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CANADA
MEDICAL RECORD

JUNE, 1900

Original Communications.

PROGRESS OF GYNECOLOGY.

By A. LAPTHORN SMITH, B.A., M.D., M.R.C.S., Eng.

Fellow of the British and American Gynecological Societies; Professor of Clinical Gynecology in Bishop's University; Gynecologist to the Montreal Dispensary and to the Samaritan Hospital; Surgeon to the Western Hospital and Consulting Gynecologist to the Women's Hospital.

Appendicitis as a complication of pelvic disease. A number of papers have recently been read on this subject, among the most important being one by Dr. McLaren, of St. Paul, at the meeting of the American Gynecological Society at Washington in May. It has been pointed out that dysmenorrhœa, which is a common disease in young girls, is frequently due to disease of the tubes; secondly, that disease of the tubes is often due to infection from the vermiform appendix; and thirdly, that disease of the vermiform appendix or appendicitis is always due to infection by the color bacillus, and that the color bacillus increases in numbers in proportion to the length of time the bowels remain unmoved. My own experience in over a hundred operations for pus tubes quite bear out this theory; for in about fifteen cases the vermiform appendix was adherent to the right tube and in one case to the left tube, and in nearly all there was severe dysmenorrhœa. Although gonorrhœa was the principal cause of the pus tubes, yet in some of the cases there was no possibility of this being the case as they were young girls of irreproachable character. Many of these cases occurred in the practice of *confrères* who called me in consultation; in some of them appendicitis had been

diagnosed and in others salpingitis, but at the operation both conditions were found to be present, so that there was no mistake in the diagnosis. The lesson to be learned is that the first thing to do in treating dysmenorrhœa and inflammation of the right side of the pelvis is to have the bowels thoroughly moved. No reliance must be placed on enemas for this purpose as they only empty the rectum. Ten grains of calomel followed in five hours by a saline. Several cases have recently been reported where all arrangements had been made for removing the appendix, but as soon as the calomel and saline had moved the bowels the patient rapidly got well. However, when a patient has had more than one attack, however slight, she should have the appendix removed soon after recovering from the second attack, while in severe attacks incision and drainage should be done within twenty-four hours.

Several cases have been reported in the journals where immediate recovery followed this method without breaking up the wall of adhesions which nature almost always throws up to save the general peritoneal cavity from infection. Many other cases are recorded where these adhesions were broken up in the endeavor to be very thorough in the effort to remove the remains of the appendix, and in all of them the patient died.

Vaginal hysterectomy for procidentia. Although it is not very certain for how many thousands of years the womb has been falling out of the body, it is probable that it was the first gynecological disease to receive treatment. Of course until within the last ten or twenty years the relief obtained by pessaries was only partial, because, as a rule, the perineum was torn, and the outlet of the vagina at the vulva was as large as any other part of it, so that it was difficult to keep any support in. Large ring pessaries, and stem and cup pessaries held in by a perineal bandage were the most effective, but were very inconvenient, while sometimes quite dangerous owing to the cutting of the pessary through the vagina into the peritoneal cavity. The present methods are much more satisfactory, and have the merit of effecting a

complete cure. We have two operations to choose from according to the degree of prolapse and the size of the uterus. If the uterus is small and not far enough out of the body to have become ulcerated, the safest operation is to make a small incision in the abdomen, and catching the fundus with bullet forceps draw it up to the meatus and scarify the whole anterior surface of the fundus, and then sew it to the abdominal wall with buried chromicized catgut. Then to close up the vaginal outlet by a large posterior colporhaphy. If, however, the uterus is very long (sometimes it is seven or eight inches deep), and especially if it is ulcerated, it is better to perform vaginal hysterectomy, and after bringing the stumps of the broad ligaments together to sew up the roof of the vagina and then to close up the perineum. The objection is often raised that the woman is too old to undergo such operations, but I have found by experience in many cases that there is no foundation for the objection. The two last cases of this kind I operated at the Western Hospital a week ago and two weeks ago respectively on women sixty-five years and seventy-five years of age. In the first one I had already done ventrofixation three months ago followed by colporhaphy at the same sitting; but the uterus was so long that when the fundus was attached high up on the abdominal wall, half way to the umbilicus, the cervical end with the vagina was at the vulva In this case I removed the lower four inches of the uterus, and sewed the vagina to the cervical canal remaining. The result seems to be good. In the second case, age seventy-five, there was a large malignant-looking ulcer on the cervix, due to the cervix sticking to the clothing when she sat down, and I therefore removed the whole uterus, which was about five inches long, and closed the perineum. Although the arteries were very hard and there was an arcux senilis, she bore the operations remarkably well; she was only on the table half an hour for the two operations, and did not lose more than three ounces of blood, most of which was during the perineoraphy. She is quite convalescent with a pulse of eighty. The result promises to be very satisfactory.

HISTORY OF THE FORMATION OF THE MEDICAL FACULTY OF THE UNIVERSITY OF BISHOP'S COLLEGE.

By FRANCIS W. CAMPBELL, M.A., M.D., L.R.C.P., London, D. C. L., Dean, Faculty of Medicine, University of Bishop's College.

Those who in the early part of the present century established in Montreal the first Medical School in Canada, now the Faculty of Medicine of McGill University, were far-seeing men. The future of Montreal, as a centre for Medical education was evidently not beyond the horiscope of their vision. Events have thoroughly proved the wisdom of the action which they took and persevered in, often, no doubt, amidst much discouragement. A few years later, in 1845, the Montreal School of Medicine was incorporated, and its lectures were delivered in both the French and English languages. This system of double lectures was found not to work satisfactorily and was discontinued. It then became what it is to-day, the medical educational institution for our French speaking confreres. During its history it has in turn been simply a teaching body or School, a Faculty of Victoria University, Cobourg, and now is a Faculty of Laval University.

Such was the position of Medical teaching in Montreal in 1851—This was before my day, but I can imagine existing lines to have been then, as I know them to have been twenty years later. It was this condition which induced the formation of the St. Lawrence School of Medicine, a copy of whose first and only announcement was as follows:—

ST. LAWRENCE SCHOOL of MEDICINE of MONTREAL.

Midwifery and Diseases of Women and Children.	F. C. T. ARNOLDI, M.D., late Lecturer on Midwifery, School of Medicine, and on Medical Jurisprudence McGill College. Surgeon Montreal General Hospital, and member of the Board of Examiners College of Physicians and Surgeons, L. C.
Institutes of Medicine, Physiology, Pathology and Therapeutics.	GEORGE D. GIBB, M.D., L.R.C.S.I., Physician to the Montreal Dispensary.

Theory and Practice of Surgery.	R. L. MacDonnell, M.D., L.K., Q.C.P. and R.C. S.I., late lecturer on Institutes of Medicine, and on Clinical Medicine, McGill College, late Surgeon to the Montreal General Hospital.
Anatomy, Descriptive and Surgical.	THOMAS WALTER JONES, M.D., L.R.C.S.E.
Theory and Practice of Medicine.	A. H. DAVID, M.D., L.R.C.S.E., Physician to the Montreal General Hospital, Member of the Board of Examiners College of Physicians and Surgeons, L. C.
Materia Medica and Pharmacy.	GEORGE E. FENWICK, M.D., Physician to the Montreal Dispensary, late Curator to the Museum, McGill College.
Ophthalmic and Aural Surgery.	HENRY HOWARD, M.R.C.S.I., Surgeon to the Montreal Eye and Ear Institution.
Chemistry.	ROBERT PALMER HOWARD, M.D., L.R.C.S.E., Physician the Montreal Dispensary.
Botany.	* * * * * *
Clinical Medicine.	At the Montreal General Hospital by Dr. DAVID.
Clinical Surgery.	At the Montreal General Hospital by Dr. ARNOLDI.
Comparative Anatomy and Zoology.	Dr. GIBB.

Anatomy being the basis of Medicine and Surgery special care will be devoted to its cultivation, and every facility will be afforded the pupil by dissections and demonstrations; and in order to enable him to prosecute his studies in this department more profitably, the dissecting rooms will be lighted with gas and will be kept open from 6 A.M. to 11 P.M. daily, during which time competent demonstrators will attend to superintend the pupils.

The business of this School will be carried on in a commodious building, situate in the immediate vicinity of the Montreal General Hospital, containing a large theatre, spacious and well ventilated dissecting rooms, and a Museum of Human and Comparative Anatomy and Pathology.

Five lectures will be delivered weekly throughout the

session, on each branch (excepting Forensic Medicine, Clinical Medicine, Clinical Surgery, Ophthalmic and Aural Surgery, Botany and Comparative Anatomy and Zoology, each of which will be a three months Course) from 1st November to end of April, in conformity with the rules of the College of Physicians and Surgeons of Lower Canada. They will be illustrated by numerous preparations, a large collection of plates, drawings, models and casts; and the recent discoveries in Physiology and Pathology will be practically taught by means of Achromatic Microscopes by the Lecturers on these branches.

Ample opportunities for Midwifery practice will be afforded to the Senior students in that branch, under the immediate superintendence of the Lecturer.

Students attending the lectures on Ophthalmic and Aural Surgery will have the privilege of witnessing the practice at the Montreal Eye and Ear Institution, during the session.

Board and lodging can be obtained at moderate rates in the vicinity of the School.

The fees for the lectures will be the same as at the University of McGill College.

For further particulars apply to

A. H. DAVID, M.D.
Secretary.

N. B.—The certificates of this School being recognized by all the principal Colleges in Great Britain and the United States, it will be to the advantage of students intending to complete their professional education in either of these countries, to attend the courses of lectures of this school.

The St. Lawrence School of Medicine only existed for one session. The cause which, it is said, terminated its existence should have prevented its birth. This was the fact that it could not compete on equal terms with McGill University. —The graduates from McGill received their license from the College of Physicians and Surgeons of Lower Canada, without further examination as to their knowledge and skill.

Those whose Medical course would have been completed at the St. Lawrence School, had it lived and requiring the Provincial License, would have had to present themselves before the College of Physicians and Surgeons of Lower Canada for examination on all the branches of Medical Science. The examiners of this Board were, many of them, Professors in McGill. I have been told by several who were Lecturers in the St. Lawrence School, that it was not considered either wise or fair to submit the chance of their students getting fair play from a Board largely composed of rival Professors. With the termination of its first session—the St. Lawrence School of Medicine therefore closed its doors.

The spirit, however, which had brought to life this School did not die. On the contrary it continued to grow and gain force, and when I entered upon my professional life in 1862 in the city of Montreal, I found among many a feeling of the necessity for a new, or if you like the word better, an opposition School of Medicine in this city. Various reasons may be assigned for this feeling, and they may briefly be epitomised as follows:—(1) A desire to have an up-to-date School, for the only existing English School had been for years running in the groove, which it had long followed, some subjects taught in England and the United States or more elaborately taught, not yet having been added to its curriculum. (2) A feeling that the members of the profession, outside of this school, had no chance to secure Hospital and other appointments—for when vacancies for these occurred, candidates from the outside profession were met with the united opposition of this School. (3) This same opposition was evident in private practice, and gave rise to numerous heart burnings. It was felt that the formation of a new Medical School would afford an opportunity of at least attempting to rectify some of these grievances, and if successful place the profession generally in a more satisfactory condition. It was very generally expressed that a new School would be beneficial in many ways, and that McGill had not preoccupied every avenue to science. How keen this feeling was, even at the foundation of the "School of Medicine

and Surgery," will be understood by the following lines taken from the lecture delivered at its opening by Dr. Sutherland: "What exclusive right is possessed by this Faculty? What species of idolatry is it which ought to enforce us to blindly worship the memory of its departed founders, in permitting their representatives to hold within an iron grasp all the reputation derivable from such a source. What has rendered this place a shrine at which they alone are to receive homage." I found this feeling strong in 1862, I saw it grow year by year until in 1871 it culminated in the formation of the Medical Faculty of Bishop's College. This new teaching body was free from the central point of weakness which had wrecked the St. Lawrence School of Medicine. It was, like the Medical School of McGill, the Faculty of a University. The early history of this Faculty of Medicine, and of its creation may not as yet possess the interest which attaches to older institutions. It is however advisable that its history should be written while some of those who participated in its formation are still alive. When time shall have given antiquity to an institution still in its youth—but a youth of vigour, energy, and promise, it doubtless will be surrounded by hosts of friends. These will realise and we believe appreciate the untiring, unpaid energy and determination of its founders, who brushed aside all obstacles, till success rewarded their efforts. In January 1871, Dr. Charles Smallwood, Dr. Hingston, Dr. A. H. David, and Dr. E. H. Trenholme, met and discussed the formation of a School of Medicine in Montreal, in connection with the University of Bishop's College, Lennoxville. The decision being in the affirmative, it was decided to ask me to assist them in the work. Having accepted the proposal, I attended a meeting at Dr. David's house in Beaver Hall Terrace, on the evening of 1st February, 1871, when the four gentlemen named above were present: The following telegram was read:

St. Hilaire, February 1, 1871.

To Dr. Hingston:

More particulars of Medical Corporation required, give them in person, it will hasten matters,

Signed, T. E. Campbell.

Major Campbell, C.B, who signed this telegram was Seignior at St. Hilaire, and a warm friend of Bishop's College up to his death in August, 1872. He was a lineal descendant of the Campbells of Inverawe, and served in several Imperial Regiments, his last I believe being the 7th Hussars. The Faculty of Medicine of Bishop's College owe to him a debt of gratitude for the active interest he took in its formation.

It was decided to send Dr. David to Lennoxville, and he accordingly left that night, to lay before the Board of Trustees a proposition for the establishment of a Medical School in Montreal, in connection with the University of Bishop's College. On the 3rd of February, Dr. David reported to the above five named gentlemen that his interview with the Board of Trustees of Bishop's College had been very satisfactory—the following resolution having been passed by them:

"That it is the unanimous opinion of the gentlemen present at this meeting . . . . that the proposal to affiliate to the University the Medical School about to be formed in Montreal, consisting of . . . . and others, is one of the highest importance to the University, and with this view the gentlemen now present will request the President of the Corporation at the earliest possible period to call a meeting of the Corporation to consider this proposal."

On the 9th of March, 1871, a special meeting of the Corporation of Bishop's College was held in the Cathedral school-house (now Synod Hall), the Hon. Edward Hale, Chancellor of the University, being in the chair. A motion accepting the offer of the proposed Medical School, and that it go into operation not later than the following October, was unanimously passed.

The following gentlemen were then appointed Professors in the Medical Faculty of Bishop's College: Charles Smallwood, M.D., LL.D., D.C.L., Professor of Midwifery; A. H. David, M.D., Edin., L.R.C.S., Edin., Professor of the Theory and Practice of Medicine; William H. Hingston,

M.D., L.R.C.S., Edin., Professor of Surgery; Francis Wayland Campbell, M.D., L.R.C.P., London, Professor of Institutes of Medicine; Edward H. Trenholme, M.D., B.C.L., Professor of Materia Medica. Dr. Smallwood was named Dean and Dr. F. W. Campbell, Registrar, at a meeting of the new Faculty held on the 14th of March at Dr. Hingston's house.

On the 18th of March at a Faculty meeting, a code of rules for its government was adopted. The only rule worthy of special mention was the following: "Should the resignation of any professor be deemed advantageous to the interest of the School, he shall, upon the written request to do so of any six of his colleagues, resign forthwith his appointment." From this date till the 7th of June, the Faculty was engaged in the work of completing its formation. On this day it struck its first shoal, by Dr. Smallwood severing his connection with it, on account of having "received an appointment from the Signal Office of the United States War Department, and also from the Hon. Minister of Marine and Fisheries," which would occupy all his spare time. The resignation was accepted and Dr. Hingston elected Dean in his place. At the annual Convocation of the University held at Lennoxville, in the latter part of June, the Faculty attended, each member receiving the degree of M.A. *honoris causa*. The end of July the Faculty issued its first annual announcements, which created no small excitement, as it had been hoped by many that the efforts which had been put forth to strangle its birth would have been successful.

The Faculty at the time stood as follows:

Wm. H. Hingston, M. D., L. R. C. S. E., D. C. L., Prof. Principles and Pratice of Surgery, Dean of the Faculty.

Aaron H. David, M. D., Edin. L. R. C. S. E., D. C. L., Prof. Theory and Pratice of Medicine.

Robert T. Godfrey, M. A., M. D., Prof. of Midwifery and Diseases of Women and Children.

Jean Lukin Leprohon, M. A., M. D., Prof. of Hygiene.

Francis W. Campbell, M. A., M. D., L. R. C. P., Lond. Prof. of Institutes of Medicine, Registrar of Faculty.

Edward H. Trenholme, M. A., M. D., B. C. L., Prof. of Materia Medica and Therapeutics.

J. Baker Edwards, M. A., Ph. D., D. C. L., Prof. of Chemistry, Practical Chemistry, and Microscopy.

Richard A. Kennedy, M. A., M. D., Prof. of Anatomy.

William Gardner, M. A., M. D., Prof. of Medical Jurisprudence.

George Wilkins, M A., M. D., Prof. of Pathology.

Silas E. Tabb, M. A., M. D., Prof. of Botany.

James Perrigo, M. A., M. D., M. R. C. S. Eng., Demonstrator of Anatomy and Curator of Museum.

The second vicissitude of the Faculty came about soon after its first announcement was issued, and was the withdrawal of Dr. Hingston (now Sir William Hingston) from the Deanship and Professorship of Surgery, this action on his part having become necessary in order to retain his connection with his Hospital (the Hotel Dieu). It appears that many years previously the medical control of this hospital was, by notarial deed, placed in the hands of the Montreal School of Medicine (at this time affiliated with Victoria College, Cobourg, Ont.). On the announcement of the Medical Faculty of Bishop's College being placed in the hands of the public, Dr. Hingston was notified by the Montreal School through its Secretary, the late Dr. Pelletier, that he must sever his connection with Bishop's College, or his connection with the Hotel Dieu would cease on a date named. The future of the new School was, of course, uncertain, and after weighing well the *pour et contre*, he determined, with deep regret, to withdraw. I need hardly say that the Faculty felt that Dr. Hingston's retirement was a severe blow. Several meetings were held, and the situation thoroughly and thoughtfully discussed. The decision was to proceed and prepare for the opening of the School in October. Dr. David was elected Dean and Dr. Godfrey was transferred to the chair of Surgery, Dr. Trenholme to that of Midwifery, and Dr. Kollmyer was taken into the School and elected Professor of Materia Medica. The future being now clear, the Faculty began to look around for a building in which to carry on its work. In this search great difficulty was experienced, as several buildings, which were

deemed suitable, were refused by their proprietors to be rented for such a purpose. At last a top flat was secured in a building on the northeast corner of McGill and Notre Dame streets, it being sub-leased from the Chemists' Association. The date for opening the school was fixed for the 4th of October, 1871, and the opening lecture to be delivered by the Dean, Dr. David. This fact was duly advertised, also that the Registration book was open. The first name entered upon it was Wolfred Nelson, a son of the late Dr. Horace Nelson, and a grandson of the late Dr. Wolfred Nelson, an ex-Mayor of Montreal and well known in Canadian political life. The opening lecture was delivered on the date named. The audience was not large, but among those present was the late Dr. William Sutherland, Professor of Chemistry in McGill University. Work was then commenced and the lectures regularly delivered, and the dissecting-room opened. Many interesting anecdotes of this first session might be given, but they would occupy too much space; one will suffice. My class for the first two weeks consisted of two students, viz., Mr. Richmond Spencer, and Mr. Robert Costigan. About the end of the second week, on arriving to deliver my lecture, I found that my class had diminished by one-half. Mr. Robert Costigan was absent. I was told he had been induced to leave and go to McGill College. Depressed by this desertion, but not discouraged, I lectured for a whole week to the remaining member of the class, when Mr. Costigan returned to his first love. He attended the College for three years, and graduated M.D. from Bishop's, April, 1874. The means used to detach Mr. Costigan were not fair. I will not say more, though the details are as clear in my mind to-day as if they had occurred but yesterday.

By the time the registration book closed in December, twenty-five students had registered their names. On the 4th of April, 1872, the first Convocation of the Faculty took place at Lennoxville, the Chancellor of the University, the late Hon. Edward Hale, conferring degrees. The entire

Faculty were present. The following are the names of the first graduating class:—

Wolfred D. E. Nelson,	Montreal, Que.
Henry S. Cunningham,	St. Catharines, Ont.
Philippe Desilets,	Three Rivers, Que.
Joseph F. A. Lanouette,	Champlain, Que.
Andre Latour,	Lachine, Que.
Richard Webber,	Richmond, Que.

The first session was considered as being more than satisfactory. As a result of this success, the idea of erecting a building for occupation by the School was mooted and seriously discussed. There were difficulties in the way—financial difficulties, of course. These were soon relieved by a generous offer on the part of Dr. Godfrey, our Professor of Surgery, to erect such a building as the School required, on the Faculty agreeing to pay interest on the cost. I need hardly say that this offer was accepted. Plans were prepared and discussed and finally adopted. That such an idea had very early in the history of the Faculty taken root, is proved by the fact that Dr. Hingston had secured for this purpose a lot of ground on the corner of Mance and Ontario Sts. This land was purchased by Dr. Godfrey, and work was commenced on the building. Although not completed, yet it was in such a forward state, that the second session opened on time within its walls, the introductory lecture being delivered by me. The session showed a registered class of thirty students being an increase of five over the previous year. This was considered a satisfactory showing, seeing that this faculty was competing for students on an advanced schedule. By this I mean that we were teaching subjects which up to that time had not been included, as distinct branches, in any Medical School in the Dominion. These were, Pathology by Dr. Wilkins, Hygiene, by Dr. Leprohon, and Practical Chemistry by Dr. J. Baker Edwards. Subsequently—within a year or two—Dr. Wilkins took up Practical Physiology and Histology. In 1877, Dr. O. C. Wood of Ottawa, through his son, Dr. C. A. Wood, a graduate of the College, offered a

Gold Medal, to be known as the "Wood Medal," to be competed for annually on the following terms:—1st, Competitors must attend at least two sessions at Bishop's College; 2nd, 75 per cent of the whole number of marks must be taken—including all subjects; 3rd, If the graduating class, at any time be less than four, the Medal may be withheld, unless the Faculty thought that the best man had shown such excellence, that he was deserving of it. Dr. O. C. Wood having died, Dr. C. A. Wood has donated the sum of $1000, which is invested to produce the Medal yearly.

In 1880, Dr. C. E. Nelson of New York founded the "Robert Nelson" Gold Medal. For this purpose he donated the sum of one thousand dollars. The Medal was in commemoration of his father, Dr. Robert Nelson, who began his medical career in Montreal, where he obtained special eminence in surgery. He subsequently removed to New York, where he died. This Medal, was donated as a special prize in Surgery, and for it there was to be a special examination, which must be written, oral, and the performance of operations on the Cadaver. To compete for this Medal, students must have attended two sessions at Bishop's, and have obtained 75 per cent of the allotted marks on all subjects. With the exception of one or two years, this medal has been awarded since its endowment, and at times the competition has been very keen and close. I believe the Faculty secured this magnificent Medal, which is of the value of $60.00, through the influence of Dr. Wolfred Nelson, who, as I have already mentioned, was our first registered student, and a member of our first graduating class. In 1882, Dr. David, who had been Dean of the Faculty since the active work of the School began, died, after a lingering illness. The loss which the Faculty sustained by his death was very great, for from its inception he had been its most zealous friend and faithful adviser. To show its appreciation of his work, the Faculty founded the "David" Scholarship, which some years later was changed to the "David" Silver Medal. This is awarded to the student obtaining the highest number of marks in the Primary Examination. The other Prizes in the Faculty are

"The Chancellor's Prize" (books), to the student who passes the best examination on the Final branches; Prize for the best examination in Histology; Prize to the best Dissector, and best examination in the practical Anatomy course (first year) and a similar Prize for the same (second year). A scholarship, consisting of a reduction of one half the fees, in all theoretical subjects of the Medical course, to the applicant showing the highest aggregate of marks, taken in the Provincial Matriculation examination. A similar scholarship to the graduate in Arts of Bishop's College who shows the highest aggregate number of marks in the Arts course. The vacant position of Dean, and the Professorship of the Theory and Practice of Medicine, was filled in 1882, by my election thereto, and which positions I still occupy. In another year the Faculty will be in the thirtieth year of its existence, and until recently the work has been performed by all as a labour of love, the various members not receiving any money reward for their labour. A surplus there has been over expenses—but this has been used in the purchase of equipment—so that the amount so expended now stands at many thousands of dollars. Within the last few years, however, it has been found advisable to obtain special workers, and we now possess two who devote their entire time to College work. These naturally are paid. At this moment the College is as fully equipped for its work as is any College in the Dominion. Our endeavour, and in this I know we are successful, is to give a thoroughly practical training. In one department, Midwifery, whose successful practice has such an important bearing on the success of a general practitioner, we possess advantages certainly not surpassed, if equalled, by any Medical College in Canada—we possess a Women's Hospital which is under the charge of our Professor of Midwifery, where the practice is so extensive as to give our graduates practical charge of as many cases as fall, as a rule, into the hands of the young practitioner during the first four or five years of his professional life. The University has graduated M. D. 222 students. Of these thirty have passed to their rest. Those who survive are in the full pursuit of their life work

in almost every quarter of the globe. More than the usual success has been obtained by many, due beyond doubt to the eminently practical training they received.

Some have risen to distinction—carving for themselves a name and a professional reputation extending far beyond the cities in which they reside, and reflecting honour on the University which is their Alma Mater. In the special field of Ophthalmology—Dr. Wood, of Chicago, stands pre-eminent among the practitioners in the United States who follow this specialty. This gentleman graduated in 1877, and practiced for at least ten years in Montreal as a general practitioner, filling during that time in Bishop's the chairs of Chemistry and Pathology. Another graduate who occupies a distinguished position in this same field is Dr. H. B. Chandler, of Boston—one of the Surgeons of the Boston Eye and Ear Hospital. I every now and then see evidence of the very excellent work he is doing. In the field of general Medicine I find Dr. Tetreault, of Orange, New Jersey, occupying the position of Medical Health Officer, and a recognized authority on Sanitary matters. In the City of New York I find Dr. Wolfred Nelson holding an enviable position as a Life Insurance Specialist. In Kingston, Jamaica, West Indies, Dr. Bronstorph, who graduated in 1884, I am informed, has risen to the position of one of the leading Surgeons, and has a reputation for Surgical knowledge, and skilful operator, which extends all over the Island. Dr. A. J. Richer, one of our graduates, and on the Faculty Staff, is rapidly coming into notice as an authority on Tuberculous diseases, and is the head of the Sanatorium at St. Agathe. In the far West, at Belt, Montana, I hear of Dr. Vidal, who graduated in 1890, being so pressed with work as to need for several years past, two assistants. Dr. Blackmeer, who graduated in 1884, is Professor of Medical Jurisprudence in the Barnes Medical College, (St. Louis), with a class of over four hundred students. In Montreal I find Dr. Maude Abbott one of our first lady graduates doing excellent work in the Pathological Laboratory of the Royal Victoria Hospital—also Drs. Jack and Foley—who graduated from Bishop's in

1889 and 1890—forging rapidly to the front as Skin Specialists. Dr. C. R. Wood (M. D. Bishop's 1891)—is in Ujjain, India, doing excellent work as a Medical Missionary. In Literature, my fellow Professor and Bishop's College graduate, Dr. W. H. Drummond, has won a place of great eminence. His book of poems, "The Habitant," is read and admired all over this Continent. These are but a few samples to show that our teaching has not been in vain.

Ever since the Faculty was organized, its members felt that a Dental Department would prove a valuable addition to the University. It was, however, not till about 1895 that the matter took shape and it was then in a measure forced upon it by the action of the Dental Board of this Province. That body had established the Dental College of the Province of Quebec, and sought affiliation with another University. As we had for years given the Medical portion of the Dental Curriculum to many students, we were forced in self defence to seek a change in the Dental Act. In this we failed before the Quebec Legislature, that is we succeeded before the Legislative Assembly—but failed before the Legislative Council. A year later the attempt was made again, and resulted in a compromise.

The Dental College became affiliated to the University of Bishop's College. The result has been excellent to both of the contracting parties. The Dental College has prospered beyond the hope of its most sanguine friends, and the Medical and Dental students fraternize in a way that is calculated to add to the prestige of the two Faculties and the University. Lectures in the Dental Department are delivered in both the English and French languages.

During the twenty-nine years of its existence the Medical Faculty has had many vicissitudes. It has had its periods of despondency and of exultation, but it has, in spite of bitter opposition, never wavered in its determination to continue the struggle till complete success rests upon its Banner. A large measure of this success has already been obtained. To the present members, and those who succeed them, remains the duty of pressing forward on

the line of their predecessors, Of the original members of the Faculty only Dr. Perrigo and myself remain—before very long we also will be gone. The hope of the school lies in its own graduates, of whom I am proud to say ten are to-day on its teaching staff. It requires Hospital facilities for its clinical teaching. Will not some man or number of men, possessed of the means, come forward in answer to the appeal which is being made for this object ? The Faculty has done, and is doing good work, and deserves recognition.

The establishment of this Faculty of Medicine and Dentistry has exerted a most beneficial effect upon the entire University. The name of Bishop's College is known to-day in every quarter of the Globe, and this is very largely due to its Medical Faculty. If the friends of the University would remember that its Faculty of Medicine is as integral a part of it as the Faculties of Arts and Divinity, it would inspire additional enthusiasm among its workers. I hope the future—the near future, will show evidence of it.

Selected Article.

FOUR CASES OF DIABETES MELLITUS OF APPARENT BACTERIAL ORIGIN, AND THEIR SUCCESSFUL TREATMENT.

By J. P. SHERIDAN, M. D., of New York City.

In the latter part of 1898 a writer in the *Medical Record* related his experience with bichloride of mercury in the treatment of diabetes mellitus, and advanced the novel theory of the bacterial origin of this affection.

At the time of publication of the article in question I had some diabetics under treatment. As a moderately rigid antidiabetic diet and the time-honored remedies did not check the glycosuria in my patients, I adopted the newly proffered theory and eagerly prescribed the advocated chemical.

To-day, after a year's trial of germicidal remedies in diabetes, I have become a firm believer in the bacterial origin of diabetes. It is true, the bichloride of mercury did

not prove a success in my hands, but this only tends to demonstrate the existence of a peculiar diabetic toxine, which has to combated by other means. This toxine, in my opinion, is particulary apt to attack the nervous matter, which in turn gives rise to the well-known disturbance of metabolism in diabetes—namely, preventing the deposition of glycogen in the liver and muscles and causing its discharge by the kidneys in the form of grape sugar. The irritation of the vaso-motor centers, to which may be attributed all the symptoms of diabetes, seems to be caused by this toxine. It is plainly the physcian'y duty to eliminate the toxic influences, for he thereby relieves the irritation of the nervous centers. However, he must be most careful in the selection of the proper remedy and in the administration of its indicated dose. The failures in diabetic therapy have to be ascribed either to a wrong medicine or its improper administration, or to both. The ideal autidiabetic drug should not only exert distinct germicidal and antiseptic powers, but should be a powerful alterative. At the same time, the system should not become weakened and emaciated by its prolonged administration. On the contrary, the ideal diabetic remedy should afford great tonic properties.

Bichloride of mercury and auri et sodii chloridum, which latter is so much lauded of late by a Chicago physician, possess some of these desiderata, bur neither proved of any success in my hands in the treatment of diabetes mellitus. This non-success is due to three factors :

(*a*) The specific toxine of diabetes is affected only by a specific antiseptic.

(*b*) Bichloride of mercury or auri et sodii chloridum, when pushed to their physiological tolerance, do not effect the decline of the glycosuria.

(*c*) Bichloride of mercury, as well as chloride of gold and sodium, when administered for any length of time and in larger doses, reduce the oxidizing power of the red blood cells, thereby weakening the system and producing rapid emaciation.

The remedy answering all the demands for an ideal antidiabetic I find in a combination of bromide of gold with bromide of arsenic, called by its makers " arsenauro." This preparation undoubtedly exerts a specific influence upon the bacteria and the toxine of diabetes mellitus, which is elucidated by the following four cases :

CASE I.—Mr. C. L., aged fifty, American, clerk, consulted me on June 8, 1898. Family history was negative.

Patient complained of polyuria, the existence of which dated back about three months. The frequency in urination he thought to be due to a stricture, the possible result of a neglected gonorrhœa. Patient had a moderate appetite, felt quite thirsty at times, and had lost some weight. The urine (which was voided to the amount of about seven pints daily), on June 10, 1898, showed a specific gravity of 1038, and contained 7.1 per cent. of sugar, as ascertained by means of Stern's urinoglucosometer. A restricted diet and the administration of codeine caused only a moderate improvement of the symptoms. Bichloride of murcury. which was given for the last three weeks of December, 1898, in the doses recommended, not only produced no beneficial influence whatsoever upon the diabetic condition, but actually aggravated the condition of the patient. Early in July, 1898, my attention was drawn to the chloride of gold and sodium which was handed to the patient in tablet form and administered first in doses of a fiftieth of a grain. The dose was gradually increased to a twentieth of a grain. After five weeks' trial of this drug it had to be abandoned, as the condition of the patient had become alarming in the meantime.

At about this period I ran across an article in the *New York Medical Journal* regarding the use of arsenauro in diabetes, and determined to test this product, having previously used it with satisfactory results in malarial toxæmia.

On February 7, 1899, eight drops of arsenauro were given in half a glass of water three times daily. The restricted diet was ordered to be continued. Patient reported to me in one week. The glycosuria and polyuria were greatly diminished. The feeling of thirst was not experienced any longer, and he expressed himself as feeling perfectly well. The dose of arsenauro was gradually increased until he reached his full limit of toleration, which supervened at fifty drops. The quantity was lessened to forty-five drops, and continued in this dose for sixteen weeks. After this period I examined the urine, which revealed a specific gravity of 1.020 and was absolutely free of sugar. Patient was discharged as cured, with the instruction to continue the arsenauro for at least six months.

CASE 2.—M. H., a woman, aged thirty-four, American, unmarried, came to consult me September 11, 1898. In July previous, during the hot spell, she perspired greatly and suffered from excessive thirst. Her weight, which normally was a hundred and sixty-five pounds, had diminished to a

hundred and thirty-five pounds. Frequent micturition was distressing her greatly. Appetite was voracious for some time, and her strength graduelly declined. When first seen by me the daily quantity of her urine amounted to eight pints. Specific gravity, 1.046; sugar, 7,538 grains a day. She complained of incessant thirst, inordinate appetite, pain in back, and extreme feebleness. She was put on a restricted diet on September 20th, but no medication given her. Patient improved somewhat, but not sufficiently. In December, 1898, bichloride of mercury was given and the same diet continued, without effecting any noticeable change in the patient's condition. In February, 1899, she was put on arsenauro, and the same diet still continued. The medicine was started in eight-drop doses three times daily, to be taken in a glassful of Vichy water. Ten days after, great improvement had taken place. The urine became reduced to forty-nine ounces, specific gravity 1.028, and the sugar output to two hundred and ten grains for the twenty-four hours. After this the dose of arsenauro was gradually increased until the patient reached her full physiological limit; this took place at forty-drop doses—that is, after the administration of two drachms a day. Patient was instructed to occasionally discontinue the administration of the remedy for twenty-four hours, and then to start again on thirty-five drops.

This latter dose was taken for some months, with the result of rendering the urine entirely free of sugar, She was advised to continue with the medicine for at least six months longer. I examined her urine of late and found it absolutely normal and free of sugar.

CASE 3.—H. E. B., a man, aged thirty-seven, American, railroad conductor, consulted me in March, 1899, on account of an irritable bladder. Patient was compelled to urinate quite frequently during the day as well as during the night. His other symptoms left no doubt as to his real affection—diabetes mellitus. The disease, so far as I could ascertain, dated back for about a year, and seemed to be devoid of further complications. The quantity of urine voided varied from twelve to fifteen pints a day, with an average specific gravity of 1.042. Sugar average four thousand grains for the twenty-four hours. The treatment consisted in restriction of diet and the administration of arsenauro, ten drops of which were ordered to be taken in half a goblet of water three times a day. This dose was gradually increased until patient took sixty drops three times daily. When this quantity, three drachms, was taken every day, the patient's lids began to puff and his bowels became loose and caused

griping. The medicine was discontinued for twenty-four hours, but again ordered to be taken in fifty-five drop doses. Patient had taken the fifty-five-drop doses for eight weeks, when I again examined his urine, which contained only a trace of sugar. One month later he was perfectly well, and all vesical irritation had disappeared—in fact, I pronounced him well. I advised patient to report to me from time to time, but to continue tke arsenauro for at last six months.

CASE 4.—B. R., aged forty-seven, a woman, unmarried, American, milliner, thin and emaciated, able to attend to her business, consulted me April 22, 1899. Patient complained of great weakness, which had gradually increased for several months. She had excessive thirst and had voided a greatly increased quantity of urine, but her appetite was moderate. Her skin was dry, and she complained of intense pains in the calves of her legs, especially in the morning. There was distressing pruritus vulvæ present. The specimen of urine sent to me for examination presented a specific gravity of 1.045, and contained 8.1 per cent. of sugar I restricted the patient's diet as to starches and sugar, and placed her at once on ten-drop doses of arsenauro, to be taken in a half tumblerful of water three times daily. After one week the dose of arsenauro was increased three drops every day until she reached its toleration. Physiological saturation was obtained when forty-five drops were taken three times a day. The administration of the remedy was then stopped (as I am in the habit of doing) for twenty-four hours, after the lapse of which it was again ordered to be taken in forty-drop doses. This dose was kept up for six weeks. On July 3d she had gained seven pounds in weight; urinallysis demonstrated entire absence of sugar; the pruritus had entirely disappeared, and there were no evidences whatsoever of symptoms pertaining to diabetes mellitus. Patient was advised to continue the medication for at least another six months.

The four cases which so readily yielded to this antioxic treatment were apparently of bacterial origin. Arsenauro, by saturating the system arrested bacterial activity, or killd the germs, or neutralized their toxines. However, only by saturation with the proper medicine—and, by the way, arsenauro is the only powerful alterative neutralizer which which can be pushed to an almost incredible dose without doing bodily harm—can such results as are recorded in the foregoing be obtained.—*Interstate Medical Journal.*

Progress of Medical Science.

MEDICINE AND NEUROLOGY.

IN CHARGE OF

J. BRADFORD McCONNELL, M.D.

Associate Professor of Medicine and Neurology, and Professor of Clinical Medicine University of Bishop's College; Physician Western Hospital.

RICKETS—THE TREATMENT OF.

For patients in the first few years of life, from 1½ to 5 years, my plan of campaign is practically the same for all. For those with heavy bodies and heads, protuberant bellies, head sweats, and commencing or acquired bow-legs or knock-knees, the food supply is carefully attended to, the digestive functions restored as soon as possible, starchy food being limited, fats being recommended, especially bacon fat and dripping, which I believe has for these cases a high nutritive value. For very young children especially the addition of some cream to the dietary is most valuable. Condensed milk, if it be taken, should be replaced by cow's milk boiled, and a weak gravy soup or broth will often help to stop the rickety tendency. For marasmic patients nothing acts so well as a daily rubbing under each axilla of cod liver oil. For all these rachitic patients, then, varying the dose slightly according to age, I prescribed cod liver oil and syrup of the phosphates of iron. In very hot weather I let the children leave off the oil, but the mixture generally is very well taken, and the results are most satisfactory. In cases with any tuberculous or syphilitic history, the syrup of the iodide of iron should be substituted for that of the phosphates. Next as to the treatment of the rickety deformities, especially of the leg bones. In the case of patients under the age of 4 years, even with very marked bowed and bent tibiæ, and some degree of knock-knee, I can assure the parents with great confidence that after nine months' to fifteen months' treatment these deformities will be very greatly improved or altogether remedied. I am prepared to leave any question of operation to a later age—say that of 5 or 6 years. By that time we can see whether ordinary treatment has been able to effect anything, the bones have got harder, and there is less risk of producing the calamitous condition of pseudarthrosis. These children's legs should be put up in

splints, preferably outside ones, which may purposely be made three or four inches too long. The splints should be taken off once every month or three weeks in the winter and once a fortnight in the summer. I do not deny that a rickety child's legs occasionally becomes much straighter with no treatment whatever. Still I feel sure that the great mass of these rickety children are far better when off their feet—for this reason, that the deformity of the pelvis is so much less apt to occur, as little or no pressure is acting upwards through the acetabula while the child is lying down or even sitting up.—From Dr. E. Mansel Sympson's article in *Pediatrics*, October 15, 1899.

TYPHOID FEVER, DIET IN.

Dr. E. J. Abbott (*Northwestern Lancet*, August 15, 1899) says that it has been his practice for years to allow his typhoid patients what is termed "soft diet" instead of milk diet, namely, a diet consisting of milk if it is agreeable, buttermilk, all kinds of soups and broths, eggs, raw or soft, or the yolk, if they like, of hard-boiled eggs. By hard-boiled eggs he does not mean an egg that is boiled four or five minutes, just sufficient to coagulate the albumen, but an egg that is cooked from one-half to three-quarters of an hour. The yolk of an egg in this condition is easily digested and is nutritious. He also permits custards, rice, farina, junket, tea, coffee, chocolate, cocoa, ice cream, and particularly milk and cream-toast and all foods of that class. The writer says he has never yet had cause to regret feeding his patients in this way, and is convinced that this diet leaves less waste of indigestible material as a possible irritant to the ulcerated surface than does an exclusive milk diet. The writer also advises the lengthening out of the intervals of feeding from two to three or four hours, perhaps even longer, and thinks that by doing this his patients relish their food more than before, and that they will digest it better and will recover from the fever stronger and in better condition than they would otherwise.—*Medical Age*, October 10, 1899.

CONVULSIONS IN CHILDREN.

Drs. Gossage and Coutts make the following remarks in their paper: All that is necessary during an actual attack of convulsions in most cases is to loosen the clothing about the neck, chest and abdomen, and to lay the child on its

back with the head slightly raised until it recovers consciousness from the fit and the subsequent drowsiness. The placing of the child in a hot bath, as is such a common practice, probably does no harm, and if the child be in feeble health it may be advantageous to use a mustard bath, which has decided stimulating properties. Cases, however, where the unconsciousness is unduly profound and prolonged, and especially if with this further fits are associated, require more active measures. Chloroform inhalation is the most efficacious of these, and profound unconsciousness is no bar to its employment, recovery from the anæsthetic being usually accompanied by regain of consciousness. The inhalation of chloroform may be replaced, or in severe cases followed by the rectal injection of chloral in doses of 3 gr. to an infant of six months, to which 2 to 3 gr. of potassium bromide can be added if desired. Some authorities have recommended the inhalation of nitrite of amyl in 1-minim doses, and Eustace Smith praises the hypodermic injection of morphine in doses of $\frac{1}{24}$ gr. to an infant of six months, and says that it can be repeated, if necessary, in the course of half an hour. Any local irritation which may be regarded as an exciting cause of the fit calls for appropriate treatment.—*British Medical Journal*, August 19, 1899.

EPILEPSY—BROMIDE OF CAMPHOR IN.

Hasle (*Thèse de Paris*, 1899), after carefully selecting a number of cases of epilepsy from the abundant material at Bicêtre, obtained the following very constant results: (1) As regards epilepsy proper (*haut mal*), the action of bromide of camphor was doubtful, and was less effectual than the mixed bromides of potassium and sodium and ammonium. (2) In attacks of *petit mal*, and in all cases of epileptic vertigo, however, its effect was incontestable; it at first diminished the frequency of the vertiginous attack, and finally made them disappear altogether. The condition to be observed in prescribing was to begin with moderate doses, made gradually progressive, and lasting for a sufficient time. Owing to its disagreeable odour it is best taken in capsules of 20 centigrammes, or dragees of 10 centigrammes, beginning with two capsules per diem, and augmenting by two capsules the second week, etc., till eight capsules per diem are taken, then as gradually diminishing the dose till two capsules per diem are reached and maintained for some time.—From abstract in *Epitome, British Medical Journal*, August, 5, 1899.

DIARRHŒA, CHRONIC INFANTILE.

Irrigation of the large bowel, carefully and thoroughly carried out each day with a fountain syringe and No. 12 catheter (not too flexible) is of decided benefit. A gallon of fluid should be employed for each irrigation, the liquid being at 98° to 100° F. Saline solution, boric acid solution, or nitrate of silver, 7½ grains to the gallon, have all in my hands been most useful. The child lies with the hips elevated; the catheter, well oiled, is allowed to gently pass six or eight inches up the bowel, the liquid being allowed to flow gently during its introduction, and the reservoir not raised more than three feet above the child's body.—From Dr. A. Jacobi's paper in *The Therapeutic Gazette*, August 15, 1899.

THE TREATMENT OF SCARLET FEVER.

This subject was discussed at some length in the section of Diseases of Children at the annual meeting of the American Medical Association (reported in the Philadelphia *Medical Journal*, July 1), and Dr. R. A. Birdwood, Medical Superintendent of the Park Hospital, Lewisham, has stated his experience in the *Hospital*, April 15, 1899. In an ordinary mild uncomplicated attack of scarlet-fever Birdwood keeps the child in bed for three weeks on a low diet with stewed fruit till three days after the temperature has fallen to normal. The bowels are opened daily, and the urine tested for albumin on alternate days. The reason for so long a stay in bed is that if nephritis supervenes it usually does so about the end of the third week, and the maintenance of the regular action of the bowels seems to have a marked and beneficial effect in preventing œdematous swellings of the legs. They are also detained in bed whilst albuminuria or dilated heart persists, and when in bed are blanket-bathed daily. It is not prudent to use the bath during this time, as faintness or a bad colour comes on occasionally. During convalescence, if all goes well, a warm soap and water bath is given three times weekly. As a rule, this is sufficient treatment for desquamation. A. Gilbert recommends anointing the skin with lard, vaseline or lanolin. If desquamation continues, a weak acid solution, such as an ounce of dilute acetic acid to half a pint of water, applied to the soles or palms on lint for a quarter of an hour, or else rubbing with glycerine and borax, does much to remove adherent epithelium. Desquamation may go on for three or

four months, or even longer, and it is quite common for it to come on twice and sometimes three times.

High Temperature.—B. Gilbert objects to the use of coal-tar antipyretics, and to the full bath unless the fever is very high and there is very active delirium. The nervous excitement can best be allayed by chloral hydrate. Slagle and Ewing agree in objecting to antipyretic drugs, but advocate the free use of cold water for drinks, enemas and packs. By drinking water freely they contend that the toxins are eliminated. Quayle prescribes lithia water and Ewing prescribes potassium acetate in addition. Garrison has used acetanilid for eight years, and finds it useful; it promotes a feeling of well-being, and if combined with soda bicarbonate does not diminish the renal secretion. Garrison does not hesitate to employ antipyrin if the pulse denotes high arterial tension, and has given it to young infants in doses of a quarter of a grain. Birdwood finds that the high temperature of scarlet fever is well controlled by sponging with tepid water, and the patient generally feels better after it is done. It is good practice to sponge whenever the four-hourly temperature exceeds 39° C. Hyperpyrexia of scarlet fever is not controlled by baths or drugs; the former may be frequeutly repeated, but the temperature rises again, and the patient becomes rapidly worse. Now and again a patient recovers after a temperature of 41° C., and this encourages one to keep on with tepid sponging. An undoubtedly good effect is sometimes observed in the reduction of temperature on removal of blankets, and leaving the patient covered with a sheet only. If either sponging or removal of blankets induces shivering or a feeling of coldness, or actual coldness of the extremities, it should be discontinued, and warm water bottles should be used. A thirsty fever patient should be given plenty of drink, and it is well to remember that there is sometimes a repugnance to milk. Water relieves thirst best, and should be given. Grape or orange juice is generally liked, and does good. Barley water is a suitable drink.

Sore Throat.—A chlorine gargle is used at the Park Hospital (chlorate of potash, ʒiss.; hydrochloric acid, ʒvj., with five pints of water added after the evolution of the gas) when an acid preparation is desired, or Liq. sodæ chlorinatæ 1 in 15 of water when an alkaline. Equal parts of either of these chlorine solutions and warm water are mixed just before use. If the patient is not old enough to gargle, a ball syringe with a long nozzle attached is used for flushing

out the fauces. Two 4 oz. syringefuls are enough. Should the patient resist the attempt to pass the nozzle between the teeth, there is no occasion to use force to do so. The fauces can be well washed by passing the nozzle between the cheek and the teeth, so that its point goes just beyond the last molar tooth. This should be done first on one side, then on the other. The patient should be held with the face downwards. The practice of gargling the throat is far better than swabbing, for the tissues are often soft enough to be damaged by the latter proceeding.

Nose and Ear Discharges.—A solution of boric acid (ʒii. to 5 pints) is used by Birdwood; before use it is mixed with an equal quantity of warm water.

Nephritis.—Birdwood usually orders loin poultices or fomentations. In some instances the drawing of a few ounces of blood has been followed by a flow of urine; in others, no such result has ensued. Seidlitz powders or compound liquorice powder should be given, not calomel. Solomon prescribes cascara and sodium phosphate, and also a decoction of scoparius (ʒi. to Oi) to relieve the kidney congestion.

Joint and Muscle Pains.—Solomon has found acetanilid useful in relieving the severe headache and pains in joints, but where muscular pain was complained of he gave phenacetin instead. Birdwood employs salicylate of soda.—Dr. Francis J. Allan's abstract in *Treatment*, September 14, 1899

HABITUAL CONSTIPATION.

The treatment detailed is intended for habitual constipation. For the immediate unloading of the bowel one of the simplest and least harmful methods is the giving of one or more enemata of warm water, containing salt in the proportiou of a teaspoonful to a pint. Soapy water may be used instead, if something stronger is needed. The amount to be injected varies with the age. For youug babies, one or two ounces in sufficient, and for those of two years, two or three times this amount. Either the hard-rubber syringe or the infant's syringe may be used. A useful injection consists of half a teaspoonful of glycerin in full strength. This is best given from a small hard-rubber syringe holding not more than half an ounce. The opening in the nozzle should be larger than ordinary, as the glycerin does not flow readily. If the mass in the bowel is large and hard, an injection of warm sweet-oil, retained some hours if possible, is better than any-

thing else. It should be followed by an enema of soapy water. In some cases it is necessary to insert the finger or a small spoon-handle into the bowel and break up the masses carefully.

Glycerin suppositories—glycerin and soap—of a size for children are often excellent for opening the bowel. Gluten suppositories are also serviceable in many instances. A more economical plan is to employ little home made suppositories of castile soap, or, in place of these, a soap stick which can also be made at home, and which has the value of lasting for repeated usings. It consits of a smooth conical stick of firm castile soap two or more inches long, half an inch thick at the base, and tapering toward the other end to the thinness of about one-quarter of an inch. It should be greased with vaselin before using, inserted part way into the bowel and held there until a tendency to an evacuation shows itself.

If none of the methods described is effectual, laxative drugs must be employed. Their use, however, ought to be deferred as long as possible, and is much better left to a physician. Probably the best and least harmful of drugs is cascara in some form. There is made a cascara cordial which has a pleasant taste and is very effectual. Another very useful preparation is the syrup of senna, which is easily taken by children, as its taste is agreeable. Little sugar coated pills, each containing one-tenth grain or less of aloin are sometimes of service, one being given daily to a child of two years. A small quantity of manna, about five grains, can be given to a baby of six months once a day or oftener, dissolved in the milk, as its taste is sweet, or ten grains of phosphate of soda may be used in a similar manner, Magnesia or spiced syrup of rhubarb answers very well, but only for occasional use.—*Jour. A. M. A.*

CARE OF THE MOUTH.

Perhaps no part of the body is so often neglected as the mouth; especially is this noticeable in the case of children. A mother who will religiously bathe her ehild and keep its body sweet and clean will often fail to cleans its mouth. A new-born infant should have its mouth washed after each feeding; a soft cloth wet in a weak solution of boracic acid should be used for this purpose. If this were always done we would rarely find a case of infantile sore mouth.

After the teeth come and the mouth is large enough, a small, soft brush should be used; the teeth and mouth should be thoroughly cleaned at least twice daily.

In illness where sordes and mucus accumulate rapidly, and where the tongue and lips are parched and stiff, attention is needed every hour; the mouth should be kept moist and the same treatment carried out through the night as during the day. Boracic acid solution, listerine, lemon juice, glycerine and distilled water are all refreshing, and soften the tissues; where the lips are chapped or fissures appear, a lubricant of cold cream or sterilized vaseline should he applied. Where the gums are spongy or soft; and bleed readily, a few drops of tincture of myrrh added to pure water will help to harden them. Small squares of old linen or soft gauze should be used instead of a brush where one is ill or week. These should be immediately burned after use.

Every part of the mouth should be cleansed; behind the wisdom teeth, the roof of the mouth and under the tongue; lemon juce and water will remove the fur from a thickly coated tongue. Where the teeth are sensitive the water used should be slightly warm.—*South Cal. Practitioner.*

ATROPINE IN DELIRIUM TREMENS.

Touvine (*Archives Medicales Belgiques*) administers atropine to his alcoholic patients in one sixtieth grain doses hypodermatically. The result is to quiet them, and to put them to sleep in a few minutes. It is believed that the prompt action of the atropine is due to its stimulating effects on certain centers of the brain, thus inducing the quiet and sleep.—*American Practitioner and News.*

THE TREATMENT OF HICCOUGH.

M. J. Noir records the case of a girl, six years and a half of age, who suffered from persistent attacks of hiccough. M. Noir, on seeing her in one access, which had continued for six hours and a half, drew out the tongue and held it protruded for the space of a minute and a half, which calmed the spasms as if by enchantment. They did not reappear. This procedure is not altogether new, but is not, we think, sufficiently appreciated.—*Progres Medical.*

SURGERY.

IN CHARGE OF

ROLLO CAMPBELL, M.D.,

Lecturer on Surgery, University of Bishop's College; Assistant-Surgeon, Western Hospital;

AND

GEORGE FISK, M.D.

Instructor in Surgery, University of Bishop's College; Assistant-Surgeon, Western Hospital.

AN IMPROVED METHOD OF ABDOMINAL INCISION.

George R. Fowler, in the *Medical News* of March 3, 1900, says that two cardinal points must be borne in mind in making the incision through the abdominal wall. It should be so made that all parts involved in the intended operation are readily within reach. Weakening of the wall of the abdomen should be avoided by carrying the incision, whenever practicable, in the direction of the fibers so as to avoid cross-sectioning the muscular and fibrous structures. The incision in all cases of appendicitis should be so planned as to admit of removal of the appendix. In his experience access to the base of this organ is secured in the largest number of cases through an incision so planned that its center strikes a point corresponding to the intersection of a line extending from one anterior superior spinous process of the ilium to the other, with a vertical line drawn half-way between the median line and the right anterior superior spine. This differs from Clado's point.

The skin incision commences at the upper rounded prominence of the anterior superior spinous process of the ilium, is carried almost horizontally to the outer edge of the rectus abdominis muscle, from which point it is curved downward and extended parallel with the edge of the rectus for a distance of two and a half inches, or more, as required by the exigencies of the case. The skin, fat and fascia are divided, and the triangular-shaped flap with rounded corner dissected and reflected downward and outward, exposing the aponeurosis of the external oblique.

A retractor is applied at the lower angle of the wound and another at the middle of the horizontal incision. Traction upon these in the direction of the course taken by the

external oblique exposes the latter for a distance of three or more inches, if necessary. This structure is divided in the direction of its fibers to the extent of its exposed portion, two more retractors applied, and the sheath of the rectus exposed and likewise opened. The rectus muscle and the underlying deep epigastric artery and veins are now retracted toward the median line, the outer edge of the incised aponeurosis being retracted in the opposite direction. A space of four inches in its transverse diameter is thus exposed.

With the rectus well displaced toward the median line, care being taken to retract the deep epigastric artery and veins as well, and the outer edge of the incised external oblique aponeurosis retracted in an outward direction, the following parts are exposed: In the outer two-thirds of the space between the retractors is to be seen the muscular portion of the internal oblique, this terminating in the aponeurotic portion of this muscle at the point where the aponeurosis divides to enclose the rectus (the linea semilunaris). The inner third includes that portion of the exposed space left by the inward displacement of the rectus muscle, and is occupied by the posterior lamella of the sheath of the latter. In this space the transverse incision is to be made. For this operation the remaining structures of the abdominal wall may be considered as one layer, and the transverse incision carried directly through these in the direction of the fibers of the internal oblique and transversalis into the peritoneal cavity. The incision is commenced at the inner end of the space beneath the rectus muscle and access gained to the cavity of the peritoneum at this point first; after which, with the finger as a guide, the section is completed. Retraction of the edges of the transverse incision will be found to give ready access to the region of the cæcum.

At the completion of the operation the parts are to be replaced and sutured. The transverse incision is closed by running a catgut suture including all of its layers. In closing the incision in the external oblique aponeurosis, care must be taken to include in the suture the incised edge of the sheath of the rectus muscle. The muscular structure itself should not be included in the suture, since the interposition of this between the incised edges of the sheath which may follow the attempts to include the muscle will prevent the prompt union of the aponeurosis.

In view of the supreme importance of securing immediate firm and permanent union of the aponeurosis of the external oblique, it is best to employ kangaroo tendon for the

suture material in the case of this structure at least. Finally, the skin wound is to be close. This may be done by the ordinary interrupted suture, although this, as all skin incisions, is best closed by the subcuticular suture.—*Medicine*.

A NEW METHOD OF DILATING A STRICTURE OF THE ESOPHAGUS.

J. S. Pyle, in the *Philadelphia Medical Journal* of Feb. 3, 1900, describes a rare case of stricture of the esophagus following typhoid fever. In Keen's work on the surgical complications of typhoid two cases are mentioned, and Osler has described a case. While this complication is rare, the real interest of Pyle's communication relates to his novel method of treating the stricture. The difficulty of swallowing precluded the taking of solid food, and as time progressed the ingestion of liquids was attended with great difficulty. The stricture was situated at the esophageal opening of the diaphragm, and it could not be enlarged by the use of probangs or dilators. He was able to pass a small bougie, and later devised a small instrument somewhat after the plan of a Barnes dilator. Between two layers of fine rubber tissue a silk bag is placed, the whole being, when dilated to the full extent of the silk, about the size of the little finger. This was mounted upon a small rubber tube and carried with the aid of a small wire through the stricture. With a suitable pump the apparatus was filled with water and the stricture successfully dilated. This was accomplished with very little discomfort to the patient and the complete relief of the stricture.—*Medicine*.

THE TREATMENT OF EPIDIDYMITIS.

H. M. Christian, in the *Therapeutic Gazette* of March 15, 1900, says that for the last few months applications of guaiacol have been adopted as a routine practice at the University and Polyclinic Hospital of Philadelphia. Since this form of treatment was instituted, about sixty cases of epididymitis have been treated. These were all acute walking cases. In all but six great relief from pain followed during the course of the first twenty-four hours after application. All were able to keep on their feet through the whole of the attack, with little discomfort. The application of the drug was followed in all cases by a smarting and tingling sensation in the skin, lasting for about an hour.

In all cases the testicle was first gently massaged with

a 20-per cent guaiacol ointment made up with lanolin. Some of the ointment was then spread upon lint and applied to the part, the whole being enveloped in a layer of absorbent cotton, over which was applied a snugly fitting laced suspensory bandage. The dressing was reapplied every second day. At the end of about six days after the inflammation and pain had ceased, the guaiacol was substituted by an ointment composed of

℞ Unguentum hydrarg.....
Unguentum belladonnæ.....
Ichthyol.....
Lanolin.....ãã ʒ ij.

It was found that this application produced a prompt lessening of the inflammation and a rapid return to the normal size.—*Medicine.*

TREATMENT OF AORTIC ANEURISM.

Moritz Schmidt, in the *Medical Chronicle* for March, 1900, discusses the early diagnosis and treatment of aortic aneurism. During the past eleven years he has seen fifty-four cases. Of these thirty-eight had paralysis of the left recurrent laryngeal nerve. Tracheal tugging was present in nineteen of thirty-one cases. He regards this as one of the most decisive symptoms in the early stage of the disease. A less definite indication is a murmur. This may be due to tumors of the mediastinum and is frequently absent in aneurism. He prefers iodide of potassium and strict rest in the treatment of aneurism. In addition Tufnell's limited diet is employed, which includes a marked reduction in the amount of fluid allowed the patient. A lessening of the fluid to 1200 grammes is not difficult, but a further reduction is often followed by distress and must be gradually employed. In one of his cured cases the amount of fluid was reduced to 340 grammes; this was followed by a nervous condition which compelled the raising of the amount of fluid to between 500 and 600 grammes. His paper is illustrated with radiographs. He comes to the conclusion that the treatment of aortic aneurism should be undertaken early, and the condition should be regarded as a curable one, and a rigid system of dietetics and medicinal measures instituted. If these are undertaken with confidence, he thinks that the results in the treatmen of this condition will be greatly improved.—*Medicine.*

SUPRARENAL EXTRACT IN THE URETHRA.

In a discussion before the New York County Medical Society (*Medical News*, March 24, 1900), J. A. Moore stated that he had used suprarenal extract more than two hundred times in the urethra. He has found instrumentation possible without bleeding, and with the production of very little irritation if the extract has been previously used. This should consist of a 10-per-cent infiltrate solution, which may be injected without causing the slightest irritation, and is followed by a decrease in the irritability in the pathogenic structures. When a structure is to be stretched, it lessens the congestion, increases the caliber of the urethra, and prevents bleeding. The effect of suprarenal extract is evanescent, and if two or more sounds are to be passed it is necessary to employ a second injection. There is no danger of constitutional symptoms, nor has the extract any action on the urethra. In six meatotomies he used a 12-per-cent solution injection hypodermically and had very little bleeding after the operation. In gonorrhea the injection of suprarenal extract in two cases gave complete relief from the smarting, and there was no pain in urination during the acute stage.—*Medicine.*

To avoid the harmful effects of the X-ray from either a static machine or a coil as an exciter one should never have the tube near the patient; it should be two or three feet feet away when using the fluorescent screen, and should be three feet or more from the plate when taking x-ray photographs. Between the patient and the Crookes tube there should always be placed a thin screen of aluminum, which should be grounded by connecting it to the gas-pipe with a proper wire.—F. H. WILLIAMS.—*N. Y. Med Rec.*

SEQUELÆ TO HERNIOTOMY.

(1) The wound may not unite by first intention, and if the sac has been very adherent the disturbance of the cellular tissue may cause some sloughing. In such cases the wound should be reopened and stuffed with iodoform gauze. (2) Diffuse general peritonitis may set in; this is known by the persistence of the vomiting, the continuance of the pain, distention, and tenderness of the abdomen, with elevation of temperature. This may be due to leakage from a perforation, to a gangrenous condition of the gut, or to the introduction of septic matter from without at the time of operation, as in

any other abdominal section. Immediate laparotomy should be done. (3) The reduced gut, which has been returned as uspicious, may become gangrenous and obstruction of the bowel may still continue. If this condition be suspected, the abdomen should be opened and the gangrenous bowel sought for, and either resected or incised, and kept outside the abdomen with the object of forming an artificial anus. (4) The bowel may not be gangrenous, yet be so injured that it may not be able to resume its proper functions, and the patient may die in consequence if not relieved by a laparotomy. (5) The bowel may be temporarily paralyzed by local inflammation so as not to be able immediately to resume its functions, though after some days it may recover completely its normal condition. In such cases there is obstinate constipation, without vomiting or other signs of peritonitis. (6) Cases of acute mania have followed the operation for strangulated hernia, some of which have proved fatal.—SHEPHERD, "American Text-Book of Surgery."—*N. Y. Med. Rec.*

SURGICAL HINTS.

NEVER USE MORPHINE BEFORE ANÆSTHESIA in patients who are in a state of stupor or traumatic shock. In these the drug has a distinct tendency to increase these conditions.—NEVER HAVE ANY MORE ASSISTANTS at an operation than are absolutely necessary. They are apt to get into each other's way, and the more people help you, the greater the difficulty of securing asepsis.—EXCEPTING IN EMERGENCY CASES, every patient about to be operated on is entitled to as careful an examination as if he were applying for life insurance, and to treatment before the operation for any complicating condition.—THERE ARE CERTAIN PATIENTS in whom it is very desirable that they shall make no violent movements while they are being anæsthetized, as for instance in certain fractures. In these cases a full dose of morphine an hour before the anæsthesia will contribute a great deal to secure a quiet etherization.—WHEN USING COCAINE hypodermically, it is seldom necessary to use a solution stronger than one per cent., and then always have the patient in a recumbent position. The danger of cocaine lies in the possibility of syncope from failure of the heart's action, and lying down is the best preventive.—WHEN OPERATING, never put too many instruments in one tray, as it becomes more difficult to find just what you want. It is best to have several small trays, and to put the cutting

instruments in one, the artery forceps in another, and the special instruments required in the particular operation you are doing in a third.—DURING THE REMOVAL OF TUMORS having many attachments, it is a good principle to free first all the points that are easily detached, and to pediculate the tumor, as it were, where it is most difficult to free it. This will usually result in the largest vessels being included in the pedicle, so that with your ligature or clamp you may safely secure the most dangerous region, and cut above it without danger.—IN OLD OVARIAN LESIONS, it is often a fact that the patients show a decided insufficiency in the secretion of urea. It is well to subject such patients to preliminary treatment for this condition, for two reasons: The first is that if the proper treatment increases the excretion of urea the patient will have a better chance of recovering from the operation, and the second is that if the patient's urine shows no improvement, the prognosis is rendered more serious, and forewarned is forearmed.—*International Journal of Surgery, N. Y. Med. Record.*

CURLED HORSEHAIR IN PLACE OF A SCRUBBING-BRUSH.

W. S. Forbes, in the *Penn. Med. Jour.*, says that ordinary curled hair forms one of the best mechanical devices for cleansing the skin that has yet been discovered. In its preparation about three drachms of curled hair is employed, and this is easily shaped by the hands into a loose pad about the size of the hand. When desired, the flattened mass may be held together by stitching with sterilized silk, cat gut or other aseptic material, but this is opitional. When once fashioned, it will hold its shape without change. It can not cut or tear the skin, and it is easily cleansed with boiling water before and after each surgical operation. A solution of bichloride of mercury, one to one hundred, and steam to 100° do not act upon it. It may be kept in alcohol after being sterilized, and is thus always ready for use. It is cheap and efficient, and is far superior to the scrubbing-brush of tainted memory.

OBSTETRICS.

IN CHARGE OF

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Professor of Obstetrics, University of Bishop's College; Physician Accoucheur Women's Hospital; Physician to the Western Hospital.

TREATMENT OF ACUTE PUERPERAL SEPSIS.

H. N. Vineberg brings out the following points in a paper on puerperal sepsis.

1. Puerperal sepsis is wound fever or wound infection, and wound infection in the female genital canal, as elsewhere, calls for surgical measures, such as free drainage, irrigation, and the removal with a sharp instrument of any débris or exudate that may form on the surface of the wound. These means failing to accomplish the desired result, perform ablation of the diseased organ.

2. In a given case of puerperal sepsis a thorough search is to be made of the whole of the genital canal, in order to determine the site of the original infection.

3. If this is situated in the uterus, curettage, drainage, and irrigation are to be employed. In 95 per cent. of the cases of puerperal sepsis nowadays met with, this plan of procedure will be all that is necessary to bring about a cure.

4. In the remaining 5 per cent, roughly speaking, these measures fail to arrest the infection. An exploratory laparatomy is then indicated, the further course to be guided by the pathological lesions found. In most cases total hysterectomy will be required.

5. When large collections of pus form and are so situated that they can be readily reached either with a vaginal incision or with one above either of Poupart's ligaments, no time should be lost in resorting to surgical relief. When, however, they are not so favorably situated, judicious delay is advisable, with the hope that ultimately the pus may be evacuated without the risk of soiling the general peritoneum; —*Jour. Obstet.*

ANTISTREPTOCOCCUS SERUM IN PUERPERAL SEPTICEMIA.

H. W. Webber reports a case in which a favourable result was obtained from one injection of antistreptococcus serum. The injection consisted of 10 cubic centimetres of

serum. This injection was given in the afternoon, and by the next morning the temperature had fallen two degrees, the pulse become slower by thirty beats. The aspect of the patient was much better. The vaginal discharge had decreased in amount, had lost its foul smell, and was much cleaner.

Alex. J. Anderson cities a case of puerperal septicemia which had run for one week, and, the patient being in a very low condition, they gave injections of antistreptococcus serum. The first injection was given on a falling temperature. In one hour and a half it was down to 99.4° but three hours later went up to 102°. The second injection was given the next morning, and the temperature, which was 101.8°, went up to 103.8°, but got down below normal by 10 next morning. The next day another injection was given when the temperature was going up, and had the effect of keeping it down to 101.4°. The following day the temperature was 99.4°. An injection was given and the temperature fell below normal and remained there three days. He used ten cubic centimetres of the serum at a time.

S. J. Barker reports a case successfully treated by serum.

Sergueu reports a case of acute sepsis in which injections of Marmorek's serum were apparently followed by success. The patient was a primipara, 21 years old, who at the end of gestation suddenly became septic. No discoverable cause. The emptying of the uterus brought no relief, and subcutaneous saline infusions produced no improvement. As a last resort 20 cubic centimetres of Marmorek's antistreptococcic serum were injected, and, whether *post hoc* or *propter hoc*, from that time improvement began.—*Journal Obstet.*

AIR EMBOLISM IN PLACENTA PREVIA.

Hubl publishes two cases from Braun's clinic. The first was a woman 40 years old with a rachitic pelvis. The patient collapsed while version was performed. Postmortem showed the right side of the heart filled with air. The upper margin of the placenta was detached, and a blood vessel the size of a crow's quill was wide open and probably formed the entrance gate of the air. In the second case death occurred about nine hours post partum, also after version. Death was preceded by several attacks of collapse. No postmortem in this case. The author discusses the differential diagnosis of chloroform collapse and air em-

bolism. In the latter there is usually a sudden escape of liquor amnii and a consequent rush of air into the cavity of the uterus.

APPARENT DEATH OF THE NEW BORN.

Keiffer believes that attempts to resuscitate apparently still-born children are frequently given up too soon. He cites a case in which breathing did not begin until thirty-five minutes after commencing artificial respiration, and another in which fifty minutes elapsed before this result was obtained.—*Journ. Obstet.*

HEART DISEASE FROM AN OBSTETRICAL POINT.

A. H. Wright believes that a woman having a heart lesion which is compensated should not be prevented from marrying. Abortion should not be induced on a woman with heart disease, unless very serious symptoms are present. Premature labor should be seldom or never induced. Mitral stenosis is the most serious heart lesion during pregnancy and labor; aortic stenosis comes next, then probably aortic incompetency. Mitral insufficiency is the least serious lesion.

Treatment during Pregnancy.—Administer the following according to indications: strychnine, digitalis, or strophanthus, cathartics, nitrite of amyl, nitroglycerin; and regulate the diet.

Treatment during Labor.—Keep up the action of digitalis, especially during first stage. Give strychnine and stimulants, if required, and chloroform. As soon as the first stage is completed deliver with forceps. The patient must be watched very carefully during the third stage, as this is the most serious period.—*Jour. Obstet.*

OBSERVATION ABOUT SORE NIPPLES.

According to Platzer, sore nipples are caused through biting and pulling during the process of nursing. The best treatment of fissures are applications of carbolic acid solution. Ulcerations should be washed with corrosive sublimate solution and dusted with dermatol. In mastitis nursing must be interrupted, the breasts compressed, and ice bags applied. Among 1,000 nursing puerperæ in Kezmarsky's clinic sore nipples were observed in 51.5 per cent.—*Jour. Obstet.*

THE

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Editorial.

THE TRAIN.

We copy the following from the *Stylus*, a medical journal published in St. Louis, Mo., and most heartily endorse every word that it contains. The train has arrived in Montreal, and the dust that it creates as it sweeps along our streets almost chokes one. More than once, when following in its wake, we have been obliged to lessen our gait so as to be able to breathe air not composed of about half dust. We have heard ladies complain of the dust raised by carriages on our unwatered streets, while their trains raised almost as much on our unwatered sidewalks. Of a truth, if these disgusting trains are not abolished, we will be compelled to ask that our sidewalks be watered as well as our streets. We very much doubt whether, if this were done, it would induce the ladies to wear sensible skirts. It at all events would render life pleasant to those whom necessity compelled to walk behind them, and they could collect on these streets, without annoyance to others, all the filth they desire—no, not desire, yet nevertheless get.

"There are many kinds of trains, but the dirtiest, the most vulgar, the most to be avoided, the most horribly suggestive, is the long dress train on the dirty street. It is not a

matter of fashion, it may not be a matter of health, although our hygienists, with good reason, think so; it is mainly a matter of dirt—of vile, disreputable, unmitigated, dirty dirt. We saw a beautifully-dressed young lady on Broadway yesterday. Her little hands were daintily gloved, her dress was the latest and the best, her face was pure and sweet and gentle, but then—

"She was walking on a pavement that had not been swept—except by others of her exclusive class—since morning. Some of the things on that pavement are not to be described or even named, for chewers and consumptives and coach dogs had been there and left their mark. Miss Vere de Vere swept on while a cloud of dust and other things around and underneath arose to do her homage—Bah.

"Is the picture too strong? It is at least true."

JEAN LUKIN LEPROHON, M.D.

The death of this well-known Montreal medical man took place on the 23rd of May from pneumonia, at the age of 78 years and two months. He filled at one time a prominent place among the profession in Montreal by whom he was highly esteemed. Of late years advancing age obliged him to reduce his work, so that among the younger members he was hardly if at all known. Dr. Leprohon belonged to a very old French-Canadian family, his great-grandfather coming to Canada in 1758 as an officer in a French regiment, and, after the conquest, he settled in the country. He graduated from McGill University in 1843, so that he was among the oldest, if not the oldest, of its living medical graduates. On the formation of the Medical Faculty of Bishop's College, he accepted the Professorship of Hygiene, which position he filled for several years with much ability. He was one of the three original founders of the Women's Hospital of this city—the sole survivor being Sir William Hingston. He also for years took a very active interest in the Montreal Dispensary, of which at his death he was a consulting physician. He had also filled the office of Vice-President of the College of Physicians and Surgeons of the Province of Quebec. Among the

older members of the profession in Montreal he was held in high esteem. He was a typical specimen of that *politesse* which is so characteristic of our French-Canadian brethren.

FERROL.

Since our attention was drawn to this preparation, which is advertised in the RECORD, we have used it somewhat extensively in both private and hospital practice. The results on the whole have been very satisfactory, practically bearing out all that is claimed for it. In one or two instances it was not well borne, but in the great majority it was readily taken and easily assimilated. This preparation is not presented for sale to the general public, and is not advertised in ordinary newspapers. On the contrary it is only advertised in medical journals and presented to the medical profession for prescription. Among the profession in Toronto it is largely used, and what is most unusual, nearly every physician of any note in that city has above his signature certified to its efficacy and to his faith in it. Any preparation certified to by such men as Drs. Geikie, Temple and Ryerson must at least be worth investigation. It was these and other names which induced us to use Ferrol, and we have no regret that we did so.

THE LACTOPEPTINE MEDICAL ANNUAL FOR 1900.

The New York Pharmacal Association, whose headquarters are at Yonkers, N. Y., have sent us a copy of their Medical Annual. It is beautifully printed and covered. It also contains some copies of unique medical engravings, which cannot help being viewed with much interest. The reading matter is useful and some of it very amusing. The Association will be glad to send a copy to any physician who may ask for it.

PERSONAL.

Dr. Wyllie has been appointed Professor of the Practice of Physic in Edinburgh University, rendered vacant by the death of Sir Thomas Grainger Stewart. He took his M.D. from Edinburgh University in 1865. He had been connected for many years as a Lecturer on Medicine with the Extra-Academical School.

Dr. E. R. Brown (M.D., Toronto University), of Montreal, was in the accident which took place on the 28th of May on the Canadian Pacific Railway, near Labelle, P.Q. He was much shaken up and received a number of bruises, but fortunately escaped serious injury.

Book Reviews.

Gynecology—A manual for students and practitioners, by Montgomery A. Crockett, M.D., adjunct professor of Obstetrics and Clinical Gynecology, Medical Department, University of Baffalo; attending Gynecologist to the Buffalo General and Erie County Hospitals. Series edited by Bern B. Gallaudet, M.D., Demonstrator of Anatomy and Instructor in Surgery, College of Physicians and Surgeons Columbia University, New York; Visiting Surgeon Bellevue Hospital, New York. Illustrated with one hundred and seven engravings. Lea Brothers & Co., Philadelphia and New York.

In the author's own words "a book can be too condensed or too expanded. In the aim to avoid either extreme, the present volume endeavors to give an intelligent idea of the present status of gynecology. To be valuable, such a work must be representative. The writer has therefore endeavored to reflect the accepted views of the foremost authors and practical gynecologists as expressed in the rich standard literature of the subject. His own experience in practice and teaching has been embodied, and has at least served to make his presentation more uniform and clear." We think that Dr. Crockett has succeeded admirably in his endeavor to write a text book for students; everything is briefly and clearly stated. The busy practitioner will also find it very handy for consulting, and for refreshing his memory while driving from case to case. The author only claims that it is a pocket text book, but we think it is all that he has claimed for it, and even more. It is thoroughly up to date and should have a large sale.

Saunders' American Year-Book of Medicine and Surgery.—Being a yearly digest of scientific progress and authoritative opinion in all branches of medicine and surgery, drawn from journals, monographs and text-books, of the leading American and foreign authors and investigation: under the general editorial charge of George M. Gould, M.D. In two volumes of about 600 pages each, on Medicine and Surgery, respectively, each volume complete in itself and for sale separately, cloth $3 net, half morocco, $3.75 net. Published by W. B. Saunders, Philadelphia, 1900.

Volume II, of Saunders' American Year-Book of Medicine and Surgery is devoted to Surgery, and is not quite so large as volume I, which treats of the medical subjects. The diligent editors, to meet the great demand for this work, have gathered together an abundant supply of material, and this has led the publishers to issue it, for the first time this year, in two volumes, each complete in itself.

This arrangement has a double advantage. To the physician who uses the entire book, it offers an increased amount of matter in the most convenient form for easy consultation, and without any increase in price; while the man who wants either the medical or surgical section alone secures the complete consideration of his branch without the necessity of purchasing matter for which he has no use. This work is deservedly popular, and ranks as one of the best yearly compendiums now published. Volume II. treats of the following subjects: General Surgery, Obstetrics, Gynecology, Orthopedic Surgery, Ophthalmology, Otology, diseases of the Nose and Larynx and Anatomy. The subjects are dealt with by men well known by their constant contributions to medical and surgical literature and scientific progress; *e.g.* Keen, Dabosta, Hirst, Darland and Baldy. All the features of the work that have in the past proved so valuable will be retained.

The publisher has done his work up in the usual attractive and serviceable finish, and the type is of such size and character as to prove attractive to the eye, so that the latest and best is here given in a very convenient form.

R. C.

Saunders' American Year-Book of Medicine and Surgery—Medicine.—As intimated above, the Year Book is now published in two volumes—one devoted to Surgery, the other to Medicine. That this is an advantage is without question. I find it quite impossible to criticise the contents of the Medical volume, for it is simply a collection of the current medical literature of the past year. This clearly shows that our leading scientific workers have, during that time, not been idle; on the contrary the amount of material collected proves that in spite of much to discourage, some advance of a practical character has been made. It, however, is but slight, and it must be admitted that pure Medicine still lags behind Surgery in its advancement. Indeed at times I am inclined to think that we have

been unfortunate in casting aside the old to take hold of the new. Still as things go we must follow the crowd, being conservative enough to judge how far we must go before being obliged to cry "halt." The contributors to this volume are all men eminent in their special departments, and they have done their work well.

F. W. C.

The International Medical Annual and Practitioners' Index.—A work of reference for Medical Practitioners, 1900. Eighteenth year. New York, E. B. Treat & Co., 241-243 West 23rd street; Chicago, 199 Clark street. Price $3.00

This annual is an established favorite with Canadian Medical men on account of the editors of a great many sections being practitioners attached to British Hospitals either in the British Isles or India. The same condition prevails in the present volume, as thirty-three out of the forty-two editors or collectors are practitioners residing in Great Britain. Their work, however, is fully equalled by the American Editors, among whom are Dwight Chapin, Samuel Gant, G. M. Hammond and H. P. Loomis of New York. Its contents do not show that during the past year there has been any special extension of our Therapeutic knowledge. They prove, however, that disease has been studied closely, and that a more exact diagnosis is as a consequence now possible. Treatment, however, still lags behind. The field is fully covered in this volume, and the selections have been made with care, and in some cases are more fully copied than we have found in some other similar volumes. It is well worth its cost.

F. W. C.

The International Text Book of Surgery, by British and American Authors. Edited by J. Collins Warren, M.D., and A. Pearce Gould, M.S., F.R.C.S. In 2 Volumes. Price, cloth $5.00; sheep or ½ M. $6.00 Pub. W. B. Saunders, Philadelphia.

The second Volume of this work takes up regional surgery, and is illustrated with many excellent cuts from original photographs and several colored plates. The division into regions is very good, and each author deals most thoroughly with his division. It is hardly just to single out one or two authors for special praise, as the entire work is so creditable, but Dr. H. Holbrook Curtis in his chapter on Surgery of the Nose shows clearly the recent advances in the surgical treatment of the accessory cavities of the nose. His illustrations of before and after operations in the case of nasal deformities is most interesting. In the chapter on Surgery of the Neck A. Pearce Gould discusses many interesting points. In dealing with Parotid Bubo he speaks of intraperitoneal operations and peritonitis as causes, adding, that "no explanation can at present be given of the association of this secondary suppuration with operations within the peritoneal cavity." Possibly this condi-

tion can be considered a reversion of the phenomenon of occhitis, ovaritis or metritis following mumps.

Surgery of the Breast by J. Collins Warren is splendidly illustrated and concisely written. A careful perusal will aid in forming a diagnosis in cases of suspected malignancy.

Taken together, these two volumes cannot but be heartily recommended as a thoroughly comprehensive and up-to-date production. G. F.

Martin and Rockwell's Chemistry and Physics—A. Pocket Text-Book of Chemistry and Physics. By Walton Martin, M. D., and William H. Rockwell, Jr., A.B., M.D., of the College of Physicians and Surgeons, New York. In one 12mo. volume of 336 pages, with 137 illustrations. *Just Ready.* Cloth, $1.50, *net.* Flexible red leather, $2.00, *net.* Lea Brothers & Co., Philadelphia and New York.

An acquaintance with the general principles of Chemistry and Physics is absolutely necessary for the student who would intelligently follow such important subjects of a medical curriculum, as Physiology, Materia Medica, Hygiene, etc.

But the subjects are so very wide that every lecturer on Chemistry in a Medical College finds himself again and again confronted with the question : " How much and what portions of Physics and Chemistry shall I lay before my students ? " This book is an attempt to answer this question, and is a very creditable attempt.

In the first 182 pages we find brief but terse and vigorous statements, as to mode of occurrence, preparation and properties of the more important elements and compounds. In Organic Chemistry, only the Methane and Benzene series of hydrocarbons and their derivatives are taken up. Special attention is given to the compounds " which are of medical interest not only medicinally, but in physiological chemistry ".

The second part of the book, 187 pages, is devoted to Physics, and is a very satisfactory treatise on elementary physics, and takes note of the latest developments, as witness the brief reference to wireless telegraphy. In the writer's opinion, the book would be improved by reducing the portion devoted to Physics, and enlarging that allotted to Chemistry. The work seems disproportioned, when we find the part devoted to Physics discussing the construction of the telephone and wireless telegraphy ; but look in vain in the chemical portion for any reference to such important substances as Calcium Carbide and Acetylene, for example.

We find also a few statements throughout the text that are scarcely correct, and which we expect will be altered in another edition. Among them we may mention the statement on page 72 " seventy elements now known," whilst symbols are given for more than that number on page 22. Then again on page 76 the statement is made that " *potassium* Iodide occurs in sea water and is taken up by sea weeds ; " whilst this may not be absolutely in-

correct, it would be more accurate to write thus of *Sodium* Iodide. On the whole, however, we are favorably impressed with the volume, and can recommend it as a text book for medical students if used in connection with a course of lectures and demonstrations in Chemistry and Physics.

J. T. D.

The Essentials of Hematology.—A practical guide to the clinical examination of the blood for diagnostic purposes. Illustrated. Published by the Palisade Manufacturing Company, Yonkers, N.Y.

This little work on the clinical examination of the blood is published by The Palisade Manufacturing Co., makers of "Hemaboloids." Starting with a careful description of the instruments needed, and their methods of use, the author passes on to the simple methods of staining best suited for blood work.

The brochure is carefully compiled, and the information it gives is accurate and up to present day requirements. It is well illustrated.

A.B.

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