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Original Communications.

AN ANOMALOUS CASE OF TYPHOID FEVER.

By ROBERT J. DWYER, M.B., Tor., M.R.C.P.

MR. PRESIDENT,—Typhoid fever is a disease with which we are all so familiar that one feels like apologizing for selecting it as an item for this evening's programme.

A recent case, however, which, through the kindness of Dr. Allan, I had the opportunity of studying, presented such atypical features in its onset and course, that I thought a recital would not only be interesting but also prove useful by pointing out the necessity for bearing this disease in mind, in any febrile condition, the nature of which is in doubt.

History.—The patient, a tailoress, aged 21, was admitted to St. Michael's Hospital, November 20th, 1902, with the following history: Several days previously she had swallowed a small cuff holder, and two days before admission, owing to severe epigastric pain, a physician was called in. She was then somewhat pale, the temperature was normal. The following evening she went to Dr. Allan's house, and while there was seized with a severe hematemesis, losing about half a wash basin of blood. The next morning she came to the hospital; there she complained of nausea and much epigastric pain and weakness; she was very pale, temperature, 98.7; resp. 24; pulse, 80. During the next four days she had six hemorrhages in all, the amounts lost varied from a pint to three ounces or less. On the fifth day the nurse reported the stool as being very free and dark in color. For the first nine days the temperature fluctuated between 98.4 and 99.4, once going up in the evening to 100.1. On the tenth day it ran up suddenly to 102, and for the next two weeks kept ranging between 102

and 103, once going up to 104, but at no time did it go below 102. At the end of the two weeks it went up to 104.3, and from that time till death, a week later, was never more than 103.

A notable feature of the temperature was the absence of variation between the morning and evening register. Up to the time I saw her on the 19th day, the general features of her illness were the fever, occasional vomiting, epigastric tenderness and sleeplessness. The pulse rate had gradually increased during this period, from 80 to 112. Her condition at this time was as follows: Temp. 103, resp. 22, pulse 112, a slight cough, she was blanched and somewhat emaciated, tongue moist and thinly coated, complained of great weakness, there was some mental dullness; she answered intelligently, but slowly.

Physical Examination.—Lungs clear, short cardiac systolic murmur at the apex very limited in extent, however, the abdomen very firm and markedly retracted, complained of considerable pain and tenderness in the epigastrium, neither the liver nor the spleen could be palpated, but the area of dullness of the latter was slightly increased. Careful search failed to discover any typhoid spots, and indeed there was little in the appearance of the patient to suggest this disease unless it would be the slight splenic enlargement. At this time, too, some stiffness of the arm and legs and back, and some fine tremor of the hands were apparent. These latter symptoms were not sufficiently pronounced to materially interfere with movement, and were ascribed to the weakness and abdominal tenderness, especially as they were most marked when attempting to turn her for examination.

Blood was taken for a "Widal" test, and the report three days later was "slightly positive." On subsequent inquiry, however, I was told that it was not sufficient to be diagnostic. Up to this time the patient had been fed mostly per rectum, and as it was deemed that sufficient time had elapsed more liberal feeding by mouth was ordered. This was taken and well borne. On the next day for the first time there was slight abdominal distension, which gradually became more marked, and persisted in moderate degree till death. Three days later she began to be delirious and have involuntary evacuations, all her symptoms becoming gradually worse, finally ended in death ten days later.

During the last week or so the tremor and rigidity became more pronounced, being somewhat more marked on the left side, the arms kept rigid at the sides, the hands flexed, the fingers spread apart, the legs were held straight and rigid, and the feet were hyper-extended till the heels were in line with

the calves, the head held rigidly in the middle line, and slightly retracted. Owing to the condition of the patient it was not possible to make any observation as to the sensory functions, neither knee jerks, nor extensor response were obtained.

Notwithstanding every care a bed sore was formed in the sacrum, and rapidly advanced. There were also indications of the same forming over the heels. The blood count made several days before death showed red 1,500,000, whites not increased.

Post-mortem Report.—The body showed marked emaciation. Rigor mortis and *post-mortem* staining also present. On further inspection a number of punctate cutaneous hemorrhages were found in the left groin and inner side of thigh. Over the sacrum was a circular bed sore about three inches in diameter and extending into the muscular and tendinous structures.

Section.—On opening the abdomen the intestines were seen to be pale and moderately distended, and further examination of these showed about a dozen healing typhoid ulcers, situated in the lower two feet of ileum. Otherwise there was nothing of note in either the large or small bowel. The stomach was moderately distended and contained a quantity of fluid. About midway between cardia and pylorus, and less than an inch in front of lesser curvature was a shallow depression, circular in outline and almost a quarter inch in diameter. It extended through the mucous mem, and had no appearance of inflammation about its edges. In short, it presented the appearance of a healed ulcer. At the lesser curvature, and about opposite the one just mentioned, were three larger and more irregular depressions with red injected edges. These were not so deep as the first, and did not present the typical appearance of gastric ulcers. The spleen was considerably enlarged and soft. The kidneys were normal in size, and the capsule was more adherent, cut surface was somewhat pale. Liver normal in size and pale on section.

Thorax.—The lungs presented the appearance of passive congestion in dependant parts.

Heart.—The pericardium contained almost $\frac{3}{4}$ iv. of clear serous fluid. The organ, as a whole, was pale and soft, but not friable. The right side was occupied by *post-mortem*. Thrombi valves normal, except for slight thickening of mitral cusps. The spinal cord was also removed up to and including portion of the cervical enlargement, but nothing abnormal was found, either in meninges or on section. Unfortunately no examination of the brain was allowed.

REPORT OF GYNECOLOGICAL CLINIC AT THE NEW YORK SCHOOL OF CLINICAL MEDICINE.

By AUGUSTIN H. GOELET, M.D.
Professor of Gynecology and Gynecological Surgery.

Gentlemen,—The first case I show you to-day is one of more than usual interest, because of the variety of conditions present and because the question, "What may be done to cure this patient?" requires discriminating judgment. She is only 29 years old, but has had three children and two miscarriages, the last being during the past year, and she is a complete physical wreck. If it were possible to get her away from her children and other household cares and build her up, it would be better to do that first before instituting any operative procedure for her cure, but in this class of patients such a course is not feasible.

Now what do we find on examination? We will first palpate the abdomen in the erect position, and without difficulty we discover the right kidney prolapsed to the fourth degree and the left to the third degree—quite enough to make an invalid of any woman, but there is more. Microscopic examination of her urine shows that there is already a pyelonephritis which is the result of the prolapse. Now that you have all been able to make out the prolapse of both kidneys to your entire satisfaction, we will place the patient in the recumbent position, and again palpate the abdomen. You observe that the right kidney can be made out in this position without difficulty, but the left comes down only to a limited extent on deep inspiration. In fact, if this patient was not so thin, it would be difficult to palpate even the lower pole of the left kidney, and unless we had examined her previously in the erect position, we would very readily overlook the displacement on this side. Examination of these cases only in the recumbent position is frequently the cause of failure to detect prolapse of this organ.

We will now proceed to examine the pelvic organs. You observe that there is a very marked cystocele with an incomplete laceration of the perineum, and when she is made to strain the cervix presents at the vulva.

This is badly lacerated also. Upon digital examination we find the uterus retroverted, with complete relaxation of the utero-sacral ligaments. Without the support of these ligaments the uterus will not retain its position in the pelvis. I regard them as the most essential support of the organ.

Now what shall we do to cure this patient? That is what she has come for and what she is entitled to. I will ask you all in turn, what you would do for her if she consulted you in your private practice? You seem to hold a variety of opinions. One gentleman says he would remove the uterus to cure the prolapse. Would she then be cured? And would it be justifiable at her age?

Several operations will be required to effect a cure in this case, and if the patient was stronger they could all be done at the same time, but owing to her weak state I think it would be wiser to divide them, giving her ten days or two weeks between to enable her to recover her strength. On the next clinic day at the hospital I shall first fix both kidneys, and after curetting the uterus I will repair the cervix. This will be enough for her to endure for one day. Then two weeks later I will repair the perineum and do a ventral suspension. This will keep her in bed about four weeks.

I shall not attempt any plastic work on the anterior vaginal wall to overcome the cystocele, because when the uterus is drawn up and attached to the abdominal wall the vagina is drawn up with it and the cystocele will disappear. The result is more certain because the vaginal wall is now in a state of subinvolution. The patient will be cured, but the permanency of the result will depend largely upon the avoidance of pregnancy for at least five years.

The next case is also one of retroversion of the uterus with moderate rectocele. The patient is a widow, 38 years old, who was never pregnant. She complains of backache, bearing down pain in the pelvis, and menorrhagia. She has been treated with tampons before coming here, and has worn a pessary without permanent benefit. She says when the pessary is worn it irritates, and menstruation is more profuse and prolonged. You will observe on examination that the uterus is freely movable, and that it can be readily replaced, but that it does not remain so. You will observe also that there is complete relaxation of the utero-sacral ligaments, but the upper posterior vaginal wall is closely connected with the rectum and not separated from it, and relaxed as you so often find in these cases of retroversion in women who have borne children. The appendages are normal, but there is a chronic endometritis and the uterus is large and heavy.

On my next clinic day at the hospital, after curetting the uterus, I will do a simple operation in this case which I have under trial, and about which I have thus far said very little. It is unique in its simplicity, and in appropriate cases should prove very useful. Its object is to hold the cervix in the posterior cul-de-sac of the vagina and consequently in the hollow

of the sacrum, so the fundus will fall forward and the intra-abdominal pressure will be exerted against the posterior face of the uterus. The technique is as follows, viz. :

The cervix is drawn forward, and the posterior surface of the vaginal portion of the cervix is denuded of its mucous membrane. Then a corresponding surface of the same area on the posterior vaginal wall well up in the posterior vault of the vagina is also denuded, and these two surfaces are united by means of sutures. This attachment takes the place of the disabled utero-sacral ligaments, and in those cases where there is not undue relaxation of the upper vaginal wall the result is very satisfactory.

In this case I will also narrow the lower part of the vagina by doing a posterior colporrhaphy, because of the rectocele, but as a rule in these cases where this operation is appropriate this is not required.

The next case I show you has also retroversion of the uterus, but in order to effect a cure here it will be necessary to do a ventral suspension. The patient, who is 28 years old, has been married nine years, and has had three children, the last, four years ago. You will observe in this case that there is complete giving way of the utero-sacral ligaments, and that the vagina is greatly relaxed, and is but loosely attached to the rectum at its upper part, but the uterus is freely movable and can be replaced. Hence the operation that I would do in the last case, which I have designated "Posterior Cervico-vaginal Fixation," would not be appropriate here. Neither would shortening of the round ligaments be effective, because these ligaments when shortened do not hold the uterus up in the pelvis, though they may draw the fundus forward against the pubes. Hence, after this operation, the organ would sag down in the pelvis, and we would have prolapse, which may cause quite as much inconvenience as the retroversion.

Therefore, in this case, I believe a ventral suspension is the only positive means of cure. I do not hesitate to do this operation in appropriate cases, when the uterus is freely movable as well as when it is fixed, and during the child-bearing period, because the operation *per se* has no mortality, and when properly done it does not interfere with subsequent pregnancy.

SYMPTOMS AND TREATMENT OF CALCULOUS ANURIA.*

By E. L. KEYER, JR., M.D.

Calculous anuria may claim your attention, not because of its frequency, nor because of the vague and irregular nature of its symptoms—for it is not frequent nor are its symptoms other than absolutely characteristic—but calculous anuria may claim the respect of every practising physician because it is a condition which, though grave and threatening rapidly fatal to us, shows during the greater part of its progress no signs adequate to arouse alarm in the mind of the patient or of his doctor.

It is to all appearances a perfectly benign condition. The patient walks about almost entirely well and quite free from fear of any imminent danger, when suddenly the crash comes, the disease culminates in an explosion of intense uremia. Hence most practitioners fail to realize the gravity of the patient's condition until it is too late; although the one reason why they do not make the diagnosis sooner is because they do not attach sufficient importance to it. Therefore, in calling your attention to-night to the diagnosis and treatment of calculous anuria, I might be more explicit and say that I wish to impress upon you the necessity of a timely diagnosis in order that you may be able to institute successful treatment.

Calculous anuria, as the name indicates, is a condition in which the kidneys cease to secrete urine because of calculous obstruction. In order to understand the mechanism of this, you must recognize that the kidney ceases to secrete for one of two reasons. Either its duct is obstructed or it is intensely congested. You are doubtless more or less familiar with the condition of hydronephrosis and dilatation of the kidney on account of some obstruction to the outflow of urine through the ureter. Inasmuch as stone is a fairly frequent cause of hydronephrosis, we must distinguish between the obstruction by stone which causes dilatation of the kidney and the obstruction by stone which causes anuria. The distinction is this: If the stone obstructs the ureter suddenly and completely, the kidney does not dilate, the urine which it secretes into the pelvis finds no means of escape, presses back upon the secreting structure of the organ, and causes an intense congestion, which is followed by a cessation of function, and ultimately, if the

* Paper read before the Clinical Society of the New York Polyclinic Medical School and Hospital, December 8th, 1902.

patient survives and the obstruction is not relieved by atrophy of the organ.

On the other hand an imperfect, gradual, or intermittent ureteral obstruction—whether by stone or by anything else—causes an increase of pressure, which is only relative, and which varies in intensity from day to day, as a little urine escapes around the obstruction; and the result of this irregular back-pressure is a gradual dilatation and forcing outward of all parts of the kidney pelvis, so that finally hydronephrosis is produced.

Thus calculous anuria is caused by sudden and complete obstruction of the ureter, while hydronephrosis is caused by gradual, incomplete or intermittent obstruction. Post-mortem examination of the kidneys of persons dying from calculous anuria habitually discloses complete obstruction of only one ureter. But the opposite kidney is in almost every case seriously diseased. So that when the ureter of one kidney is obstructed the opposite one is not able to eliminate the necessary quota of excrementitious matter, and it too gives way—but gives way slowly—under the strain put upon it. Were this not the case, and were it possible for fatal calculous anuria to occur with the unobstructed kidney in a normal condition, every nephrectomy would be likely to be quite as serious a matter as calculous anuria; for nephrectomy, by removing one kidney, has very much the same effect as has the complete obstruction of one ureter.

Legueu has recorded thirty post-mortem examinations of cases of calculous anuria, and Morris has collected twenty-eight. Legueu found the opposite kidney absent thrice; atrophied and otherwise damaged by calculus in twenty instances, while in six there had been previous obliteration of the opposite ureter. In Morris's cases the opposite kidney was absent six times, atrophied or otherwise almost entirely disorganized twenty times, and much enlarged, presumably by congestion, twice. In only one of these fifty-eight fatal cases was the opposite kidney in anything like a normal condition; and in that case there was a slight evidence of parenchymatous nephritis. Hence, Legueu has justly inferred that calculous anuria is caused by three factors: first, a long standing change in one of the kidneys, markedly impairing its function, or else a complete atrophy or absence; second, a recent or recently aggravated lesion of the principal kidney, this lesion being mechanical and caused by the calculus; third, a reflex inhibitory effect upon the disorganized kidney leading to complete suppression of its imperfect functional power.

Hence we must understand that the existence of calculous anuria means that the patient has been living for some time

past chiefly on the functional activity of one kidney, and that the anuria is due to mechanical obstruction to that function and reflex inhibition to the action of its fellow.

Such is calculous anuria. Its symptoms are classified in three stages: first, the premonitory stage; second, the tolerant stage; third, the uremic stage. In the premonitory stage there is more or less pain referred to the kidney, and this may be an index of the kidney chiefly affected. This stage lasts a few hours, or perhaps a few days. The patient then passes into the second stage of the disease. In this, the tolerant stage, there are no symptoms whatever, except the absence of urination. There is no pain, there is no sensation of discomfort, weakness or sickness. The patient goes about his business, eats, drinks, works, as usual, but urinates little or not at all. He may go on in this way for three or four days, or a week, passing not more than two or three ounces of urine a day, or there may be a let up in the symptoms and a copious outflow of urine, after which the anuria may occur.

As I have already remarked the diagnosis of calculous anuria in this stage of the disease is a matter of no great difficulty; but the complete absence of any grave symptoms is what throws the physician and his patient off the scent; and the absence of urination is regarded as a merely temporary and insignificant matter, until the third or uremic stage shows the gravity of the condition and usually determines the patient's fate.

This third stage comes on gradually, with such suggestive symptoms as hiccoughing, headaches, insomnia and nervousness, a rapid tense pulse, vomiting and subnormal temperature. These symptoms rapidly grow worse, the vomiting grows more severe, the intellect becomes dull and stuporous, the patient's mind may wander, he may have maniacal attacks, the intestines are distended and may be filled with gas, and in a few days the patient sinks and passes away.

In 20 to 28 per cent. of all cases the patient recovers from the attack, either by the passage of the stone or by its slipping back into the kidney pelvis in such a way as to relieve the obstruction.

Such are the symptoms of what Morris has aptly termed the gravest and the most fatal of the many serious complications of urinary lithiasis.

Of the diagnosis of the disease I need speak no further. I hope I have sufficiently impressed upon you the necessity of foreseeing grave danger lurking behind the apparently superficiality of the attack while in the tolerant stage. I know of no disease that can be confused with calculous anuria, unless it be hysterical anuria. This may simulate calculous anuria

quite closely, just as hysteria may simulate almost any condition. It is not possible to give any hard-and-fast criteria by which to distinguish the two diseases; but a careful study of any case should distinguish the hysterical element when present.

The treatment of calculous anuria is obviously single—it is the knife. Henry Morris, who is the greatest authority on this subject, states “so useless is medicinal and expectant treatment that I have refused to attend consultations in cases of calculous anuria unless I have permission beforehand to operate at once if I think the case suitable.” This is the proper attitude to assume. The patient may insist that he is entirely well; but the well-informed practitioner cannot afford to allow himself to be deceived until it is too late, until the uremic stage has come, and the patient’s chances of recovery are practically lost.

Among Morris’s operations twenty-one were performed on or before the fifth day of the disease, with a mortality of 30 per cent. Sixteen operated on after the fifth day gave a mortality of 50 per cent.; after this a 75 per cent. mortality in cases not operated upon.

There is one further point to which I wish to refer, that is the choice of operation. Patients in these cases, no matter how seemingly well they may be, are in reality suffering from a grave disease, hence the operation for the relief of calculous anuria should be of the simplest possible description.

No attempt should be made to extirpate the kidney, or to investigate for the presence or absence of calculus beyond inserting a finger rapidly into the pelvis. Indeed, if the calculus is large and impacted, it would seem wiser not to disturb it, even though it were readily excised. All that the patient requires is simple nephrotomy and drainage of both kidneys, and nothing else should be attempted upon him at that time.

Selected Articles.

GENERAL PUERPERAL SEPTICEMIA TREATED BY INTRA-ABDOMINAL IRRIGATION WITH NORMAL SALINE SOLUTION; RECOVERY.*

BY JAMES HAWLEY BURTENSHAW, M.D.

Adjunct Professor of Gynecology in the New York Polyclinic Medical School and Hospital
New York.

A number of cases have been reported in which the abdominal cavity has been subjected to irrigation for puerperal sepsis, with indifferent results; but the accompanying report is unique, so far as I am able to determine, on account of the length of time the irrigation was practiced, the effect of the irrigation on the kidneys and peritoneum, and the ultimate recovery of the patient without the ordinary sequels of septic peritonitis.

The patient was a French woman, aged 24, unmarried, secretary to a woman of considerable wealth. She became pregnant during the latter part of August, 1902. During October and November she made frequent attempts to produce abortion by means of various drugs, hot water vaginal douches and the like, but unsuccessfully. Early in December a meddling woman friend initiated her into the mysteries of instrumental procedure, and during the evening of December 9th she inserted an ordinary wooden penholder into the cavity of the womb and allowed it to remain there until the following morning. The membranes were not ruptured by this maneuver, but it was followed by the appearance of considerable blood, undoubtedly from a wound of the endometrium.

Abortion occurred during the afternoon of the 10th. The girl remained in bed until the next morning, when she arose, dressed and resumed her usual duties about the house. I was summoned to see her at midnight, December 16th. She had then been confined to bed two days. I found her temperature to be 104.4 F., her pulse rate 120, and her respiration rapid and shallow. She was somewhat delirious. Her abdomen was greatly distended, and was sensitive to the touch. The uterus was enlarged and soft, and the lochial discharge was scanty in amount and very offensive. From the housekeeper I learned that she had had several protracted chills, had vomited a num-

*Read before the Polyclinic Clinical Society.

ber of times, and, to the best of the housekeeper's knowledge, had urinated but once during the previous twenty-four hours.

I catheterized her, and drew off all the urine the bladder contained, about four ounces. Later examination of the specimen demonstrated a specific gravity of 1,031, numerous hyaline casts, and a considerable amount of albumin. I may state here that a blood examination the following day showed the presence of almost innumerable streptococci, while the uterine scrapings developed streptococci and staphylococci in great numbers.

I flushed out the uterine cavity with two gallons or more of hot water, and, under very superficial chloroform narcosis, gently curetted it with a broad curette, taking great care not to abrade the endometrium. Considerable foul-smelling placental tissue and blood-clot were removed in this way, and the cavity was again copiously irrigated, this time with a 1 per cent. solution of lysol. I then introduced a suppository containing one dram of iodoform, fifteen grains of starch, and glycerin into the uterus, and packed that cavity and the vagina lightly with iodoform gauze. Nearly a quart of hot solution was then slowly introduced into the bowel, but the retention of even a small quantity of the fluid caused the patient so much pain that the enteroclysis was not persisted in. Meanwhile, I had opened the median basilic vein of the left arm and withdrawn about eight ounces of blood. This was replaced by about eleven ounces of hot normal salt solution. Marked improvement in the patient's pulse and respiration was at once manifest. Her body was then sponged with tepid water and alcohol, cloths wrung out in ice water were applied to her head and abdomen, and she was again catheterized. Two ounces of urine was obtained. A rather free, loose bowel movement had resulted from the attempt at enteroclysis. It was my intention to practice continuous irrigation of the bowel with the salt solution, but the patient complained so bitterly when the procedure was attempted that I desisted.

At 11 o'clock the next day, December 17th, her temperature was again 104 F., having dropped during the early morning, after the infusion, to 103; her pulse was still 120, her breathing was rapid, and coma was developing. Only seven ounces of urine had been obtained by catheter. Subcutaneous infusion of saline solution was resorted to, the sites of the injections being the anterior border of the right axilla and under the left breast. The uterine and vaginal dressings were removed and a second iodoform suppository was introduced into the uterus, both cavities again being packed. The posterior vaginal fornix was markedly distended, owing to the presence of fluid in the peritoneal cavity. Absorption from the cellular tissue was

extremely slow, although the patient showed temporary improvement after the injections were begun. Enteroclysis was again practiced, but with very unsatisfactory results.

I had intended to open the posterior cul-de-sac and pack the pelvis with iodoform gauze, but the grave condition of the patient, especially the almost complete cessation of kidney function, appeared to preclude all hope of success attending this procedure. The approximate quantity of urine passed during thirty-six hours had been nineteen ounces.

It then occurred to me that thorough irrigation of the entire abdominal cavity with normal saline solution might accomplish several things: first, remove the collection of serum, which undoubtedly already was infected by streptococci; second, through absorption by the most extensive lymphatic system of the body, the kidneys would be more quickly and radically influenced; and third, the general agglutination of the peritoneal surfaces as a result of the inflammation might, to a certain extent at least, be prevented.

Digitalin, strychnin and whiskey had been injected hypodermatically at intervals since the night before. Several gallons of normal saline solution, prepared according to the formula of Locke, containing sodium chlorid, \mathfrak{z} iiss; calcium chlorid, gr. $3\frac{1}{4}$; and potassium chlorid, gr. iss to the quart of sterilized water, was prepared and kept at a temperature approximating 110 F. A four-quart fountain syringe and tube were sterilized by boiling. The patient was given a few whiffs of chloroform, and I made a two-inch incision into the abdominal cavity midway between the umbilicus and pubes. A rubber pad was placed under her to catch the overflow, and the tube of the syringe was inserted through the opening as far as possible into the pelvis.

For one hour the solution was permitted to flow into the cavity without intermission. Several times during this period the patient was turned on her side, and once on her abdomen, and pressure was made on her flanks to facilitate the exit of the fluid. At first, when this was done, the fluid returned was of a yellow tinge and contained many lymph flakes, but later it came away perfectly clear. Twenty minutes after the irrigation was begun ten ounces of urine of a specific gravity of 1.024 was obtained by catheter, and fifteen minutes later, six ounces. At the end of the hour her temperature had dropped to 102.6 F., her pulse rate to 110, she was in a profuse perspiration, and her mental condition had greatly improved. In all, forty ounces of urine had been drawn from the bladder, the last being of a specific gravity of 1.013. Five ounces of whiskey had been given by the mouth. At one time syncope appeared to be imminent, but was averted by raising the foot of the bed to the level of a chair seat.

At 10 o'clock at night the irrigation was repeated for half an hour. A self-retaining catheter had kept the bladder drained, and forty-eight ounces of urine had been collected. The bowels had moved freely twice. At midnight her temperature was 102 F., and her pulse rate 116. A third irrigation was practiced the following morning, again for half an hour, and at three-hour intervals until 1 o'clock the next morning the cavity was filled with the saline solution. The next day, December 19th, I closed the abdominal wound with stitches under cocain anesthesia. Her temperature then was 100.4 F., and her pulse rate 100. From 10 o'clock on the night of the 17th until noon of the 19th 210 ounces of urine were collected by catheter.

On December 20th her temperature and pulse rate were practically the same as on the day before, but her general condition had greatly improved. By December 23rd the abdominal tenderness, except in each iliac region, had almost disappeared, the lochial discharge had increased in quantity and had ceased to be offensive, and all signs pointed toward recovery. On December 25th she had a decided increase of temperature during the afternoon, but this yielded readily to a moderately large dose of quinine. Intrauterine suppositories, each containing 20 grains of iodoform, were employed daily, and the uterus and vagina were lightly packed with iodoform gauze from December 18th to 22nd.

The patient was allowed to sit up January 4th, and February 1st I examined her at my office. I found the uterus to be in good position and freely movable, but enlarged and somewhat sensitive to the touch. Both ovarian regions were sensitive, and the left ovary was enlarged. I could discover no evidence of pus foci in either broad ligament or elsewhere. Her bowels were constipated, but movements were unaccompanied by pain. The usual sequels of peritonitis appeared to be entirely absent.

In reviewing the line of treatment adopted in this case a number of pertinent queries are in order.

First.—Was there not danger of "drowning" the patient by introducing such great quantities of fluid into the abdominal cavity? I confess that I feared this might be the outcome, and had the kidneys not begun to functionate almost immediately after the irrigation was begun would have discontinued it at once.

Second.—Could not the same favorable result have been attained by intravenous infusion? So far as influencing the general systemic infection was concerned, I unhesitatingly reply in the affirmative, the opinion being based to some extent on recent reports of *lavage du sang* in streptococcic infection

with a solution of formalin. In the cases reported, however, I believe that the favorable outcome was due to dilution of the poison in the blood current, and not to any germicidal influence exerted by the contained drug. The use of normal salt solution, I feel sure, would have been attended by as good results.

With regard to the attendant peritonitis, it undoubtedly was the local action of the saline which cut short the inflammatory process and which apparently prevented adhesion formation. I am able to explain this action only on the theory that, as streptococic infection having the uterus as a starting point spreads to surrounding structures especially through the medium of the lymphatics, and as saline solution in the peritoneal cavity, as elsewhere, is primarily absorbed by the lymphatic system before entering the blood current, the consequent attenuation of the toxius almost at the point of origin would necessarily follow. Then again, while the primary effect on the blood vessels of hot water, that is, of water at a temperature ranging from 107 F. to 120 F., is to cause dilatation, and consequent engorgement, through the governing nerve mechanism, the secondary effect is that of contraction and cessation of congestion. As congestion is a natural concomitant of irritation, or inflammation, the effect produced by its disappearance is obvious. While this explanation appears plausible, I am compelled to ignore the fact that the peritonitic inflammation in this case was of streptococic origin, and consequently of a type which would be the least likely to yield to any form of treatment.

As regards the nonformation of adhesions, it is natural to suppose that, the inflammation of the peritoneum being held in abeyance and the surfaces being separated by the fluid, no opportunity would be afforded for such adhesions to occur.

Third.—Was there not danger of over-stimulating the kidneys? This factor was before me during all the time the treatment was being carried out. The conditions under which the infusions were given made it impracticable to measure the quantity of fluid administered, and I have no means of knowing even the approximate amount absorbed. The urine collected was carefully measured at frequent intervals, and it was evident that the flow from the kidneys was almost constant from the beginning. It also occurred to me that such long exposure of the intestines to the action of water at a temperature of 110 F. might have a deleterious effect, but such did not prove to be the case.

It is to be regretted that bacteriologic examinations of the blood were not made at intervals subsequent to the one made after the resection. Two specimens were obtained for this purpose, but, owing to an error, were lost.

I am inclined to think that the satisfactory outcome was in part due to the character of the fluid employed. Dr. Harvey Cushing has called attention to the fact that a solution containing 0.6 per cent. of sodium chlorid, that commonly employed, should not be regarded as a normal physiologic salt solution. He says:

As a matter of fact, this is a most misleading designation, if we mean to imply by the term a fluid which is isotonic with the body fluids, and thus one that may be used with impunity in large amounts to replace directly in the circulatory system the loss of normal blood serum. A 0.6 per cent. salt solution is, in the first place, sufficiently hypotonic to take the corpuscles perceptibly if used in sufficient quantity and, furthermore, the recent observations of Loeb and his pupils have demonstrated the actual coxicity toward cellular activities of the pure sodium chlorid solution, that is to say, when uncombined with other salts. . . . Sidney Ringer, years ago, through an accidental observation, discovered the fact that minute doses of calcium and of potassium salts, when used in combination with the usual percentage of the sodium salt, made a solution possessing a much more beneficial effect in conserving the activity of an isolated heart than the sodium solution when used alone. Thus, for the first time, was pointed out the antagonizing action of small amounts of calcium and potassium toward the toxicity possessed by the single sodium ion, and thereby was given the first indication of the necessity of combining salines in order to obtain a more perfect infusion solution. . . .

There can be no doubt that the pure sodium chlorid solution alone may, in certain ways, be injurious from its toxic effects; that, furthermore, a solution of the single salt, as weak as the 0.6 per cent. commonly employed, has a hemolytic effect on the red corpuscles. The desirability, therefore, of administering a fluid which shall be as nearly as possible isotonic with the blood—that is, shall have a molecular concentration corresponding to that of the liquor sanguinis—is evident.—*Jour. A. M. A.*

381 West End Avenue.

RUBBER TISSUE AS A DRESSING.

BY G. TUCKER SMITH, M.D., SURGEON, U.S.N.

In treating any lesion of the skin in which an ointment is indicated as a dressing, it is of prime importance that the parts should, first, be thoroughly protected from infection from without; second, the ointment used should be kept in constant touch with the parts; third, the dressings, when changed, should come away without sticking and without damaging the new-formed and delicate epithelium, and fourth, that the dressing should be kept on as long as possible. All these requirements are admirably filled by rubber tissue. The parts having been cleansed with warm sterile water and green soap, should then be dried. The ointment is next spread on and covered over smoothly with sterile rubber tissue. Sterile lint is next applied and the whole secured with gauze bandage. Several cases are cited to illustrate its benefits:

F. J. McA., warrant machinist, U.S.N., aged thirty-three years, native of Brooklyn, N.Y., was, on November 24, 1902, while at work repairing a steam launch, severely scalded by escaping steam on both feet and wrists. The pain was severe, but was relieved by wet picric acid dressings and a hypodermic injection of morphine sulphate, one-quarter grain. The next morning it was found, on removing the dressings, that large blisters had formed. These were punctured, and the serum evacuated with aseptic precautions. A 10 per cent. boric ointment was then applied to the affected parts, and over this rubber tissue, lint, and a bandage. The dressings were changed from time to time without adhering to the skin or causing pain. By December 3rd he was well, the old skin having been entirely replaced by the new without infection.

Mrs. F. B., a young married woman, came under my charge last summer. She was suffering with a severe case of psoriasis. The disease had existed for almost two years, and had been very rebellious to the usual treatment of chrysarobin and colloidion, locally, with arsenic internally. The eruption was confluent and covered the arms, forearms, the lower part of the body, the lower extremities, and the scalp. A 10 per cent. ointment of chrysarobin was applied to the arms and forearms with the rubber tissue daily. The improvement was prompt and gratifying. She had made for the body a jacket lined with the tissue. She moved to another locality early in October, but kept up the treatment faithfully. I heard from her from time to time that the eruption was gradually but steadily disappearing, and in January she wrote me that it had entirely gone, with the exception of a few small spots.

B. S., an infant, aged eight months, was recently treated by me for acute eczema of the scalp. The little fellow was suffering greatly from the itching and consequent loss of sleep. Rubber tissue was sewed into a tight-fitting hood of light cotton material. Zinc ointment (3 ss-3j) was applied, and the hood tied on closely and kept on day and night. The scalp was cleaned daily with sweet oil and the ointment and hood re-applied. The relief was evident, and in five days the eruption had disappeared.

In conclusion, I would state that doubtless this method has been used by others. As far as I am concerned it is original. I do not believe, however, that its advantages are generally known, and hence deem it worthy of report.—*The American Jour. of Medical Sciences.*

Cancer of the Uterus.

Pozzi (*La Gynécologie*) concludes his paper read before the International Medical Congress with the following deductions: 1. The surgical treatment of uterine cancer rarely insures relief extending beyond two years. 2. Hysterectomy is not justifiable if the uterus is fixed by indurations in the surrounding tissues. 3. The importance of infection of the lymph nodes has been exaggerated, since recurrence usually takes place in the cicatrix; hence extirpation of the glands, even when it is supposed to be complete, seems to have little influence on the return of the disease. 4. Abdominal hysterectomy is a more serious operation than vaginal, on account of the greater risks of infection, and should be reserved for special cases in which the vagina is narrow, the uterine wall softened, or the cul-de-sac extensively involved; also when the uterus is unusually large or complications are present—fibroids, pregnancy, pyometra, or pyosalpinx. In a few instances the abdominal route may be preferable, in order to dissect out the uterus from the diseased tissues. 5. Vaginal hysterectomy is accordingly preferable on account of the smaller risk, the ease with which it may be performed in the early stage of the disease, and the fact that even a palliative operation is preferable to a "pseudocurative" one in which the chances of an immediately fatal result are so great.—*American Jour. of the Medical Sciences.*

Progress of Medical Science.

MEDICINE.

IN CHARGE OF W. H. B. AIKINS, T. M. McMAHON, H. J. HAMILTON,
AND INGERSOLL OLMSTED.

Scarlatiniform Erythema in Tuberculosis.

Claude (*Revue de la Tuberculose*), records an interesting case in which a virulent tuberculous infection was ushered in by a diffuse scarlatiniform erythema of the skin. The patient was a young woman who came under observation on July 28. After having suffered from general malaise, loss of appetite, and muscular pains for a period of seven or eight days, the patient developed an erythematous rash two days before she entered the hospital. It appeared first on the fore-arms, chest, and thighs, and was then patchy. The day after its appearance the patient had a high fever. After admission to the hospital the erythema became general and was of a scarlatiniform type. In five days desquamation began and the rash and desquamation lasted altogether about fifteen days. There was no soreness of the throat, nor any features of the tongue suggesting scarlet fever. The temperature gradually fell to normal by August 11, then it again steadily rose to 40.8° C. before death.

Inquiry showed a family history of tuberculosis. On the day of admission the examination of the lungs was negative. With the disappearance of the rash and the subsidence of the temperature there was not a correspondent improvement in the patient's condition. She gradually emaciated and profuse sweats appeared. Examination of the lungs on August 6 was still negative, but on August 13 signs of slight dulness, with moist and dry râles, were made out at both apices of the lungs, particularly on the right side. From this date on she failed rapidly and died in coma on August 25.

The autopsy showed an acute miliary tuberculosis involving the lungs, liver and spleen, bacilli being demonstrated in the tubercles. There were no old foci of caseous tuberculosis found anywhere in the body.

Claude believes that the erythema was a manifestation of an intense intoxication produced by the poisons derived from the tubercle bacilli. He has been unable to find any similar cases in the literature, but says that the scarlatiniform erythema is analogous to that occasionally observed in anginas, diphtheria, and intestinal infections. The writer remarks that not infrequently tuberculin injections are followed by a similar scarlatini-

form rash. He comments on the early appearance of the rash, long before any physical signs were present, and regards the eruption as an expression of the virulence of the infection. Owing to its early onset, he designates the eruption as a "pre-tuberculous scarlatiniform erythema."—*American Jour. of the Medical Sciences.*

The Passage of Tubercle Bacilli into the Lymphatic and Thoracic Duct after Ingestion.

Nicolas and Descas (*Cent. f. Bakt. u. Parasit.*). Large numbers of tubercle bacilli were suspended in a fatty broth and fed to dogs. In a certain number of cases, after three hours, tubercle bacilli were present in the thoracic duct in such great numbers that they could be demonstrated in stained smears, and by inoculating the chyle into animals tuberculosis could be produced. The authors point out the importance of these results, although somewhat limited, as an explanation for the development of generalized tuberculosis arising by way of the alimentary passages.—*American Jour. of the Medical Sciences.*

The Early Diagnosis of Jaundice.

Hamel (*Deutsche Med. Woch.*) The importance of the early recognition of jaundice,—the cardinal symptom of diseases of the liver and gall bladder and of hæmocytolysis—cannot be over-estimated. But in sallow individuals slight degrees may easily be overlooked. The recognition of bilirubin in the urine is not of much assistance. For this pigment usually does not appear in the renal excretion until after the skin is obviously jaundiced. The only and rare exception is when sudden obstruction of the bile ducts occurs. But bilirubin is present in the blood and gives it a yellow colour before the skin and urine are discoloured. The bile reaches the blood directly from the lymphatics. All jaundiced organs, whether skin or internal viscera, owe their yellow colour to the yellow blood serum which circulates through them. This also applies to "hæmatogenous" jaundice. In many cases, for instance during the passage of a biliary calculus, the amount of bile absorbed gives a decided reaction in the blood, though it may not suffice to produce cutaneous or conjunctival jaundice. Examination of the blood is also useful in chronic jaundice. It shows whether the process is still active or whether a jaundiced tint is merely the result of the deposit of bile pigments, which may persist in the skin after the blood becomes normal. The writer has detected bilirubin in the blood serum in three cases in which cutaneous jaundice was absent.

Blood serum in a thin layer is normally completely colourless,

or only slightly opaque. The technique of the method consists in puncturing the lobe of the ear, and allowing 15 to 20 drops of blood to flow into a capillary glass tube $1\frac{1}{2}$ mm. thick and 4 in. long, which after being hermetically sealed with wax is placed upright with the column of blood below. In a few hours the clear serum has separated from the coagulium which remains at the bottom, and any discolouration is readily detected.—*Medical Review*.

Clinical Observations in Arrhythmia.

F. Lommel (*Deutsches Archiv für klin. Med.*, Bd. lxxii) studied two forms of pulse arrhythmia, those caused by presystolic contraction and those due to the respiratory phases. In the first form the occurrence of occasional double beats in a cycle he finds in three conditions—in increased blood-pressure, diseases of the heart muscle, and nervous disturbances; in one case it seemed due to the greater internal pressure, and in the two others the abnormal irritability of the heart seemed to inhibit the precontraction. By the exact measuring of the pulse wave which follows on the presystolic contraction and the contraction of the auricle on the cardiogram, Lommel concludes that the increased blood-pressure in the ventricle and in other cases in the auricle produces the abnormal irritability. The arrhythmic disturbances of the heart (quickened by inspiration and slowed by expiration) are only exaggerated physiologic fluctuations occurring in convalescence, cardiac neuroses, and central nervous disturbances, and very seldom in organic diseases.—*Medical Age*.

The Pathology and Therapy of Asthma.

SIFE (*Wiener Klinische Wochenschrift*) presents an exhaustive consideration of asthma, in which he maintains that it is a neurosis of the respiratory and circulatory tracts. Four factors stand out pre-eminently in this connection: (1) Hypertonia of the unstriated muscle fibers of the respiratory tubes; (2) hypotonia of the circulatory system; (3) bronchial secretion brought about through nervous influences; and (4) hyperemia of the mucous membrane of the entire respiratory tract. These four factors can be stimulated through three sources, viz: the peripheral nervous system, irritants circulating in the blood, and through the cerebrum. The author speaks therefore, of a peripheral, a hematogenic, and a cerebral asthma.—*Interstate Med. Jour.*

OPHTHALMOLOGY AND OTOTOLOGY.

IN CHARGE OF J. T. DUNCAN.

Syphilitic Necrosis of the Nasal Cavity, Accompanied with Total Blindness.

In the *Philadelphia Medical Journal* C. A. Todd reports a case of Syphilitic Necrosis of the Nasal Cavity, accompanied with total blindness.

The case here described of syphilitic disease of the nasal cavity is of interest outside of rhinology because of the ophthalmic complication.

The patient was sent to the clinic by Dr. Wilson, of the Eye Department, for Nasal Treatment. Almost complete destruction of the nasal septum was found, and, after proper cleansing of the parts, dead bone was found. Four pieces were removed on that occasion, and other pieces afterwards. All these pieces were removed without difficulty, and, after several visits, the cavity assumed a more healthy appearance.

By posterior rhinoscopy and palpation the vault of the pharynx was found to be intact; also, it was plainly seen that the anterior part of the body of the sphenoid was unhurt. The eye affection then could not be referred to extension of necrosis. The man assured me that he never had had any eye trouble before, nor headaches, but such as might be explained by a disordered stomach.

Through the kindness of Dr. Wilson, I am able to present the following data: three weeks previous to the patient's first visit, December 11th, he noticed the sight of the right eye grow dim, "as though something were coming over the eye." In six or seven days the eye became completely blind. Meanwhile the left eye fell into the same condition, and by December 7th it also became completely blind. December 11th: no vision in either eye. During the last four days he had had at different times three distinct flashes of light. For some days he had had continued pain in the region of the right temple, "a jerking headache." He was at once put on potassium iodide and the protiodide of mercury. December 16th.—Is now taking 20 grains of potassium iodide three times daily and $\frac{1}{2}$ grain of the protiodide twice. Headache was much better by the 15th, and is now gone. He had no more flashes of light. Thinks he catches some glimpses of light. Appetite has been good all along. December 18th.—With left eye distinguishes between light and shade. December 20th.—With left eye counts fingers held against the light. He can get about the house alone. December 21st.—Sight of left eye improving; with the right eye he can distinguish between light and shade. December

23rd.—Came to clinic alone. December 26th.—Reads large print with left eye. January 2nd, 1902.—Reads large type readily with left eye; with right cannot make out the letters, but sees large objects. Has been taking the potassium iodide up to ʒ iss daily, with protiodide. The mucous membrane of the nose is well healed; no ulcerations, no fetor. He continues the alkaline, antiseptic wash and vaseline. April 14th.—Returns from a visit to the country. Looks very well. Eyes same as on January 2nd. He dropped his medicine soon after January 2nd on account of cost, and has taken none since. Has kept up the nasal treatment only. June 5th.—Condition of eyes and nose the same as at last visit. At the onset of the treatment Dr. Wilson found some atrophy of the discs, but no other intra ocular lesion, with marked diminution of the field of vision and power of central vision. These conditions remain the same. The right disc exhibits no material difference from the left. There was at no time any involvement of other cranial nerves beyond what the headache in the right temporal region might indicate.

Causes of Blindness in Kentucky, as Seen in the Kentucky Institution for the Education of the Blind.

W. O. Bailey (*The American Practitioner and News*) has a study of the Causes of Blindness in Kentucky, as seen in the Kentucky Institution for the Education of the Blind. In all 228 cases were examined, of which 189 were white and 39 colored.

We find that purulent ophthalmia is responsible for a greater number of these cases than any other one disease; sixty cases, made up of fifty-three white and seven colored, or 26.3 per cent. of the total, are directly referable to this disease as a cause of blindness, and about 90 per cent. of these were due to a purulent conjunctivitis known as ophthalmia neonatorum contracted during parturition, and which we all know can almost invariably be prevented if treated by the Credé method of instilling a solution of nitrate of silver into the eyes immediately after birth. We found in these cases either atrophy of the eyeball or large corneal opacities, some accompanied by anterior synechia or staphyloma.

Trachoma or granular lids and its sequelæ come next in frequency with thirty-three cases, all white, or 14.5 per cent. of the total number examined. The local conditions found were corneal opacities with pannus, or atrophy of the eyeball following perforation of the corneal ulceration caused by the trachoma. Some showed the inturning of the lids, or trichiasis, due to contraction or shrinkage of the scar tissue on the under surface of the lids. Please notice that all of these cases were

found in the white children; very few cases have ever been found in the colored race, and those found were in the light mulattoes.

Phlyctenular keratitis or eczema corneæ is the cause of twenty-nine cases, sixteen white and thirteen colored, or 12.7 per cent. This is the scrofulous or strumous disease of the eye, and this will, therefore, account for the large proportion of the colored cases due to this disease, for we all know, being poorly fed and nourished, that he is more prone to this variety of eye trouble than any other during youth.

TABULATED REPORT OF CASES.

	White.	Colored.	Total.	Per Cent.
Purulent ophthalmia.. .. .	53	7	60	26.3
Trachoma.....	33	..	33	14.5
Phlyctenular keratitis.....	16	13	29	12.7
Congenital and lamellar cataract.....	20	4	24	10.5
Irido-cyclitis.....	14	5	19	8.3
Atrophy optic nerve.....	13	4	17	7.5
Traumatism and sympathetic ophthalmia...	12	3	15	6.6
Congenital syphilis.....	6	..	6	2.6
Retinitis pigmentosa.....	3	1	4	
Albinismus.....	4	..	4	
Congenital central choroiditis.....	4	..	4	
Congenital glaucoma with atrophy.....	3	..	3	
Hydrophthalmos.....	2	..	2	
Nystagmus.....	1	1	2	
Amblyopia with high myopia.....	2	..	2	
Amblyopia with hypermetropia.....	1	..	1	
Traumatic cataract (one eye).....	1	..	1	
Smallpox.....	..	1	1	
Anophthalmos.....	1	..	1	
	189	39	228	

A New Method of Extracting Foreign Bodies from the Ear.

There is no more delicate and even difficult task, so states the *Medical Press*, than the extraction of a foreign body from external auditory canal. Irrigation often fails to bring it away, and in certain cases adds to the difficulty by causing the object, a pea for instance, to swell and become more firmly impacted. The employment of instruments is very painful, and requires considerable dexterity, besides supposing an armamentarium specially designed for the purpose, which few general practitioners possess. The recommendation is made of a piece of soft rubber tube, the length of a cigarette, and of the proper size, to be introduced into the ear. The end of the tube is dipped in paraffin and pushed into the canal until it comes in contact with the foreign body, whereon the operator, applying his mouth to the free end, aspirates forcibly; at the same time throwing back his head. Except in cases of angular bodies of irregular contour this method is usually attended by success, the body coming away with the tube.—*Journal American Medical Association*.

J. T. D.

OBSTETRICS AND GYNECOLOGY.

IN CHARGE OF ADAM H. WRIGHT, JAMES W. F. ROSS, ALBERT A. MACDONALD,
K. McILWRAITH, AND HELEN MACMURPHY.

Puerperal Insanity.

At a meeting of the London Obstetrical Society, held January 7th, 1903, Dr. Robert Jones opened a discussion on the above subject. His paper was based on a personal experience of 259 cases of puerperal insanity, divided into 120 cases during the actual puerperal period, 83 during lactation, and 56 during pregnancy. Insanity was stated to occur once in every 700 confinements. Insanity was stated to be of a characteristic form after confinement, amounting to an almost nosological entity; but this was not the case during pregnancy nor during lactation, there being no definite type of insanity occurring in connection with these two stages. The divisions were, however, more convenient than typical. The following propositions were advanced by the author: (1) The insanity of pregnancy is more common in first confinements among single women, the disappointment, shame and disgrace of illegitimacy being an important factor in the mental break down. (2) During pregnancy the mental condition is more often acute melancholia than acute mania, and suicidal symptoms, which occurred in 41 per cent., have to be carefully guarded against. (3) The insanity of pregnancy is divided into that occurring during the earlier months and that occurring during the later months, and in these the nearer the insanity in point of time to the confinement the more acute are the mental symptoms. Insanity is not more frequent when the sex of the child is male. (4) The insanity of the puerperium comes on after the first confinement in 33 per cent. of the cases, and supervenes suddenly rather than gradually. (5) The cases which occur during lactation present characters of marked general physical exhaustion, and mentally are more often of the depressed than the maniacal form. Lactation insanity becomes chronic oftener than the insanity of the other periods. There is a tendency to low forms of inflammation, thrombosis, gangrene, and phthisis during the insanity of lactation. Both suicidal and infanticidal promptings are more common in lactational than puerperal cases, that is in cases where insanity commenced more than six weeks after confinement. (6) The early symptoms of threatening insanity are loss of sleep and headache, and these should be a forewarning of mental break down. The busy delirium of hallucinatory character, ending in acute, restless, purposeless mania with religious and erotic delusions, is characteristic of

this variety. (The writer suggested a close analogy between the emotions of love and religion, and agreed with Simpson that the organ diseased gave a type to the insanity, and that in women suffering from affections of the generative organs the delusions were more likely to be connected with sexual matters.) (7) Etiology: Heredity is more marked and in the direct maternal line in puerperal and lactational insanity, and is equally paternal and maternal in the insanity of pregnancy. A previous record of hysteria is frequent in puerperal insanity. (8) The pathology is that of heredity and stress. Is the stress due to a toxin? (9) As regards prognosis, cases of insanity during early pregnancy improve towards the end of pregnancy, whereas those of late pregnancy become worse at the puerperium. Puerperal insanity is markedly recoverable. Improvement is rapid, being often complete in three months, but generally takes four to five months. (10) Treatment: All cases presenting headache and sleeplessness must have absolute quiet and rest, and sleep must be procured. Home treatment in all cases if possible. Guard against unusual and sudden impulses of suicide and infanticide. The presence of the husband aggravates the symptoms. There is much necessity for a liberal and stimulating dietary. Change is necessary in puerperal insanity when cases tend to become stuporose. Menstruation is a sign of mental improvement. Purgatives and iron are well borne.—*Br. Med. J.*, January 24, 1903. An interesting discussion followed in which several of the members remarked that refusal to take food was one of the most characteristic symptoms.

K. C. M.

Editorials.

APPETITE AND DIGESTION.

Many busy men thoroughly enjoy what is known as a good dinner, which is a very scientific sort of thing, although it has reached its present stage of perfection through a process of evolution extending over something like 6,000 of study and practice which have been largely empirical in character. We are learning much during the last few years on the physiological aspects of a good dinner. Dr. Pawlow has thrown much interesting light on the connection between appetite and digestion, as we learn from the *Literary Digest* which gets its information from the hospital.

We learn from his investigations that we do not as a rule eat because we are really hungry. We sit down to our dinner and depend on the cook to create most of the appetite and give the proper stimulus to the digestion. An alkaline bitter to start with helps both. Then come foods which help the good work done by the bitters, such as the extractives of meat which exist in the soups. We thus get fairly well through our preliminary canter as far as the simple food is concerned. But we have other things to consider. We must eat with interest and enjoyment, having left behind us all our cares and troubles. The psychological aspect is most important. The good appetite soon created, the happy surroundings, the initial light foods excite the gastric and intestinal glands. We go on from course to course, never growing weary in well doing, and really put away quite a vast amount of food in a couple of hours. If we are moderate in our post-prandial smoking, etc., we go to our beds happy and contented—perhaps slightly philosophical—and awake the next morning without a headache. From a professional point of view not the least interesting feature is the fact that thanks to our *chef* we have been acting on strictly scientific physiological lines. As to a poor dinner, however, perhaps the less said the better!

THE ADDITION OF CHEMICAL PRESERVATIVES TO FOOD.

The fact that certain antiseptics are added in considerable quantities to our foods is perhaps not properly appreciated by the medical profession. Dr. A. E. Porter, of Leeds, England, tells us that the quantity of drugs more or less potent which may be consumed on account of such adulteration is larger than most of us suspect.

"Out of 4,251 samples of food and drink obtained from London and the provinces which were recently examined at the Government Laboratory, nearly 40 per cent. were found to contain either boron compounds, salicylic acid, formic aldehyde, or sulphites. Whilst these are the commonest preservatives in use, benzoic acid, hydrofluoric acid, alum, chloral hydrate, β -naphthol, sulphonate of soda, and alcohol are also employed.

"One or other of these substances has been found in milk, cream, butter, margarine, bacon, ham, fresh meat, poultry, game, sausages, pork pies, potted meat, meat jellies and extracts, fresh fish, herrings, shrimps, oysters, potted fish, fresh and preserved fruit, jams, vinegar, pickles, lime and lemon juice, syrups, ginger beer, ginger ale, lemonade, British wines, cider, beer, port, sherry and brandy."

One of the safest, and at the same time most widely used preservatives is boric acid. It is employed chiefly for the preservation of dairy products, and fish and meat foods. Experiments indicate that generally it has no evil effects, but there are exceptions. Those who have conducted the experiments think that milk containing boric acid is injurious to young children, and also to adults suffering from acute or chronic nephritis, and also those suffering from digestive disturbances, such as gastric ulcer or gastro-enteritis. It is also considered by some that boric acid tends to produce muscular contraction, and is therefore an undesirable addition to the food of a pregnant woman.

We regret that a rather misleading item regarding the use of antistrepto-coccus serum in scarlet fever, appeared in our last issue. We understand that the trial of the Stearns Hubbert Process Serum is still being carried on, but the base for the work has been changed on account of lack of cases in Montreal.

THE ONTARIO MEDICAL ASSOCIATION.

The twenty-third annual meeting of the Ontario Medical Association will be held, June 15th to 18th, inclusive, under the Presidency of Dr. J. C. Mitchel^l, formerly of Enniskillen, now of Toronto. For the first time in the history of the Association there will be a three days' meeting. The two important committees have their work well in hand. The Committee on Arrangements, under the chairmanship of Dr. Bruce Riordan, have, we understand, nearly completed their plans. The committee on Papers and Business, under the chairmanship of Dr. W. P. Caven, have nearly completed their programme. We are pleased to know that our friend, Dr. Thos. Cullen, of Baltimore, has promised to attend and contribute a paper. We are also glad to announce that Dr. Musser, of Philadelphia, will read a paper. During the meeting there will be a discussion on arteriosclerosis. Members who are willing to contribute papers are requested to communicate with the General Secretary, Dr. Harold Parsons, Bloor Street W., Toronto.

THE RICHARDSON TESTIMONIAL.

We understand that Dr. Thomas Cullen, of Baltimore, was the first to suggest the advisability of honoring our dear friend, Dr. Richardson, by tendering him a banquet and presenting his portrait to the University of Toronto. Dr. John Amyot started the movement in Toronto, and has been exceedingly active as the Secretary-Treasurer in completing all the details. He has been well supported by the committee having charge of the matter. Many interesting letters have been received by Dr. Richardson's *old boys* in all parts of the world. We cull a few extracts as follows :

Professor Wm. Osler, of Baltimore, says: "I am very glad indeed to hear of the Richardson testimonial, to which I am only too pleased to subscribe. Let me know how much you want. I was very closely associated with Dr. Richardson during my first two years of student life, and became very much attached to him, and it would be a very great pleasure to do anything I possibly could for such a worthy object."

Professor D. W. Montgomery, of San Francisco, Cal., says: "I owe quite a debt of gratitude to Dr. Richardson as a most excellent teacher. Lesslie Sweetnam and I were his prosectors, and he took infinite pains with us. I also shall never forget his clinics."

Dr. M. S. Langs, of Boulder, Col., says: "Please give the doctor my regards when you see him, although he has probably forgotten me entirely, as I have not seen him since some time in 1864."

Dr. Teller, of Arkansas City, Kan., says: "Enclosed you will find money order. Hoping it may help in giving as much pleasure as it has given me in sending it."

Dr. Wm. Burt, of Paris, Ont., says: "I am very much pleased with what is being done for Dr. Richardson."

Dr. James F. Bell, of Portland, Oregon, says: "It gives me great pleasure to contribute this small amount to this cause, for I entertain only the most pleasant recollections of Dr. Richardson as a teacher, physician and man; and my great regret is, that I cannot be present at your dinner."

Dr. C. Sheppard, of Ontario, Cal., says: "It affords me great pleasure to join in the testimonial to our old and esteemed teacher, Dr. Richardson, whose kindly interest and friendly advice I always remember with great satisfaction."

Dr. Octavius Wild, of Vancouver, B.C., says: "I enclose herewith my subscription towards the testimonial portrait of our greatly esteemed teacher, Dr. Richardson. Would that I could join his hosts of students and friends at the dinner to be given in his honor after Easter, but distance prohibits."

Dr. Charles T. Noecker, of Waterloo, Ont., says: "I am heartily in accord with the objects of the movement, for I think the honors should be showered on Dr. Richardson while he is with us in body and spirit, and not withheld, as is too frequently done, until the spirit world has opened and closed its gates. Dr. Richardson taught us anatomy it is true, and in a very thorough manner, but his lessons were not confined to the subjects within the covers of anatomy text-books. Well do I recollect his presence before the class, coat removed, arms bare, in short, enthusiasm personified. He is the champion of students' rights, and well does he merit the esteem in which he is universally held. I am sure that the graduates of the Toronto school, without exception, have largely benefitted by his instruction and example."

Dr. Jas. S. Freeborne, of Magnetawan, Ont., says: "I trust and believe you will meet with a hearty response. None deserves it better than Dr. Richardson."

Dr. Samuel McKibbin, of Amethyst, Colorado, says: "I am pleased that the friendship for Dr. Richardson, and apprecia-

tion of his work are finding tangible expression. It is a pleasure to me to have a part in the testimonial, as I have always been a sincere admirer of the doctor—of the man rather. His manly, straightforward, forceful qualities always made him a hero, as well as professor, in the affections of the students. I hope he may live many years yet, in which to enjoy the peaceful reflections over a life-work well done.”

Dr. A. J. Campbell, of Gravenhurst, Ont., says: “I am heartily with any effort to do lasting honor to our mutual friend, the venerable Dr. Richardson.”

Dr. F. D. Kent, of Thornbury, Ont., says: “No one would be more delighted than myself to attend the dinner to do honor to one who in my time was undoubtedly ‘the friend and champion of the boys.’”

Dr. W. S. Black, of Oakville, Ont., says: “I desire to subscribe to the James H. Richardson Fund, and I thank you for giving me this opportunity of lending a helping hand to such a deserving and praiseworthy object.”

Dr. L. H. Campbell, of Bradford, Ont., says: “He is worthy of every honor we can do him.”

Dr. J. W. Burgess, of Montreal, Que., says: “As an old pupil of a man to whom I owe a very, very great deal of gratitude, I gladly enclose my subscription toward the portrait. Kindly convey my good wishes to Dr. Richardson and the gathering.”

Dr. N. D. Richards, of Warkworth, Ont., says: “I heartily agree with you that Dr. Richardson’s services deserve recognition by his old students. There never was a man in the Toronto School of Medicine who had the love of the students as much as he had. I for one really loved him. If it is possible for me to be at the dinner I will let you know before the time. If not believe that I will be there in my thoughts.”

Dr. F. J. Bell, of Southampton, Ont., says: “I will ever hold in grateful and pleasant remembrance the sympathy and interest in the Meds that ‘Jimmie’ ever manifested.”

Dr. A. R. Robinson, of New York, says: “Would like very much to be present to grasp the hand of the *young man* and wish him a long life, etc. I remember Professor Richardson’s face as if I had studied under him but yesterday.”

Dr. James H. Duncan, of Chatham, Ont., says: “It would be difficult to express in too strong terms my appreciation of Dr. Richardson as an eloquent, earnest and most effective teacher, and as a friend ever kind, with a fatherly kindness to me. I deeply regret that I shall not be able to join with his admirers at the proposed dinner, but in spirit I shall be with you; wishing Toronto University Medical Department’s ‘Grand old man’ (for the doctor is certainly no longer young) every happiness, and joining in the deserved, yes, well-deserved, laudation of his

many excellencies that will be so freely and eloquently spoken that night."

Dr. M. J. Kelly, of Brantford, Ont., says: "As an old pupil who never sat under a superior teacher of anatomy I would willingly have contributed something more valuable."

Dr. J. P. Vrooman, of Napanee, Ont., says: "I enclose post office order to apply to fund for purchasing painting of Dr. Richardson. The idea of doing so is an excellent one, and I am truly glad to have the opportunity to contribute as my respect and liking for the old man have only increased as years went by."

THE BANQUET.

The banquet held at McConkey's restaurant, April 15th, was a most successful and enjoyable affair. Among those present, in addition to Dr. Richardson, were Professor Loudon, President of the University of Toronto, Chief Justice Moss, Vice-Chancellor, Professor Reeve, Dean of the Medical Faculty, Professor Kamsay Wright, Dean of University College, Mr. A. Dixon Patterson, the artist, Professor Cameron, who acted as Chairman, Messrs. William and James R. Roaf, (nephews of Dr. Richardson), Mr. William Freeland, (son-in-law), Dr. Charles O'Reilly, Toronto General Hospital, Dr. Thomas Cullen of Baltimore, Drs. Ingersoll Olmsted of Hamilton, A. Taylor and James L. Turnbull of Goderich, Angus McKinnon of Guelph, Frank Drake of London, S. T. Rutherford of Listowel, E. E. Kitchen of St. George, Horace Bascom of Uxbridge, D. Hoig of Oshawa, H. F. MacKendrick of Galt, C. H. Britton and W. R. Walters of East York, Jas. Johnston of Bradford, Pa., Drs. Jos. Bascom, Geo. Peters, A. Primrose, R. D. Rudolf, J. Milton Cotton, Edmund E. King, Albert Macdonald, W. H. B. Aikins, Arthur Jukes Johnson, Geo. McDonagh, A. B. Macallum, Uzziel Ogden, Wilberforce Aikins, Cleland, Amyot, W. H. Ellis, W. A. Young, James F. W. Ross, Cuthbertson, Duncan, Oldright, Adam Wright, Alexander, Geoffrey Boyd, Price Brown, Herbert Bruce, Burnham, G. H. Carveth, John Caven, W. P. Caven, Graham Chambers, George Clemens, Alexander Davidson, Dwyer, J. T. Fotheringham, Goldie, Greig, Harrington, Chas. J. Hastings, S. M. Hay, Wm. Heggie, Lehmann, W. J. McCollum, McKibbin, McKeown, A. McPhedran, Machell, Nevitt, John Noble, J. Orlando Orr, Churchill Patton, Peaker, Crawford Scadding, Silverthorne, G. B. Smith, Wallace Smuck, F. N. G. Starr, Clarence Starr, Thistle, J. D. Thorburn, Webster, R. J. Wilson, Thomas Wylie, J. E. Elliott, A. Webb, J. L. Smith, John Ferguson, D. McGillivray.

A pleasing incident occurred during the last course of the dinner when Mrs. Richardson, with her daughter, sister and

niece entered the gallery. They were seen by a few at the head table, and a slight clapping of hands commenced. All heads were at once turned towards the applause, and then in the opposite direction towards the gallery. The whole assembly then rose as one man and cheered and waved their handkerchiefs, then followed a song, more cheering and more waving. The last to wave a loving signal across the banquet hall was the Grand Old Man himself—the devoted husband to the devoted wife.

The following quotation appeared on the handsome menu card in connection with the toast to the guest :

“A man with whom we have often fished and conversed, whose experience, learning, wit, and cheerfulness made his company to be esteemed one of the delights of mankind; this man was also a most dear lover and a frequent practiser of the art of angling, of which he would say: ‘Twas an employment for his idle time which was not idly spent, a rest to his mind, a cheerer of his spirits, a diversion of sadness, a calmer of unquiet thoughts, a moderator of passions, a procurer of contentedness, and that it begat habits of peace in those that professed and practis’d it.’”

After honoring the toast to the King Dr. G. S. Cleland, unveiled the portrait, and formally presented it to the University. In doing so he referred briefly but in warm terms to the distinguished services rendered to the University in various ways by Dr. Richardson while acting as professor of anatomy. Chief Justice Moss, the Vice-Chancellor, in accepting the portrait also made some kind and complimentary references to the Doctor’s great work as a teacher and a surgeon. He also paid a fervent tribute to his services as a Senator of the University at one important period. We understand that Dr. Cleland was the first to suggest that the graduates should present a portrait of Dr. Richardson to the University at the banquet. The portrait is from the brush of Mr. Dixon Patterson and is a striking likeness of Dr. Richardson as he appeareth now in his eightieth year.

After the presentation of the portrait Prof. W. H. Ellis, on behalf of the old pupils presented an illuminated address as follows :

To James Henry Richardson, Esq., M.D. Tor., M.R.C.S. Eng., Emeritus Professor of Anatomy in the University of Toronto.

Sir,—We, your old students, have been desirous of expressing, in some suitable way, our respect for you as a teacher and our affection for you as a friend, a respect and affection which you inspired in us as undergraduates, and which the experience of later years has only served to increase.

To fulfil this purpose we have thought that we could do no better than to present your portrait to the University with which, from its earliest years you have been so closely identified, whose cause you have so loyally defended, and whose reputation you have so signally advanced.

For nearly half a century you have labored in the cause of medical education with unwearied patience and with ungrudging devotion. We wish to assure you that your labor has not been in vain.

To the foundations laid by you, and by your colleagues of the Toronto School of Medicine, the University of Toronto owes, in no small measure, the success of her Medical Faculty, and we, your scholars, owe to you, our master, for sound teaching and kindly help, for high ideals and a worthy example a debt which we can never repay but which we are proud to acknowledge.

We feel, therefore, that the building which is about to become the home of the Medical Faculty of the University of Toronto, could have no fitter ornament to decorate its walls than the portrait of one who has so many claims as yourself upon the grateful remembrance of every graduate.

It is our great privilege in making this offering to have the opportunity of testifying at the same time our loyalty to our *Alma Mater* and our love for her distinguished son.

We beg to sign ourselves on behalf of the subscribers your grateful pupils and faithful friends:

(Signed) Joseph Bascom, Wm. Oldright, W. H. Ellis, A. H. Wright, I. H. Cameron, Jas. F. W. Ross, H. Wilberforce Aikins, J. Milton Colton, Edmund E. King, Jno. Caven, George A. Peters, G. S. Cleland, J. T. Duncan, Jno. M. Amyot.

Prof. I. H. Cameron, in proposing the toast of "Our Guest," expressed the wish that Dr. Richardson might long be spared to them. As his pupils, they had perhaps forgotten much of the anatomy he had taught them, but they had not forgotten the example he had given them—that would remain with them to the end of the chapter. He referred to the doctor's piscatorial prowess, and how as a young man he had won fame as an athlete, and in the noble art of self-defence. Although he had attained to fourscore years, he still excelled in athletic pursuits—he was still able to catch fish and play the roarin' game.

Dr. Richardson, who was most enthusiastically received, expressed heartfelt thanks for the reception, and gave a short review of his medical career. He also thanked his old pupils for having so pleasantly brightened his latter days. They

had conferred a great honor upon him, and more than that had given him an assurance of their esteem. He then gave a few interesting particulars as to his student life and his work for a few years after graduating.

In 1841, after concluding his studies at Upper Canada College, he went to Rochester, where he studied under Dr. Rolph for two years. In 1843 he returned to Toronto and entered the Medical School as a student, having first to secure a special dispensation, as he did not belong to the Established Church. In 1843 the young student went to England, entering Guy's Hospital, where he obtained the diploma of M.R.C.S., being the first Canadian to win this honor. He was present at the first administration of ether in London. He was six months in Paris. He returned to Toronto in 1848, and entered upon the practice of medicine. In 1850 he was appointed lecturer in anatomy, as successor to the late Dr. Sullivan. When the new faculty of Toronto University was formed, he was appointed professor in anatomy, a position he resigned one year ago. He was for many years a member of the University Senate. He also bears the distinction of being the first student of Toronto University to take the medical degree. In the course of his remarks he related some incidents illustrating the progress of medicine during the last fifty years.

The entrance of Mrs. Richardson into the banquet hall brought back to the minds of many present recollections of a very happy event which happened, August 20th, 1900, when Dr. and Mrs. Richardson celebrated their golden wedding. After a family dinner party the dearly beloved couple received their friends from 4 to 10 p.m. in an informal way. At the close of the happy day Dr. Richardson remarked that he especially appreciated the fact that not only did the older members of the profession come to bid them God-speed, but that nearly all the younger physicians of the city also called on them. At that time we were very much pleased to be able to state that both Dr. and Mrs. Richardson were in the enjoyment of excellent health. We rejoice to-day to have the same happy tale to tell.

Personals.

Dr. Helen MacMurchy has removed to 133 East Bloor Street

Dr. Glen Macdougall has opened an office on Bathurst Street, Toronto.

Dr. King Smith has been promoted to the rank of Surgeon-Major of the 48th Highlanders.

Dr. J. Algernon Temple has removed to his new residence, 333 Bloor Street West.

Dr. George Porter, of Toronto, after a visit to the city of Mexico, returned March 24th.

Dr. Charles O'Reilly, after spending a few days in Detroit returned to Toronto, March 21st.

Dr. A. M. Hayes (Tor. '90) has been appointed Associate Coroner for the County of Lambton.

Dr. R. T. Noble will reside at 74 Gerrard Street East, when Dr. Silverthorne moves to College Street.

Dr. J. M. Elder has been appointed Assistant Professor of Surgery and Clinical Surgery, McGill University.

Dr. Wentworth Irving was married, March 14th, to Miss Maude Macleam, daughter of the late Dr. Macleam, Meaford.

Dr. Eli Thomas Eede, of Leamington, has been appointed an Associate Coroner for Essex County, in the place of Dr. J. T. Sutherland, deceased.

Dr. Duncan McEachern, for many years Dean of the Faculty of Comparative Medicine and Veterinary Science, McGill University, has resigned.

Dr. Laphorn Smith, of Montreal, left New York for Europe, March 25th. He will attend the meeting of the International Medical Congress at Madrid, to be opened, April 23rd.

Dr. G. Silverthorne, of Toronto, has recovered from his recent attack of septicemia. He has purchased a house, 236 College Street, which he expects to occupy May 1st.

Dr. Trudeau, of Saranac, spent a portion of the winter in California on account of his wife, who was in delicate health. His son, Dr. Trudeau, jr., who was acting as temporary manager of the sanitarium at Saranac, received a despatch in the latter part of March summoning him to California to see his father who was seriously ill.

Dr. Colin Campbell visited Toronto in March.

Dr. E. F. Smith has been appointed jail surgeon at Mattawa.

Dr. Sylvester, of Toronto, visited New York early in April.

Dr. George McDonagh enjoyed his visit to Jamaica very much. He went by way of Baltimore, and Dr. Thos. S. Callen sailed by same steamer for Jamaica. Dr. McDonagh returned to Toronto March 19th.

Mr. James Hutton, a medical student of Queen's University, Kingston, charged with attempted grave robbery at Lansdowne on the night of March 12th, was sentenced, March 27th, to imprisonment for two months in the common jail, Brockville.

Dr. D. Gibb Wishart has recovered from his attack of erysipelas, after having had two relapses. He and Dr. Harold Parsons, who has recovered from his second attack of septi-cemia, went to St. Catharines, April 4th, and spent a couple of weeks at the Welland.

Dr. P. H. Bryce, of Toronto, Secretary of the Provincial Board of Health of Ontario, read an address on "Some Scientific and Practical Aspects of Vaccination" before the Medical Society of the State of New York, at its ninety-seventh annual meeting.

The Municipal Council of St. John, N.B., recently honored Dr. Wm. Bayard, by tendering him a tribute of regard and personal esteem in the shape of a handsomely engrossed resolution on parchment, on the occasion of his retirement from the Board of Commissioners of the General Hospital, after a service of forty years.

Obituary.

WILLIAM WARREN BALDWIN, M.B.

Dr. Baldwin (Tor. '90), died at Olive Island, Muskoka, March 23rd.

JOHN G. GILES, M.D.

Dr. Giles (Queen's, '60) of Athens, died, March 12th, at the age of 69.

ALEXANDER GRAHAM, M.D.

Dr. Alexander Graham (Victoria, 1869), of London, Ont., died March 26th.

SAMUEL COWAN, M.B.

Dr. Samuel Cowan (Tor. '66), died, February 1st, at the Guelph General Hospital, aged 70.

ROBERT MAXWELL COOPER, M.D.

Dr. R. M. Cooper (West. Univ. '89), of London, Ont., died suddenly, March 21st, at the age of 34.

CHARLES McDONALD CAMERON, B.A., M.D.

Dr. Cameron (B.A., Victoria, and M.D., Univ. N.Y.), for many years a practitioner of Rochester, N.Y., but recently a resident of Cobourg, Ont., died, February 27th, aged 81.

THEODORE GAILLARD THOMAS, M.D., LL.D.

Dr. T. G. Thomas, of New York, died suddenly of cardiac disease at Thomasville, Georgia, February 28th, aged 71. He was for many years the greatest gynecologist, and the greatest teacher of gynecology in the United States.

THOMAS McCORT, M.D.

Dr. Thomas McCort, of Thessalon, Algoma, died, January 13th, 1903, aged 47. He was graduated from Trinity University, 1878.

PROFESSOR ENRICO BOTTINI.

Professor Enrico Bottini, the celebrated Italian Surgeon and Parliamentary Senator died, March 11th. He was best known in this country for the operation which bears his name.

ANDREW HALLIDAY, M.B., C.M., D.P.H.

Dr. Halliday, of Halifax, died, March 10th, exactly one year after the death of Dr. Muir. We learn from the *Maritime Medical News* that, "with the prospect of employment in the Provincial Laboratory and in the Halifax Medical College, Dr. Halliday had spent a year recently at Glasgow University, giving careful study to subjects pertaining to public health." He was generally recognised as one of the ablest and most scientific young physicians that Nova Scotia has produced.

D. GILBERT GORDON, B.A. (Tor.) M.D. (Trin.)

The last time the writer saw Gilbert Gordon he looked healthy and happy, and was driving with the Rev. Dr. Kerr, the captain of the Scotch Curling Brigade, to the Victoria rink for an afternoon match. A few days after we heard the sad news that he probably had tubercular peritonitis. A section was performed, March 2nd, and, although the diagnosis was found to be correct, hopes of his recovery were entertained by himself and his physician. Contrary to advice he went to Old Point Comfort, but soon grew worse, and was moved, March 10th, to Baltimore, where he was kindly cared for in Dr. Howard Kelly's private hospital until the morning of March 28th, when death put an end to his sufferings. The remains were brought to Toronto and buried on the afternoon of March 30th.

Dr. Gordon pursued his arts course in Toronto, and his medical course in Trinity, becoming M.D. in 1886. He went to Europe in 1887 for post-graduate work, spending the greater portion of his time in Edinburgh, where he took the double Edinburgh and Glasgow qualification. He commenced practice

in Toronto in 1888, and was eminently successful as a practitioner, and as a teacher of medicine in Trinity Medical College. After working for some years in the department of anatomy in the latter institution, he was appointed Professor of Sanitary Science and Associate Professor of Clinical Medicine. He was a lover of sports—in his younger days one of the best football players that ever appeared on the University campus, an excellent curler, being a past president of the Victoria Curling Club, and a very enthusiastic bowler "on the green." He was a straightforward, honest, manly man, with a charming and lovable disposition, a family physician of the best type, an excellent practical teacher, very popular with his vast host of friends, and dearly beloved by his patients. He was 45 years of age.

FRANK D. TURNBULL, M.B.

Among the recent graduates in medicine of the University of Toronto, there was none more highly respected than Dr. Frank Turnbull. After graduating he spent a year as resident assistant in the Toronto General Hospital, 1899-0. After practising nearly three years in Auburn, Huron County, he decided to go to Europe for post-graduate work. On his journey to Goderich in a canoe, March 19th, an accident in the rapids, causing his boat to upset. After a time he was found clinging to the canoe, and rescued in a dying condition. Life was extinct when the body was brought to land.

Correspondence.

To the Editor of CANADIAN PRACTITIONER AND REVIEW.

DEAR SIR,—At the last (fifty-third) meeting of the American Medical Association, held at Saratoga Springs, June 10-13, 1902, a joint resolution from the Sections of Cutaneous Medicine and Surgery and Hygiene and Sanitary Science was introduced in the House of Delegates as follows:

Whereas,—There is a burning necessity to check the spread of venereal diseases, and, assuming that the States cannot with impunity ignore the condition, it lies in the province of the medical profession to discuss and recommend to the respective State Legislatures and Municipalities means not regu-menta-tive, but social, economic, educative and sanitary in their character, to diminish the danger from venereal diseases.

Resolved,—That the Section on Cutaneous Medicine and Surgery of the American Medical Association invite the section on Hygiene and Sanitary Science to co-operate with the Section on Cutaneous Medicine and Surgery in bringing about a propagaanda in the different States, looking toward a proper recognition of the dangers from venereal diseases, and to arrange for a national meeting under the auspices of the American Medical Association for the prophylaxis of venereal diseases, similar to the International Confereuce for the Prophylaxis of Venereal Diseases, which meets again this year at Brussels, under the authority of the Belgian Government."

This was later submitted to the House of Delegates, which endorsed the action of Section and adopted the following:

Resolved,—That a joint committee of six from the sections on Hygiene and Sanitary Science and Cutaneous Medicine and Surgery be appointed by the president to stimulate study in and uniform knowledge of the subject of the prophylaxis of venereal diseases and to present to the American Medical Association a plan for a national meeting, similar to the International Conference for the Prophylaxis of Venereal Diseases, which meets again this year in Brussels, under the auspices of the Government of Belgium."

The Committee on Prophylaxis of Venereal Disease consists of: Dr. Henry D. Halton, Chairman, Brattleboro, Vt.; Dr. Ludwig Weiss, Secretary, 77 East 91st Street, New York; Dr. George M. Kober, 1600 "T" Street, Washington, D.C.; Dr. W. H. Sanders, Montgomery, Ala.; Dr. L. Duncan Bulkley, 531 Madison Ave., New York City; Dr. Frank H. Montgomery, 100 State Street, Chicago, Ill.

The peculiar social, racial and political conditions of our

country are so different from those on the continent that they necessitate an expression of solely American ideas on this mooted question, both from a socio-economic and sanitary point of view.

The Committee desires the support of the medical profession and the aid and powerful collaboration of the Medical Press of the country to help them in this work. It takes the liberty of soliciting expressions and views editorially and otherwise, and would be glad of personal correspondence from those supporting the movement and who will contribute by papers, etc., to make it a success in case the House of Delegates should favor the holding of such a Congress.

By giving this a place in your esteemed paper, the Committee feel that you will have aided materially in forwarding the work entrusted to them.

I remain with thanks,

Very truly yours,

LUDWIG WEISS, M.D.,

Secretary of Committee.

New York, March 4th, 1903.

MEDICAL ITEMS.

The University of Toronto Alumni Association of Montreal held their first annual dinner, March 12th. Among those present were Professors Hutton and Ramsay Wright, and Drs. Geo. Wilkins, John McCrae and A. S. Morphy.

Professor and Mrs. Goldwin Smith have contributed \$2,000 towards the fund for the convocation hall, University of Toronto.

The *Journal of Tuberculosis*, a quarterly magazine devoted to the prevention and treatment of tuberculosis, edited by Karl Von Ruck and Silvis Von Ruck, and published by A. H. McQuilken, Ashville, N.C., has been greatly increased in size and improved in appearance. It is in all respects an admirable medical journal.

American Urological Association meets first Wednesday of each month, except July, August and September.

Annual meetings: The last day of the American Medical Association's meeting and the day following.

This year's meeting: New Orleans, May 8th and 9th.

President: Ramon Guiteras, M.D.

Secretary: Ferd. C. Valentine, M.D., 31 West 61st St., New York.

Book Reviews.

Progressive Medicine. Fifth annual series. Volume I, March, 1903. A quarterly digest of advances, discoveries and improvements in the medical and surgical sciences. Edited by HOBART AMORY HARR, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia. Octavo, handsomely bound in cloth, 450 pages, illustrated. Per volume, \$2.50, by express prepaid. Per annum, in four cloth-bound volumes, \$10.00. Lea Brothers & Co., publishers, Philadelphia and New York.

This invaluable periodical publication differs very materially in its scope from the ordinary year-books and epitomes of medicine and surgery. As the title of "Progressive Medicine" indicates, its pages are devoted to the real advances of medical science. The editors of its different departments are all scientific men and teachers of experience, and its contents are not mere abstracts of articles appearing in current medical literature. It may be compared to an advanced text-book of medicine and surgery, kept abreast of the times by continual revision and addition. Its sections are so arranged as to cover every branch of professional work without interference or repetition. It is only possible here to direct attention to the more important features in the present issue, although a vast amount of other valuable matter is included. In the present volume, Frazier, in the section on the surgery of the head, neck and chest, describes particularly the wonderful progress which has been made in the surgery of the skull and brain, especially in the diagnosis of brain tumors and abscesses; he also particularizes the latest researches into the surgery of the thyroid gland, and some of the remarkable results achieved in recent operations upon the heart. Among other topics, he also discusses the surgical treatment of diseases of the esophagus and stomach. Herrick writes the section on the infectious diseases, devoting especial attention the importance of serum therapy in the light of recent discoveries. His description of the methods in vogue in the management of typhoid fever, and pneumonia is remarkably full and of great value. Crandall, in considering diseases of children, describes in detail the methods of feeding and of milk modification, which are of such immense practical value in the treatment of diseases of infancy and childhood. In the section on pathology, Dr. Hektoen devotes particular attention to the late studies into the specific properties of the various tissues and fluids of the body. The study of cytotoxins, agglutinins and precipitins is of such importance and of such intricacy that a lucid explanation will prove of inestimable value to the great body of the profession, who otherwise would be unable to acquaint themselves with the recent strides

achieved by workers in chemical pathology. A. Logan Turner, in the section on laryngology and rhinology, presents a summary of recent achievements in the correction of nasal deformities by means of paraffin injections. Randolph's article on Otology is devoted largely to a discussion of the methods employed in the treatment of various chronic aural conditions, heretofore considered as almost hopeless from a therapeutic standpoint. The volume is profusely illustrated and completed with an index, which is so arranged as very greatly to enhance its value to the busy practitioner as a work of reference.

An Epitome of Physiology—For Students and Practitioners of Medicine. By THEODORE C. GUENTHER, M.D., of the Norwegian Hospital, Brooklyn, and AUGUSTUS E. GUENTHER, B.S., formerly Assistant in Physiology in the University of Michigan, Ann Arbor. In one 12mo volume of 250 pages, with 57 engravings. Cloth, \$1.00, net. Lea Brothers & Co., Publishers, Philadelphia and New York, 1903.

This is a compact little treatise, free from discursive matter, but giving the established facts of physiology as developed at the present day. It is intended for and especially adapted to the needs of medical and dental students, but it will also prove of value to the practitioner who may wish to post himself on the most recent findings on the subject. No one will deny the value of epitomization, if well done, and while this compendious little work is by no means intended to take the place of the large volumes on Physiology, it certainly provides a handy and legitimate help to a knowledge of essentials to which a thorough understanding of details may be easily added. This Series of Medical Epitomes should not be confounded with the ordinary question compend, made up in question and answer form, for in the epitomes the matter is given connectedly, thus facilitating reading and study, and the questions for convenience in quizzing are appended to each chapter. Helpful illustrations are used where necessary throughout the book.

The American Year-Book of Medicine and Surgery for 1903. A yearly digest of scientific progress and authoritative opinions in all branches of medicine and surgery, drawn from journals, monographs and text-books of the leading American and foreign authors and investigators. Arranged, with critical editorial comments, by eminent American specialists, under the editorial charge of GEORGE M. GOULD, A.M., M.D. In two volumes—Volume I, including General Medicine, octavo, 700 pages, fully illustrated; Volume II, General Surgery, octavo, 670 pages, fully illustrated. Philadelphia, New York, London: W. B. Saunders & Co., 1903. Per volume, cloth, \$3.00 net; half morocco, \$3.75 net. Canadian agents: J. A. Carveth & Co., Parliament Street, Toronto, Ont.

We do not know of any similar publication, either American or foreign, that can compete in any way with this excellent Year-Book, published by W. B. Saunders & Company. It is not an indiscriminate collection of extracts clipped from any

and every journal; the matter is carefully selected, edited, and in numerous cases commented upon by the eminent authorities whom Dr. Gould has enlisted as his assistants. Every new theory and scientific discovery worthy of the consideration of the profession has found a place in this unusually complete Year-Book; and the names of the several editors are sufficient guarantee of a proper discrimination. The work comes to us in the same dress as last year—in two volumes. Volume I contains General Medicine, and Volume II General Surgery, the volumes being sold separately if desired. As usual, the illustrative feature is well taken care of, there being eleven full-page inserts, besides many excellent text-cuts. We strongly recommend Saunders' American Year-Book as the best work of its kind on the market.

A Text-Book of Diseases of the Eye. A Handbook of Ophthalmic Practice for Students and Practitioners. By G. E. DE SCHWEINITZ, A.M., M.D., Professor of Ophthalmology in the University of Pennsylvania, etc. Fourth edition, revised, enlarged and entirely reset. Octavo volume of 773 pages, with 280 text-illustrations and 6 chromo-lithographic plates. Cloth, \$5.00 net; sheep or half morocco, \$6.00 net. Canadian agents: J. A. Carveth & Co., Toronto, Ont.

This book has attained its fourth edition, which is sufficient proof of its deserved popularity. Written in the hope that it would prove of service to both students and practitioners, it has more than fulfilled all expectations. The methods of examining the eyes, and the symptoms, diagnosis and treatment of ocular diseases have received the largest share of attention. The subject matter has been given in greater detail than is customary in books of its scope, doubtless because the author, being a teacher of wide experience, recognized more fully than others, the knowledge requisite for the successful practice of ophthalmic science. In this new edition the text has been thoroughly revised, and the entire work has been reset, many new chapters have been added, such as Thomson's Lantern Test for Color-Blindness, Hysteric Alopecia of the Eyelids, Metastatic Gonorrhoeal Conjunctivitis, Grill-like Keratitis (Haab), the so-called Holes in the Macula, Divergence-paralysis, Convergence-paralysis, and many others. A large number of therapeutic agents comparatively recently introduced, particularly the newer silver salts, are given in connection with the diseases in which they are indicated. The illustrative feature of the work has been greatly enhanced in value by the addition of many new cuts and six full-page chromo-lithographic plates, all most accurately portraying the pathologic conditions which they represent. There is no question that this fourth edition will attain the same popularity as did its predecessors.

Diseases of the Bronchi. By Dr. F. A. HOFFMANN, of Leipsic. **Diseases of the Pleura.** By Dr. O. ROSENBAUM, of Berlin. **Pneumonia.** By Dr. F. AUFRECHT, of Magdeburg. Edited, with additions, by JOHN A. MUSSER, M.D., Professor of Clinical Medicine, University of Pennsylvania. Handsome octavo volume of 1030 pages, illustrated, including 7 full-page colored lithographic plates. Philadelphia and London: W. B. Saunders & Co., 1902. Cloth, \$5.00 net; half morocco, \$6.00 net. Canadian agents: J. A. Carveth & Co., Parliament Street, Toronto, Ont.

This, the fourth volume to be issued of Saunders' American Edition of Nothnagel's Practice, fulfils all expectations. The eminent authors of the valuable monographs which comprise this volume had, by their breadth of learning, their exhaustive research, and extensive practical experience, made their essays almost complete as originally written. Nevertheless, the author in the light of recent research, has made numerous valuable additions, so that the American edition represents the present state of our knowledge on the subjects under discussion. Among other things, these additions include new matter on the anatomy and physiology of the bronchi; on foreign bodies in the tubes; on the pathology, bacteriology and treatment of bronchitis, and the recent researches on bronchiectasis and on eosinophilia in asthma. Much new matter has been incorporated into the section on pneumonia, including the recent work of Hutchinson and others on the blood and urine in that disease. In the Pleurisy section will be found an account of the latest bacteriologic studies, and references to the work of Morse on the leucocytes in pleurisy, to that of Williams and others on X-ray diagnosis, and to the litten phenomenon. The work in every particular is thoroughly up-to-date, and no criticism is possible but praise.

Atlas and Epitome of Diseases of the Mouth, Pharynx and Nose. By DR. L. GRUNWALD, of Munich. From the second revised and enlarged German edition. Edited, with additions, by JAMES E. NEWCOMB, M.D., Instructor in Laryngology, Cornell University Medical School; attending laryngologist to the Roosevelt Hospital, Out-patient Department. With 102 illustrations on 42 colored lithographic plates, 41 text-cuts, and 219 pages of text. Philadelphia and London: W. B. Saunders & Co., 1903. Cloth, \$3.00 net; Canadian agents: Carveth & Co., Parliament Street, Toronto.

In designing this atlas the author has kept constantly in mind the needs of both student and practitioner, and as far as possible typical cases of the various diseases have been selected. The illustrations are described in the text in exactly the same way as a practise l examiner would demonstrate the objective findings to his class, the book thus serving as a substitute for actual clinical work. The illustrations themselves are numerous and exceedingly well executed, portraying the conditions so strikingly that their study is almost equal to examination of the actual specimens. The editor has incorporated his own valuable experience, and has also included extensive notes on

the use of the active principle of the suprarenal bodies in the materia medica of rhinology and laryngology. The work, besides being an excellent atlas and epitome of the diseases of the mouth, pharynx and nose, serves also as a text-book on the anatomy and physiology of these organs. Indeed, we wonder how the author has encompassed so much within such a limited space. We heartily commend the work as the best we have seen.

The Mattison Method in Morphinism—A Modern and Humane Treatment of the Morphine Disease. By J. B. MATTISON, M.D., Medical Director, Brooklyn Home for Narcotic Inebriates. Cloth, 12 mo. Price, postpaid, \$1.00.

This book—the outcome of thirty years study and experience—gives, in detail, a method of treating the morphine disease, original with the writer. Dr. Mattison is an authority on the treatment of morphinism, having long and large experience with the better class of morphinists, and asserts his method in advance of all others—in cases eligible for its use—to secure two leading objects—minimum duration of treatment and maximum freedom from pain. We commend it to all for whom the subject may have a special interest.

Atlas and Epitome of Abdominal Hernias. By PRIVATDOCENT DR. GEORG SULTAN, of Gottingen. Edited, with additions, by WILLIAM B. COLEY, M.D., Clinical Lecturer on Surgery, Columbia University (College of Physicians and Surgeons). With 119 illustrations, 36 of them in colors, and 277 pages of text. Philadelphia and London: W. B. Saunders & Co., 1902. Cloth, \$3.00 net. Canadian agents: J. A. Carveth & Co., Toronto, Ont.

This new addition to Saunders' series of Medical Hand-Atlases covers one of the most important subjects in the entire domain of medical teaching, since these hernias are not only exceedingly common, but the frequent occurrence of strangulation demands extraordinarily quick and energetic surgical intervention. While the well-known work of Macready will always remain a classic, it has never made any claims to deal with the operative side of the subject, and this is a side that, during the last decade, has been steadily growing in importance, until now it is absolutely essential to have a book treating of the surgical aspect of the subject. This present atlas does this to an admirable degree, and without question, will prove of very great value to the general surgeon and practitioner. The illustrations are not only very numerous, but they excel, in the accuracy of the portrayal of the conditions represented, those of any other work upon abdominal hernias with which we are familiar. Indeed, like all the other numbers of this excellent series, the work is a worthy exponent of our present knowledge of the subject, and in its field is unrivalled.

Bacteriological Technique. A Laboratory Guide for the Medical, Dental and Technical Student. By J. W. H. EYRE, M.D., F.R.S. (Edin.), Bacteriologist to Guy's Hospital, and Lecturer on Bacteriology at the medical and dental schools, etc. Octavo of 375 pages, with 170 illustrations. Philadelphia and London: W. B. Saunders & Co., 1902. Cloth, \$2.50 net. Canadian agents: J. A. Carveth & Co., Toronto, Ont.

It is only within the last six or eight years that instructions in bacteriology has been given in our medical colleges, and yet this branch of medicine has become so important that no practitioner can afford to be ignorant of it. A study of the present work will enable one to get a clear knowledge of the principal facts of the science, and to make good clinical use of that knowledge. Section XVII on "Outlines for the study of the Pathogenic Bacteria" cannot fail to be of great service, both for class work and for individual study. The publishers' part of the work is well done, though we do not like the shiny paper on which it is printed. We understand that this makes the illustrations much clearer, but it is hard on the readers' eyes.

Diseases of the Pancreas, Diseases of the Suprarenal Capsules, and Diseases of the Liver. By DR. L. OSER, of Vienna; DR. E. NEUSSEK, of Vienna; and DR. H. QUINCKE and G. HOPPE-SEYLER, of Kiel. The entire volume edited, with additions, by Frederick A. Packard, M.D., late physician to the Pennsylvania and to the Children's Hospitals, Philadelphia; and Reginald H. Fitz, M.D.; Hersey Professor of the Theory and Practice of Physic, Harvard University Medical School, Boston. Handsome octavo of 918 pages, illustrated. Philadelphia, New York, London: W. B. Saunders & Company, 1903. Cloth, \$5.00 net; half morocco, \$6.00 net. Canadian agents: J. A. Carveth & Co., Parliament Street, Toronto, Ont.

This book combines in one volume the sum of our knowledge concerning diseases of the pancreas, the suprarenal capsules and the liver. Any contribution on these subjects is of great interest to the profession, and these monographs, proceeding from such distinguished investigators, will be found of unusual importance. In the sections on the pancreas and the suprarenals, the numerous experiments upon animals cited will be of the greatest value to the pathologist, the clinician, and the pathologic anatomist, affording an insight into the more deep-seated processes, and offering an opportunity of comparing the disturbances of function produced by morbid conditions experimentally induced, with bedside and autopsy observations. In editing these sections the editor has availed himself of the writings of Korte and Mayo Robson, especially the latter's important treatise on the etiology and treatment of chronic pancreatitis. An editorial addition to the section on the suprarenal capsules which seems especially noteworthy, is the investigations and discoveries on the active principles and therapeutic properties of suprarenal extract. The excellent article on the liver is as thorough and complete as those on the

pancreas and suprarenals. Dr. Packard's careful clinical work, and his interest in the diseases of the liver, mark him as the most suitable person to edit this article. A survey of this work shows numerous critical additions, embodying the very latest contributions, besides expressions of his own views regarding subjects under discussion. He has devoted special care to diagnosis and treatment, including the surgical procedures that have recently found their place in this field. With these numerous editorial additions the articles are brought fully up to date, and have no equal in our language.

Diseases of the Skin. Their Description, Pathology, Diagnosis and Treatment with Special Reference to the Skin Eruptions of Children and an Analysis of Fifteen Thousand Cases of Skin Disease. By H. RADCLIFFE-CROCKER, M.D., (Lond.), F.R.C.P. Physician for Diseases of the Skin in University College Hospital; Honorary Member of the American Dermatological Society; Membre Correspondant Etranger de la Société Française de Dermatologie; Correspondierendes Mitglied der Wiener Dermatologischen Gesellschaft; Socio Onorario della Società Italiana di Dermatologiae Sifilografia; Late Physician to the East London Hospital for Children; Examiner in Medicine, Apothecaries' Hall, London. Third edition, revised, rewritten and enlarged. With 4 plates, 2 of which contain 12 colored figures, and 112 other illustrations. Octavo, 1,400 pages. Cloth, \$5.00; sheep, \$6.00, net. Canadian agents: Chandler and Massey Company, Limited, Toronto.

Crocker on the skin is a book built entirely upon superior merit. It has been acknowledged by the American medical press as "the best text-book in the English language." The new third edition maintains this high standard of excellence. Coming at a time when recent progress in dermatology makes an authoritative work upon the subject a positive necessity. It is a safe, accurate, eminently practical and strictly modern treatise, well and clearly written by a man of large experience and most excellent judgment. Though completely scientific, it is written in such a happy manner that the tyro may follow the writer almost as readily as the expert on diseases of the skin. It will be seen, therefore, that it appeals to general practitioners as well as specialists, while to the student it will serve as a valuable guide when he enters upon the more arduous task of practice. The etiology, symptomatology, pathology and minute anatomy, constitutional conditions, diagnosis and treatment of each disease mentioned is fully entered upon, the therapeutics, dietetics and general regimen coming in also for their due share of attention, great strength in the accuracy of statement and method and clearness of definition and differentiation being shown. The newer remedies and bacteriological researches, in their bearing upon dermatology, are carefully noted. The book proves Dr. Crocker to be closely in touch with the work and teachings of modern dermatology; and he has sifted from the vast accumulations of

recent literature the facts and opinions which have a definite value and are worthy of permanent record. The illustrations, too, showing as they do the morbid conditions of the different structures affected in diseases of the skin, are a not unimportant feature. Many valuable additions to the text are noted in the new third edition of this standard work. The whole book has been systematically gone over and numerous changes made where recent progress in dermatology and a more exact knowledge of the subject has dictated. The result is a work every page of which bears the impress of thoroughness and large personal experience.

NEW BOOKS.

Messrs. W. B. Saunders & Co. have in preparation for early publication the following new books and new editions :

"The Vermiform Appendix and its Diseases." By Howard A. Kelly, M.D., Professor of Gynecology, Johns Hopkins University, Baltimore, and E. Hurdon, M.D., Assistant in Gynecology, Johns Hopkins University, Baltimore.

"Myomata of the Uterus." By Howard A. Kelly, M.D., Professor of Gynecology, Johns Hopkins University, Baltimore.

"A Text-Book of Legal Medicine and Toxicology." Edited by Frederick Peterson, M.D., Chief of Clinic, Department of Neurology, College of Physicians and Surgeons of New York City, and Walter S. Haines, M.D., Professor of Chemistry, Pharmacy and Toxicology, Rush Medical College, in affiliation with the University of Chicago.

"A Text-Book of Operative Surgery." By Warren Stone Bickham, M.D., Assistant Instructor in Operative Surgery, College of Physicians and Surgeons, New York City.

"The Practical Application of the Röntgen Rays in Therapeutics and Diagnosis." By William Allen Pusey, M.D., Professor of Dermatology, College of Physicians and Surgeons Chicago; and Eugene W. Caldwell, B.S., Director of the Edward N. Gibbs Memorial X-ray Laboratory, and University and Bellevue Hospital Medical College, New York City.

"Tuberculosis." By Norman Bridge, M.D., of Los Angeles, Emeritus Professor of Medicine, Rush Medical College, in affiliation with the University of Chicago.

"A Text-Book of Obstetrics." By J. Clarence Webster, M.D., F.R.C.P. (Edin.), Professor of Obstetrics and Gynecology, Rush Medical College, in affiliation with the University of Chicago.

"A Text-Book of Diseases of Women." By Barton Cooke Hirst, M.D., Professor of Obstetrics, University of Pennsylvania, Gynecologist to the Howard, the Orthopedic and the Philadelphia Hospitals.

"A Text-Book of Pathology." By Joseph McFarland, M.D., Professor of Pathology and Bacteriology, Medico-Chirurgical College, Philadelphia.

"The Blood in its Clinical and Pathologic Relations." By Alfred Stengel, M.D., Professor of Clinical Medicine, University of Pennsylvania, and C. Y. White, jr., M.D., Instructor in Clinical Medicine, University of Pennsylvania.

"A Thesaurus of Medical Words and Phrases." By Wilfred M. Barton, M.D., Assistant to Professor of Materia Medica and Therapeutics and Lecturer on Pharmacy, Georgetown University, Washington, D.C., and Walter A. Wells, M.D., Demonstrator of Laryngology and Rhinology, Georgetown University, Washington, D.C.

NEW EDITIONS.

"Medical Jurisprudence and Toxicology." By Henry C. Chapman, M.D., Professor of Institutes of Medicine and Medical Jurisprudence, Jefferson Medical College, Philadelphia, Member of the College of Physicians and Surgeons, Philadelphia, etc.

"A Text-Book of Modern Therapeutics." By A. A. Stevens, M.D., Lecturer on Physical Diagnosis, University of Pennsylvania, Professor of Pathology, Woman's Medical College, Philadelphia.

"Practical Points in Nursing" for nurses in private practice. By the late Emily A. M. Stoney, Superintendent of the Training School for Nurses, Carney Hospital, South Boston, Mass.

"The Care of the Baby." By J. P. Crozer Griffith, M.D., Clinical Professor of Diseases of Children, University of Pennsylvania; Physician to the Children's Hospital, Philadelphia, etc.

Selections.

SURGICAL HINTS.

Disease germs more readily float in dry air than in an atmosphere charged with moisture. In preparing a room for operation the use of steam will tend to purify the air by causing germs to fall to the floor, which it is advisable to moisten or to cover with damp sheets.

It is a rule, to which there are practically no exceptions, that if you feel fluctuation from pus anywhere there is no reason for waiting and poulticing before evacuation. It only makes the abscess larger, infects more tissue, and prolongs the disease. If the diagnosis be uncertain have recourse to the aspirating needle.

In prostatitis there is often pain at the end of the penis, as in stone in the bladder, but it is commonly less acute than in the latter. In cystitis the pain is chiefly before urinating, and suprapubic as to location, although when very severe, it may also be felt in the perineum. In stricture the pain is apt to be at or about the seat of the obstruction.

In a case of cancer of the uterus, if the organ is not freely movable the chances are much in favor of the disease having extended beyond the limits at which an operation can be of value. - Yet, before refusing to operate the surgeon must feel reasonably certain that the immobility of this organ is not due to old inflammatory adhesions, having nothing to do with the malignant process.—*International Journal of Surgery.*

The Intravenous Injection of Germicides in Septicemia.

Some of our readers may have observed reports in the daily journals of one or more cases of septicemia in which a cure apparently followed the injection into the blood of solutions of formaldehyde in strengths varying from 1 to 250,000 to 1 to 50,000. Since these reports in the daily journals have appeared, an article has been published in the *New York Medical Journal* of January 31, 1903, by Dr. Barrows, in which he records the case of a negroess of twenty-six years who suffered from streptococcus infection, and from whose blood this micro organism was obtained in pure culture. This patient received a pint of 1-to-5000 aqueous solution of formaldehyde. Good results immediately followed, and ultimate recovery took place, at least

to the extent that at the time of the report the patient was up and about the ward. This experiment of Barrows is not of course entirely new. Other investigators have from time to time attempted to combat blood poisoning by the intravenous injection of antiseptics and germicides. But in almost every instance the injection has not been a success, and the method has been discarded, the reason being that the material which was qualified to destroy the protoplasm of the invading microorganism was also qualified to destroy the living cells in the blood stream or to act upon the cells of the blood-vessels or the tissues surrounding them in a deleterious manner.

We confess to having some skepticism as to the value of this use of formaldehyde. It is true that Ewing has made experiments in which large quantities of formaldehyde were injected into the blood-vessels of rabbits without untoward results either upon the general system or upon the blood cells, and that as long ago as 1900 Maguire reported in the London *Lancet* the results of experiments which he made upon himself, showing that such injections were apparently harmless in moderate quantity. Thus, he injected as much as 100 cubic centimeters of a 1-to-2000 solution into the vein of his arm, and shortly afterward detected evidence of aldehyde in his urine; and again, on another occasion, an even larger quantity, with the result that he produced, first albuminuria, and then hematuria. Maguire thought that 1-to-200,000 of formaldehyde solution would act as an efficient germicide.

In these days of wonderful scientific discovery it is not safe to condemn any therapeutic procedure on purely theoretical grounds, and therefore we look forward with interest to further experimentation along this line, although we cannot help feeling that it is not founded as yet upon accurate scientific observation. It must be remembered that on the one hand under ordinary circumstances the blood possesses extraordinary power to destroy microorganisms, and that it is only when prolonged disease has exhausted this power that microorganisms can exist in it with impunity. Again, it seems scarcely credible that formaldehyde can restore the bacteriolytic power of the blood, nor can we believe that an agent which is powerful enough to destroy the streptococcus can circulate in the blood without doing any damage to the endothelial cells lining the blood-vessels, and the blood cells themselves. The fact that Maguire's observations of over two years ago have not been followed by the general application of this method to the treatment of septicemic attacks seems to us to prove that the profession in general has had a well-grounded timidity in regard to the employment of so radical a therapeutic measure. An item on this subject will be found in our Progress columns in this issue.

Since this editorial note was written we have read with much interest an interesting series of experiments reported to the *St. Louis Medical Review* of January 31, 1903, by Dr. Snodgrass and Dr. Elbrecht. These investigators, recognizing the importance of this subject, no sooner heard of the experiments which had been made in New York than they promptly undertook a series in St. Louis. Their methods of research seem to have been accurately and carefully carried out. Using rabbits for the purpose of inoculation with the streptococcus, they injected formalin solutions in a quantity proportionate to that employed in New York for the woman who suffered from puerperal septicemia. It is a noteworthy fact that cultures from the heart's blood of all the rabbits gave pure cultures of streptococci, even when injections of formalin were used. They state that from their results they do not feel justified in drawing conclusions which would recommend or condemn the formalin treatment of septicemia, and they also conclude that formalin is slow to act because it requires over an hour for a 1-to-500 solution to kill the organisms, whereas 1 to 1000 required over four hours, and therefore the direct action of formalin in its dilute solutions must be extremely mild. The formalin which they employed was evidently excellent, as it was tested by the Professor of Chemistry in the Washington University and found to be of a strength of 38.98 per cent. They also state that since their experiments they have heard of two cases in St. Louis in which this method of treatment was carried out. One of these received the injection, and although the temperature and pulse were reduced, the patient died. The other patient was stated at last reports to be improving. It is an interesting fact that as the days go by more and more articles expressing disapproval of this plan of treatment are appearing, and it is probable that in a short time nothing more will be heard of it. Barrow's recommendation as to the method of treatment is summed up in his own words as follows: "Inject into the median basilic vein 500 cubic centimeters of a 1-to-5000 of formalin solution in water at the temperature of 60° to 70° Fahrenheit"—a temperature far too low for intravenous injection.—*Ed. Therapeutic Gazette.*

Intestinal Obstruction Secondary to Pyo-Salpinx.

Mr. Battle, St. Thomas's Hospital, operated on a married woman, *æt.* about 35, who had been admitted a week previously with symptoms of intestinal obstruction of some four or five days' duration. The symptoms were well marked: vomiting, abdominal pain, with peristalsis, constipation, and distension. The patient had refused to have anything done on admission, and it was only the continuance of pain, although some of her

other symptoms were relieved by treatment, that induced her to consent. The abdomen was less distended than when she was admitted, and her condition was somewhat improved, although she looked very ill and had a rapid pulse. When the peritoneum had been opened a large coil of small intestine was found extending towards the pelvis, where it was evidently fixed, as it could not be drawn up, and returning coils were found to be collapsed. In the pelvis was what appeared to be a large uterus, but the right side of this enlargement appeared to fluctuate and was softened, so that the suspicion that it was a pyo-salpinx adherent to the uterus was come to. Posteriorly, also, there appeared to be a kind of sulcus which increased the impression of its nature. The intestines were packed away with gauze plugs and abdominal sponges, and the pyo-salpinx was removed. The pus was yellow and offensive, and escaped from a tear in the enveloping wall during removal; but with considerable difficulty the whole was cleared from the pelvis, and the right side of the uterus ligatured and cut away. After careful cleansing of the parts and changing of sponges, the cause of the intestinal obstruction was investigated; this was due to the fact that a coil of small intestine had become adherent to the back of the pyo-salpinx and then taken an abrupt turn forward, so that it was acutely kinked at that point; it was necessary to separate this from the margin of the cavity that had contained the pyo-salpinx, and although the point of immediate attachment had been much diminished in size, it was not apparently altered in structure, the bowel beyond was empty and small. A second coil was also adherent over a greater extent, but had not been kinked or obstructed in any way, still it took some force to separate it, and the peritoneum was considerably changed where the adhesions had been. The amount of shock resulting from the operation was at first very severe, and it was necessary to give a saline infusion. The glass tube which had been introduced into the pelvis was retained for three days and then removed, as the discharge was without odour and small in quantity, and a stitch which had been inserted at the operation was now tied so as to close the tube opening. The progress was not marked by any rise of temperature, and all symptoms of obstruction ceased. Mr. Battle said that the obstruction was due to an unusual cause; that one hardly expected to find such urgent symptoms dependent upon a disease which was evidently itself of a chronic character. He pointed out that the operation required in the patient's then condition was necessarily very severe, but the woman had to face the risk of removal of the pyo-salpinx and the after freeing of the intestine, as the latter alone might have caused a leakage from the pyo-salpinx at the point of

separation, and this must have been followed by a fatal septic peritonitis. In many cases of removal of a pyo-salpinx, especially when the adhesions are dense, he said, the shock is severe, although the patient is in a good condition and ready for the operation; in the present case the woman was already weakened and very ill as the result of some days' intestinal obstruction. The result of the operation was satisfactory, and the patient left the hospital three weeks after operation.—*Medical Press and Circular*.

The Causation of Epilepsy.

Heretofore great uncertainty prevailed as to the cause of epilepsy, but the investigations of Mr. Bea undoubtedly throw some light upon the subject. Numerous blood examinations show the constant presence in the blood of a minute parasite just before an attack. The parasite looks like a small point, which moves rapidly, and sometimes forms into chains which become attached to red corpuscles.—*Medical Record*.

Prophylactic Measures Against Venereal Diseases, Especially in the Army.

That venereal diseases are spreading with alarming rapidity among soldiers is an indisputable fact, especially well known to the army surgeons of every nation. Thus GOULADZE (*Russ. med. Rundschau*, No. 1) brings forward statistics proving that out of 900,000 men, embracing the total strength of the standing army of the Russian Empire, there were about 35,000 venereal cases. In speaking of prophylaxis, the author insists upon the physician gaining the patient's confidence, so that the full importance of the baneful disease is clearly and understandingly impressed upon the latter's mind. He especially deprecates the use of alcohol, as he finds that out of every ten cases of infection at least seven occurred while the patient was under the influence of Bacchus. Finally, he insists upon the observance of the following prophylactic measures: (1) Avoid sexual intercourse while under the influence of alcohol; (2) absolute abstinence in case any abrasion or erosion be detected on the membrum virile; (3) but one coitus at a time, for it has been proved beyond doubt that males are more readily exposed to infection who indulge in several connections at a seance; (4) anoint the penis just before the act with a thick layer of carbolated vaseline (four per cent.), and insist that your companion wash her genitalia with a three per cent. solution of carbolic acid; (5) after completion of the act wash the penis with soap and water, and a one-half per cent. solution of sublimate, or, when not at hand, with clean plain water, or with one's own urine.—*Medical News*.