2nd and 3rd. The meeting promises to be the most successful and interesting yet held. The following papers have already been promised:

"Medical Education," President's address, by Willis B. Moore, Kentville, N. S.

"Physical Education," by John Stewart, Pictou, N. S.

"Injuries of the Elbow Joint," by J. A. Coleman, Granville Ferry.

"The Use and Abuse of Antipyretics," by W. S. Muir, Truro, N. S.

"Albumen in the Urine—its Clinical Significance," by George E. Buckley, Guysboro, N. S.

A voluntary paper by Dr. Pineo, of Chester.

Business of the utmost importance to every medical man in the Province will have to be transacted. The appointment of six members to the Provincial Medical Board will have to take place at this meeting. A committee to meet the New Brunswick and P. E. Island Medical Societies, for the formation of a Maritime Medical Association, will be asked for. The joint committee will meet at Moncton, N. B., at the date of the annual meeting of the New Brunswick Medical Society. The reports from the committees appointed at our last annual meeting will be looked forward to with interest.

You will see how necessary it is that every section of the country should be represented.

I am, dear Doctor, Yours truly,

W. S. MUIR, *Secretary.*

Editor "Medical News."

### CANADIAN MEDICAL ASSOCIATION.

The 23rd Annual Meeting of the Canadian Medical Association will be held in Toronto on the 9th, 10th and 11th of September next.

JAMES BELL, M. D., *Secretary.*

### TENTH INTERNATIONAL MEDICAL CONGRESS.

TO BE HELD IN BERLIN, AUGUST 4TH TO 9TH.

The Committee of Organization of the Tenth International Medical Congress, R. Virchow, President; E. von Bergmann, E. Leyden, W. Waldeyer, Vice-Presidents; O. Lassar, Secretary-General, have appointed the undersigned members of an American Committee for the purpose of enlisting the sympathy and co-operation of the American profession.

We are assured that the medical men of our country will receive a hearty welcome in Berlin. The Congress promises to prove of inestimable value in its educational results and in securing the ties of international professional brotherhood. It is most important that the American profession should participate both in its labours and its fruits.





TO THE MEDICAL PROFESSION.

# EMULSION OF COD LIVER OIL

— AND THE —

## Hypophosphites of Lime and Soda.

**GUARANTEED NOT TO SEPARATE NOR SPOIL IN ANY CLIMATE.**

**This Preparation** is a compound of the purest Norwegian Cod Liver Oil and the Hypophosphites of Lime and Soda with Glycerine.

By combining the Hypophosphites in this manner with the Oil, not only the remedial power of all are increased, but we are enabled to administer the Phosphorous that is loosely combined in them, in a form that will be most readily assimilated; the stomach receives it without irritation, and it is taken up along with other food and carried into the economy to be there resolved and to supply the waste which often constitutes the first link in a chain of morbid action.

In cases of consumption and all pulmonary diseases, with emaciation, cough, debility, hemorrhage, and the whole train of too well-known symptoms, the benefits of this article are most manifest.

**Cod Liver Oil** in its natural form alone, cannot be very well borne by the stomach from want of digestive power in that organ; it causes cructat ons, and is apt to derange the digestive organs, and even causes vomiting and diarrhoea, and so strong is the disgust it excites at times that, although the patient stands in the greatest need of it, the use of the remedy has often to be discontinued.

**Recognizing this fact**, we have succeeded in putting it in a form that the most susceptible stomach will tolerate, it BEING A PERFECT EMULSION, sweet and PALATABLE AS CREAM.

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# LIQUID MALT EXTRACT.

Containing all the Nutrient Properties of Malt, with the least possible Amount of Alcohol.

This is a perfectly pure, and extremely agreeable preparation of malted-barley with hops, combining the nutritive and digestive properties of malt, with the well-known bitter-tonic qualities of hops. The very low percentage of alcohol contained in it (less than three per cent.), and the large amount of nutritious extractive matter (fifteen per cent.), render it the most desirable preparation for administration to nursing women invalids, children, etc. In the usual dose of a wineglassful three or four times daily, it excites a copious flow of milk, and supplies strength to meet the great drain upon the system experienced during lactation.

The diastatic principles of the malt render this preparation of great service in cases of malnutrition, dyspepsia, etc., causing the assimilation of starchy foods, increasing the appetite, storing up fat, etc., etc.

The rapidly increasing demand for the MALT EXTRACT in the Dominion of Canada, has induced us to start its manufacture in the city of Montreal, on account of which we are enabled to supply the demand at greatly reduced prices.

**Single Bottle 40 cts. One Dozen, \$3.00.**

**JOHN WYETH & BROTHER, Manufacturing Chemists.**

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Please Mention THE MARITIME MEDICAL NEWS

# WYETH'S COMPRESSED TRITURATED DRUGS.

Safer, Pleasanter, and more Efficient and Convenient Medication for Infants,  
the Fastidious, and Idiosyncratic.

## AN INNOVATION.

Brunton points out that the introduction of the method of giving small doses at frequent intervals has "the very great advantage that the desired effect can be produced with greater certainty and with less risk of an overdose being taken."

## WHAT ARE COMPRESSED TRITURATES.

The Compressed Triturates are "intimate mixtures of substances with sugar of milk." In no way are they allied to the sugar of milk globules or pellets, dependent so largely upon chance for the absorption of the medicaments poured down the side of the bottle. The following directions are those given in the Pharmacopœi, U. S., for the preparation of Triturates: "Take of the substance ten parts, sugar of milk in moderately fine powder ninety parts, to make one hundred parts; weigh the substance and the sugar of milk separately; then place the substance, previously reduced, if necessary, to a moderately fine powder, into a mortar, add about an equal bulk of sugar of milk, mix well by means of a spatula and triturate them thoroughly together. Add fresh portions of the sugar of milk, from time to time, until the whole is added, and continue the trituration until the substance is intimately mixed with the sugar of milk and finely comminuted."

## RESUME OF ADVANTAGES.

1. The Compressed Triturates are made with the pure drug and sugar of milk.
2. The process of trituration employed so finely subdivides and separates the mass of medicament that this is said to be more active than would be the same quantity given in the ordinary way.
3. They contain each a very small dose, so that by giving one at a time—they may be repeated often—the taste of the drug is hardly, if at all perceived.
4. Being made with sugar of milk, one of them, if not taken whole, added to a little milk or other fluid is at once "broken up" and distributed throughout the liquid.
5. Pulverulent substances, like calomel, are by this means especially distributed well, and for the moment suspended throughout the fluid.
6. Being very small and not globular, they are easy to swallow.
7. They do not harden and become insoluble with time, nor do they crumble, like pills.
8. They afford the advantages derivable from the administration of small doses repeated often, which are: 1. That if the drug be given in but little liquid, the absorbent power of the mucous membrane, of the mouth and gullet, are called repeatedly into requisition. 2. That if given on an empty stomach (as is generally desirable) unpleasant symptoms are avoided. 3. In the case of idiosyncrasy the doses can be stopped before large amounts have been given. 4. Administered in this way, drugs are better tolerated than is otherwise the case.
9. A greater effect is alleged to be obtainable by this method from a small quantity of medicine than is possible by the usual plan.
10. In some cases Compound Triturates are repeated as often as every five or ten minutes, and it is surprising how soon a very small dose of medicine repeated often amounts to a very large quantity.
11. If taken whole, one of the Compressed Triturates dissolves and falls to pieces in the stomach at once, and is never voided unchanged.
12. They afford accuracy of dose, without the trouble and annoyance of weighing or measuring.
13. They can be taken at any time and in any place, even when the patient is following his ordinary avocation.
14. They are only a few lines in thickness and about one-fourth the circumference of a lead pencil.

## Sample List of Compressed Triturates.

Aconite Tinct. ....	1 min.	Anti-Con- } Aloin 1-5 gr.	Styach. ....	1-60 gr.
Arsenious Acid .....	1-100 and 1-50 gr	stipation } Belladon. Ex. 1-8 gr.	Ipecac. ....	1-16 gr
Belladonna Tinct. ....	1 min.	Apomorphine Mur. ....	.....	1-50 gr
Calcium Sulphide. ....	1-10 gr.	Atropin Sulph. ....	.....	1-100 gr
Capsicum Tinct. ....	1 min.	Digitilin .....	.....	1-100 gr
Digital Tinct. ....	1 min.	Euonymin Resin. ....	.....	1-8 gr.
Hydrarg. Perchlor. ....	1-100 gr.	Hydrarg. Iod. Rub. ....	.....	1-20 gr.
Hydrarg. Cum Creta. ....	1-3 gr.	Hydrarg. Iod. Vir. ....	.....	1-8 gr.
Hydrarg. Subchlor (Calomel). ....	1-10 gr.	Morphine Sulph. ....	.....	1-20 and 1-8 gr.
Hyoscyamus tinct. ....	1 min.	Opium Tinct. (Laudanum). ....	.....	2 min.
Nux Vomica Tinct. ....	1 min.	Pilocarpin Mor. ....	.....	1-20 gr.
Tinct. Canph. Co. (Paregoric). ....	2 min.	Podophyllin Resin. ....	.....	1-4 gr.

Waistcoat Leather Pocket Cases, containing ten tubes of 25 Triturates each (any selection), supplied at \$1.25.  
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In all orders specify WYETH'S and avoid disappointment.

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Delegates of American medical societies and institutions, and individual members of the profession, will be admitted on equal terms. The undersigned, therefore, beg to express their hope that a large number of the distinguished men of our country will appreciate both the honor conferred by this cordial invitation and the opportunity afforded us to fitly represent American medicine.

The Congress will be held at Berlin, from the 4th to the 9th of August.

The arrangements in regard to a few general meetings and the main scientific work, which is delegated to the sections, are the same as in former sessions. A medico-scientific exhibition, the programme of which has been published a few weeks ago, is to form an ingredient part. It is to the latter that the Berlin Committee is very anxious that both the scientific and the secular press should be requested to give the greatest possible publicity.

S. C. BUSEY,	WILLIAM T. LUSK,
Washington, D. C.	New York.
WM. H. DRAPER,	WM. OSLER,
New York.	Baltimore, Md.
R. H. FITZ,	WM. PEPPER,
Boston, Mass.	Philadelphia, Pa.
H. HUN,	J. PEYRE PORCHER,
Albany, N. Y.	Charleston, S. C.
A. JACOBI,	J. STEWART,
New York.	Montreal.

(In connection with the above, we append a copy of a letter received from Dr. A. Jacobi, of New York.)

110 WEST 34TH ST., NEW YORK,  
April 7th, 1890. }

*Mr. Editor*,—In a letter dated Berlin, Karlstrasse, 19, March 22d, Dr. Lassar, the Secretary-General of the Tenth International Congress, directs me to inform the medical profession of America that a programme of the Congress and other communications will be distributed two months before the meeting amongst those who will have registered previously and received their tickets of membership.

The latter can be obtained by sending applications and five dollars to Dr. Bartels, Leipzigerstrasse, 75, Berlin, S. W. By so doing the members will save much crowding and time during the first days of the Congress.

For the American Committee of the Tenth International Medical Congress.

A. JACOBI, M. D.

#### INVITATION FOR AN INTERNATIONAL MEDICAL AND SCIENTIFIC EXHIBITION.

In connection with the Tenth International Medical Congress to be held in Berlin, between the 4th and 10th of August, there is to be an International Medical and Scientific Exhibition. The exhibits will be of an exclusively scientific nature, as follows:

New or improved scientific instruments and apparatuses for biological and strictly medical purposes, inclusive of apparatuses for photography and spectral analysis as far as applicable to medicine.

New objects and preparations in pharmacological chemistry and pharmacy.

New foods.

New or improved instruments subservient to any of the departments of medicine, including electrotherapy.

New plans and models for hospitals, convalescent homes, and disinfectant and bathing institutions and apparatuses.

New arrangements for nursing, including transportation, baths, &c.

New apparatus in hygiene.

Applications or inquiries inscribed "Ausstellungs-Angelegenheit," and accompanied with a printed card containing the name and address of the firm thus applying, ought to be directed to the Secretary-General, Dr. O. Lassar, Carlstrasse, No. 19, Berlin, N. W. Germany.

R. VIRCHOW, *President*.

E. VON BERGMANN, }  
E. LEYDEN, } *Vice-Presidents*.  
W. WALDEYER, }  
O. LASSAR, *Secretary-General*.

#### Books and Pamphlets Received.

PRACTICAL ELECTRICITY IN MEDICINE AND SURGERY.—By G. A. Liebig, Jr., Ph. D., lecturer on Medical Electricity, College of Physicians and Surgeons, Baltimore, Assistant in Electricity, John Hopkins University, &c., and George H. Roche, M. D., Professor of Obstetrics and Hygiene, College of Physicians and Surgeons, Baltimore; visiting Physician to Bay View and City Hospitals, &c. \$2.00 net. Publishers, F. A. Davis, Philadelphia.

THE NEUROSES OF THE GENITO-URINARY SYSTEM IN THE MALE WITH STERILITY AND IMPOTENCE.—By Dr. R. Uitzmann, Professor of Genito-Urinary Diseases in the University of Vienna. Translated by Gardner W. Allen, M. D., Surgeon in the Genito-Urinary Department, Boston University. Price \$1.00. F. A. Davis, publisher, Philadelphia.

(The above works will be noticed in next issue.)

THE ANIMAL SUTURE, ITS PLACE IN SURGERY.—By Henry O. Marcy, A. M., M. D., LL. D., Surgeon to the Private Hospital for Women, Cambridge, &c., &c. In this pamphlet the author details the different varieties of Animal Suture, the animals from which derived, manner of preparation and comparative tendencies to become incorporated with the tissues or to cause irritation. There is much of information and interest and of practical value.

A PRACTICAL SPLINT FOR INFLAMMATORY CONDITIONS OF JOINTS.—By F. Stillman, M. Sc., M. D., Chicago. The contents of this article can only be appreciated by reading the pamphlet itself. The splint it is claimed possesses the following advantages:—1. Extension at any angle with motion. 2. Extension at any angle with fixation. 3. Fixation at any angle. 4. Motion complete or limited. 5. Exposure of surface about the joint, allowing compression (elastic or otherwise), hot and cold applications, blisters, dressings, without disturbing the action of the apparatus.

THE FOUR COMMENCEMENTS—VALEDICTORY ADDRESS TO THE GRADUATING CLASS ('90), AT THE UNIVERSITY OF LOUISVILLE.—By J. M. Bodine, M. D., Professor of Anatomy and Dean of the Faculty.

THE CURE OF HÆMORRHOIDS BY EXCISION AND CLOSURE WITH THE BURIED ANIMAL SUTURE.—By Henry O. Marcy, M. D., &c., Boston, U. S. A.

STIRPICULTURE; OR, THE ASCENT OF MAN.—By A. P. Reid, M. D., &c., Superintendent for the N. S. Hospital for Insane. (Read before the N. S. Institute for Natural Science, 1890). In order to elevate the race (especially the faulty classes of it) and to prevent the transmission and perpetuation of defects, moral and physical, Dr. Reid urges the following:—1. In view of the known laws of hereditary transmission those inheriting a defective organization should be prevented from perpetuating it. 2. The marriage tie should be regarded as indissoluble. 3. A correct appreciation of the dignity of labor should be exemplified and instilled. 4. Attention should be paid to moral training

with fixed or positive religious ideas. 5. A general and practical education should be imparted. 6. There should be definite instruction in sanitary laws.

THE STATUS OF COCAINE IN SURGERY.—By John A. Wyeth, M. D., Professor of Surgery at the New York Polyclinic and Hospital, &c.

A RATIONAL BRACE FOR THE TREATMENT OF CARIES OF THE VERTEBRÆ (POTT'S DISEASE).—By Charles F. Stillman, M. Sc., M. D.

A LECTURE ON SEXUAL PERVERSION, SATYRIASIS AND NYMPHOMANIA; REMARKS ON HYPERTROPHY AND ATROPHY OF TISSUE; THE LOCAL TREATMENT OF SYPHILITIC PHENOMENA.—By G. Frank Lydston, M. D., Chicago. Three pamphlets of considerable interest.

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### Notes and Comments.

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THE discovery and announcement of new drugs still continue. Among late arrivals are the bark of the *Naregamia alata* which has expectorant powers and is said to be of special benefit in pulmonary catarrh and emphysema, &c.; *Hypnal*, (different from Hypnot) a new hypnotic; *Puerbotano*, (Calliandra Houstoni) a Cinchona substitute; *Aristol*, which promises to be useful in dermatological affections.

A virulent type of diphtheria has been present in Halifax during the last three or four months. The disease is still prevalent. Along with the severe cases there are some very mild ones. It is astonishing how many people will cling to the self persuasion that their child has a cold or a "quinsy sore throat;" even though the throat gets worse and worse before their eyes and ultimately the child very much choked, they will still delay sending for a doctor which they should do early, if only to make sure. The result is a greater mortality and poorer statistics of treatment than would be the case if the doctor were called early, instead of, as not seldom, to confirm to the parents the fact of approaching death.

THE following additions have been made to the Faculty of the New York Post-Graduate Medical School and Hospital:—Charles B. Kelsey, M. D., Professor of Rectal Diseases; Charles H. Knight, M. D., Professor of Laryngology and Rhinology; Reynold W. Wilcox, M. D., Professor of Clinical Medicine; Dr. S. Lustgarten, formerly Privat Docent in Vienna University, Instructor in Syphilis and Dermatology.

THE Halifax Medical College closed a successful session on April 10th. Most of the candidates for examination submitted themselves for the final and primary examinations at Dalhousie University. Owing to the interruption in the teaching of the first classes which took place two years ago, only one candidate, Mr. H. V. Kent, presented himself for the final examination which he successfully passed. The degrees of M. D., C. M., were subsequently conferred upon Mr. Kent at the Dalhousie convocation.

In the primary subjects the following gentlemen passed:

*Anatomy*.—Messrs Kent, Johnson, Hamilton, McCharles, Grant and Purcell (the last named also in *Histology*).

*Physiology* (including *Histology*).—Messrs. Johnson, Hamilton, Grant and Woodworth.

*Materia Medica*.—Messrs. Grant, Johnson, Hamilton, McCharles, Woodworth.

*Chemistry*.—Messrs. Johnson, Grant, Hamilton, McCharles, Woodworth.

A number of gentlemen whose names we have not at hand passed in Botany and Practical Chemistry.

MR. GUY CARLTON JONES, M. R. C. S., passed the final examination at the Halifax Medical College and was duly granted the degrees of M. D., C. M.

MR. G. N. DRYSDALE won the silver class medal in Physiology, this medal being offered for competition among the first year's men.

THE idea of opening the session a month earlier, (*i. e.*, about Sept. 25th) was abandoned and the next session will open as usual in the latter part of October.

DR. PAGE of Truro, examiner in medicine for Dalhousie University, was in town for a day or two. Dr. Stewart, co-examiner in surgery, was unable to be present

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### Personal.

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DR. F. U. ANDERSON has returned from his trip to Europe. We shall be glad if he has something to tell our readers of what he saw.

DR. ROSS, of Halifax, has our congratulations upon completing his course and obtaining his degree, that of M. D. Univ. McGill.

DR. H. V. PEARMAN, late junior house surgeon at the Victoria General Hospital, Halifax, has gone to London to take advantage of the clinical opportunities of that city.

COLCHESTER COUNTY, N. S., has gained the services of the following medical gentlemen, both of whom have been educated in New York:—Dr. Smith L. Walker, who has settled in Truro; and Dr. M. O. Dickens, who has located in Folly Village.

DR. W. S. MUIR, of Truro, has been nominated by the President of the Canadian Medical Association as the reader of the address on *Materia Medica* and *Therapeutics* at the next meeting of the Association, which will be held in Toronto in September.

DR. JACQUES, till recently senior house surgeon to the Victoria General Hospital, has been appointed superintendent of that institution. It is understood that Dr. Jacques' duties are not such as to interfere with the usual functions of the visiting physicians and surgeons.

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## Nova Scotia Medical Society.

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### TWENTY-SECOND ANNUAL MEETING.

July 2nd and 3rd, 1890.

The Twenty-Second Annual Meeting of the Nova Scotia Medical Society, will be held at Granville Ferry, Annapolis County, on Wednesday and Thursday, July 2nd and 3rd. All desirous of reading papers or presenting cases, are requested to notify the Secretary of such papers or cases on or before the first of June next.

W. S. MUIR,

Secretary.

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In calling the attention of the profession to this institution, the Faculty beg to say that there are more major operations performed in the Hospital connected with the school, than in any other institution of the kind in this country. Not a day passes but that an important operation in surgery and gynecology or ophthalmology is witnessed by the members of the class. In addition to the clinics at the school published on the schedule, matriculates in surgery and gynecology can witness two or three operations every day in those branches in our own Hospital.

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*Surgery.*—Lewis S. Pilcher, M.D., Seneca D. Powell, M.D., A. M. Phelps, M.D., Robert Abbe, M.D.

*Diseases of Women.*—Professors Bache McEvers Emmet, M.D., Horace T. Hanks, M.D., Charles Carroll Lee, M.D., J. R. Nilson, M.D.

*Obstetrics.*—Professors C. A. von Ramdohr, M. D., Henry J. Garrigues, M. D.

*Diseases of Children.*—Henry Dwight Chapin, M. D., Joseph O'Dwyer, M. D., J. H. Ripley, M. D.

*Diseases of the Eye and Ear.*—D. B. St. John Roosa, M. D., W. Oliver Moore, M. D., Peter A. Callan, M. D., J. B. Emerson, M. D.

*Diseases of the Nose and Throat.*—Clarence C. Rice, M. D., O. B. Douglas, M. D.

*Venereal and Genito-Urinary Diseases.*—Frederic R. Sturgis, M. D., L. Bolton Bangs, M. D.

*Diseases of the Skin.*—R. W. Taylor, M. D.

*Diseases of the Mind and Nervous System.*—Professors Charles L. Dana, M. D., Graeme M. Hammond, M. D., A. D. Rockwell, M. D.

*Anatomy and Physiology of the Nervous System.*—Professor Ambrose L. Ranney, M. D.

*Hygiene.*—Professor Edward Kershner, M. D., U. S. N.

*Pharmacology.*—Professor Frederick Bagoë, Ph. B.

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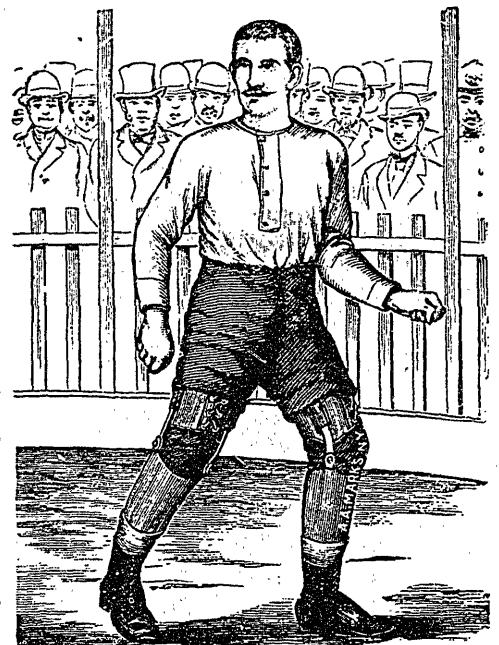
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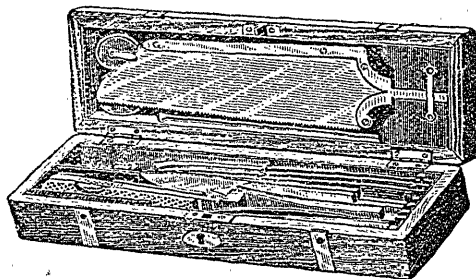
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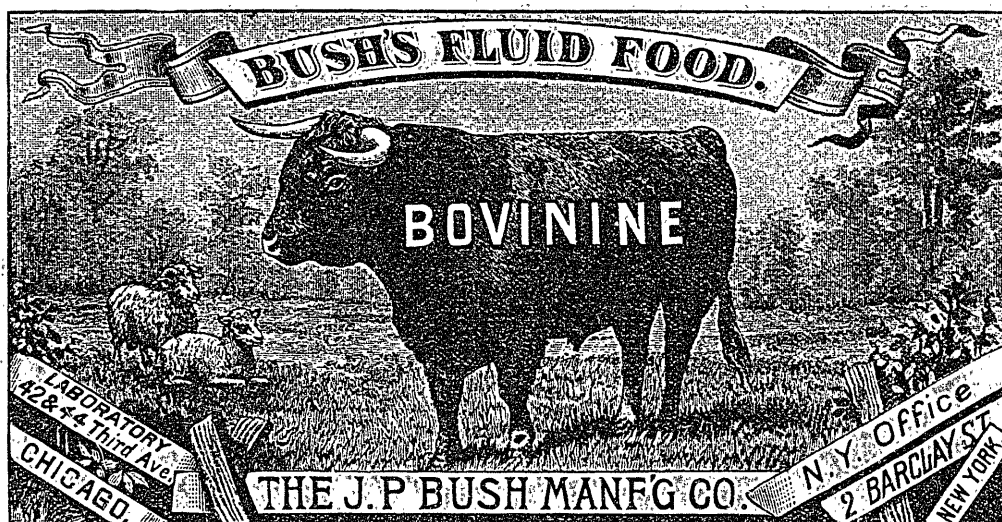
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This axiom, formulated by the lamented Fothergill, conveys a world of meaning to the intelligent physician. If a food can be obtained containing all the elements necessary for the nourishment and support of the body and which can also be readily assimilated under every condition of disease, an immense advantage is obtained in controlling symptoms and restoring wasted tissues. Mal-nutrition and mal-assimilation are potent factors in a long train of severe illnesses. **Bush's Fluid Food, Bovinine**, combines in a concentrated form all the extractive or albuminous properties of uncooked beef together with its stimulating salts.

Dr. Geo. D. Hays, of New York Post Graduate School, in an exhaustive paper on Artificial Alimentation thus alludes to Bovinine: “Of the preparations of raw food extracts one has a clinically proved value. It is rich in nitrogenous substances and phosphates. It is readily digested and absorbed and can be relied upon for the entire sustenance of the body for a considerable period.”

The blood corpuscles which carry such a wealth of vitalizing power, are found in Bovinine intact, as revealed by the microscope in countless thousands.

B. N. Towle, M. D., of Boston, in a notable paper on Raw Foods, read before the American Medical Association at Washington, D. C., May 6th, 1884, thus refers to Bovinine: “I have given it to patients continually for months with signal comfort especially in complicated cases of dyspepsia attended by epigastric uneasiness arising from inervation, and in nervous debility of long standing. Raw food is equally adapted to acute lingering diseases”

PALATABLE TO THE MOST FASTIDIOUS TASTE.

Samples to Physicians on Application.

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**The J. P. BUSH MANUFACTURING COMPANY**

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# THE TRUTH ABOUT PEPSIN.

The competition among pepsin manufacturers for the past year has been so great as to lead to not a little misrepresentation by the less scrupulous as to the actual facts. The controversy over the subject of pepsin tests and standards and comparative digestive power has gradually simmered down to a recognition of certain facts which all physicians should now recognize. These may be briefly stated as follows:

Since the last revision of the U. S. Pharmacopœia there has not been a single instance where the remedial value of a preparation has been so greatly enhanced, through the instrumentality of the manufacturing pharmacist, as in the case of pepsin.

This achievement has resulted from the elaborate researches which have been conducted in the department of our laboratory devoted to original work. We have thus been enabled to increase the proteolytic or digestive power of commercial pepsin to a standard forty times higher than that required by our Pharmacopœia, and, at the same time, imparted to our product certain qualities which have been heretofore regarded as verging on the impossible.

Our pepsinum purum in lamellis and pepsinum purum pulvis meet all the requirements of a typical preparation, not only as regards their freedom from toxic substances, but in point of digestive activity as well. Both are capable of dissolving two thousand times their weight of coagulated egg albumen under the conditions of our published test, but should the experience of physicians indicate that a still greater activity is desirable, we are prepared to meet their wants in this direction, as a degree of activity has already been reached by us which is many times that of our present standard.

We supply pepsin in the following forms:

**Pepsinum Purum in Lamellis; Pepsinum Purum Pulvis; Pepsin, Saccharated, U. S. P., 1880; Pepsin, Glycerole, Concentrated; Pepsin, Lactated; Pepsin, Liquid, U. S. P., 1880; Pepsinum Purum Tablets, 1 gr., Sugar Coated.**

All information desired by physicians as to our pepsin products, our general line of standard medicinal preparations, pharmaceutical specialties, and the latest therapeutic novelties and improvements in methods of medication, will be promptly furnished on request.

## NORMAL LIQUIDS.

In Normal Liquids, which we introduced in 1883, we made the first attempt to meet the requirements of physicians and pharmacists for a uniform and reliable class of fluid preparations of drugs not open to the objections and uncertainty of fluid extracts made by U. S. P. process.

The standard decided upon for these fluids was the result of long experience in the collection, purchase, examination and analysis of crude drugs with a determination of the amount and character of their active principles. The reliability of normal liquids soon led to their large consumption, and the medical profession have evinced their preference for them to such an extent as to make them now an established and popular method of exhibiting the toxic and narcotic drugs.

It is believed that the best interests of pharmacy and medicine will not be served unless **these or like preparations are officially recognized.** For concentrated tinctures of a definite strength, the name "normal liquids" appears to be happily chosen, as it implies a definite standard of strength. The list should embrace preparations of the more potent crude drugs, 1 Com. representing 1 gramme of drug of standard strength.

As a step in this direction we have long supplied the following normal liquids:

Aconite Root.  
American Hellebore.  
Belladonna Leaves.  
Belladonna Root.  
Cannabis Indica.

Cinchona Calisaya.  
Coca.  
Colchicum Root.  
Colchicum Seed.  
Conium Fruit.

Ergot.  
Foxglove.  
Gelsemium.  
Henbane.  
Ipecac.

Mandrake.  
Nux Vomica.  
Rhubarb.  
Stramonium Leaves.  
Stramonium Seed.

Circulars and reprints of articles on normal liquids and the necessity for a higher standard of accuracy for toxic and narcotic drugs sent to physicians on request.

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