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Vol. XI.

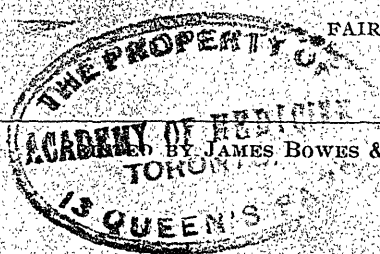
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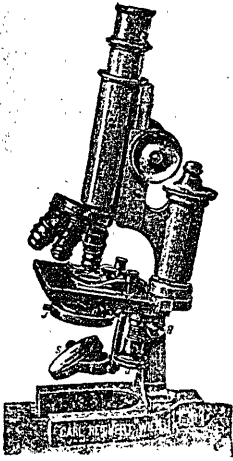
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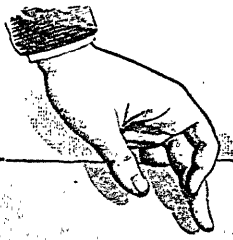
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Original Communications.

PYREXIA; ITS PATHOLOGY AND TREATMENT.

By M. A. B. SMITH, M. D., Class Instructor in Practical Medicine and Lecturer on Therapeutics, Halifax Medical College.

The treatment of hyperpyrexia is, to my mind, one of the most difficult problems that confront the physician. The coal tar products have been given on the theory that there is increased oxidation in fever, and that these diminish it; and the cold bath has been used on the same theory.

They are all, let us say, dangerous remedies. I have introduced this subject to state certain fears of my own of the Brand treatment. But what the physician needs first is a sound physiology and pathology. And I will now (if you will pardon so lengthy a reference) state the views of Prof. William H. Porter of the Post-Graduate Medical School, New York, at a length sufficient only to make them clear, going to show that this cold bath is contrary to the pathology of fever.

At the Post-Graduate School last February, Prof. Porter read before the Clinical Society of the school a paper on "Febrile Conditions, their Relation to Body Heat Production, and their Treatment." His line of argument was this:

"The usually received theory on which our treatment of the febrile state has been based has been that in fever there is increased heat production. It is necessary to have a correct conception in the first place

* Read before N. S. Branch British Medical Association, Nov. 29th, 1899.

of how heat is normally produced in the body. Physiologists tell us there are two sources of heat, the oxidation of food stuffs, and secondly that produced by friction. Ninety per cent. of heat produced is due to oxidation of food stuffs or body tissues, viz., the combustion of the starches, the fats and the proteids. Ten per cent. is due to such friction as occurs in connection with the ever-flowing currents of blood and lymph, as they course through the blood vessels and lymph channels. To this may be added the friction of the joint surfaces as they play upon each other, the play of the muscle fibres and various soft structures upon each other, and we may admit a certain amount of frictional heat production as the result of the movements of the molecules and atoms against each other."

I may say that this view of the sources of heat does not seem to quite coincide with that given in Michael Foster's Physiology, which says: "We may conclude that since metabolism is going on to a greater or less extent everywhere, heat is everywhere being generated; but that, looked at from a quantitative point of view, the muscles and the glandular organs must be regarded as the main sources of the heat of the body, the muscles being the more important of the two."

Proceeding Prof. Porter says: "From whatever source derived, the friction heat production is a very small quantity as compared with the oxidation production, so that in all our calculations the great source of heat production still remains in connection with the oxidation or chemical reduction processes that are continually taking place within the system. Consequently the elucidation of this intricate and most important problem has chiefly to do with the oxidation of the food stuffs and body tissues."

The temperature of the body is not a simple problem of oxidation and friction *production* of heat, as the generally uniform temperature is 98.6° without absolute regard to the amount of food taken or to the surrounding temperature. There are therefore two other factors, the *dissipation* of heat and its *storage* in the system.

There may be increased surrounding temperature and increased oxidation, and still the body heat may remain normal. Or there may be a lowered surrounding temperature and "no proportionate increase in the consumption and oxidation of food stuffs or body tissues, possibly even a slight decrease in oxidation processes," and still the body heat may remain normal. There are, therefore, three elements in the main-

tenance of the body heat, viz., its formation, its storage and its excretion or dissipation.

Beyond certain limits, with reference to food and surrounding temperature, we cannot go, however, and still find the body heat normal.

“To explain these varying pictures, we are told by some in a more learned manner, that there is in the brain a heat centre or centres, all of which is probably true, as the nervous system is generally interpreted, but just where these centres are located or the *modus operandi* by which they control these three factors, we are in absolute ignorance. The manner of action of these centres or how they can be with certainty affected by medicinal agents, has yet to be more fully and clearly elucidated. We do know this much from a practical standpoint, and one that can be utilized for the benefit of the patient viz: that heat is produced, that heat is stored and that heat is excreted.”

At this point Prof. Porter takes his stand and he says: “We can also determine quite accurately whether we are dealing with an increased or a decreased heat production, with excessive excretion or augmented storage of the heat which is produced within the system; even if we cannot yet explain all the intricate phenomena that are connected with and that make possible these undeniable facts.”

To produce the normal excrementitious products of the physiological economy, and maintain a normal state of the system, a uniform temperature and body weight requires the perfect utilization of a given quantity of food daily. As already observed, however, a reasonable deviation from this absolute standard may be indulged in, but not for any considerable length of time.

The most accurate method of arriving at the amount of food required daily is to take as our standard the average of all the estimates of the physiological chemists, of the amount of nitrogen and carbon dioxide eliminated daily, when a fairly uniform condition of the system is being maintained—these two substances being the end products upon which all our calculations are founded.

To produce the requisite amount of nitrogen and carbon dioxide to be eliminated in the case of an individual weighing 150 pounds, 399.67 grammes or 14.13 ozs. of proteids, fats, glucose, and mineral salts are required. This is given as an ideal standard to determine the heat production of the animal economy, both in healthy and in connection with febrile conditions.

With a diet of this composition and amount there is a daily heat production (oxidation and frictional), of in round numbers, 7,000,000 foot pounds. "With this quantity of heat produced daily, we have maintained a uniform temperature of 98.6°F."

It is further known that even with a positive decrease in the heat production, the temperature remains normal. On the other hand, with increased oxidation the temperature remains normal. These two diametrically opposite conditions of oxidation, while the body temperature remains unchanged, can be explained only by accepting the fact that in the former instance there is a decreased excretion of heat from the body, with a proportionate storage within the system of the little heat that is produced, while in the latter there is an increased exertion with decreased storage.

Proceeding from these as fundamental facts in relation to the *normal* state of the system, Prof. Porter goes on to determine whether in the febrile condition there is an actual increase or decrease in the heat production of the body.

He takes typhoid fever as his example, because in it there are a large number of days in which to apply observations and computations.

It will be admitted that during the 28 days of fever, a patient does not, at most, utilize more than one-half the normal quantity of food stuffs. The oxidation heat production on full rations for 28 days is 175,237,916 foot pounds, this added to the friction heat for the 28 days, which is 19,470,879 foot pounds, makes a total heat production of 194,707,795 foot pounds for 28 days.

Take now the typhoid case. For the same number of days we assume the friction heat the same as in health, although it is probably reduced, certainly cannot be materially increased. The decreased muscular activity will counterbalance the increased frictional activity of the circulation. It is fair to let the frictional heat stand the same. But the heat produced by oxidation reduction is unquestionably reduced one-half on account of the diminution in the food supply. Therefore the heat production from oxidation is only 87,618,958 foot pounds, and including frictional heat, only 107,084,837 foot pounds, instead of the normal 175,237,916 foot pounds in 28 days. Prof. Porter says that, assuming there is a rise of temperature above normal (he does not say how great), and assuming that the rise is due to increased oxidation, 15,576,623 foot pounds of heat would be required in addition to the total loss of 87,622,958 pounds, making 103,199,581 foot pounds

which must be generated *from some other source than the food* supplied to the system, if the average increased temperature is to be maintained throughout the febrile period as the result of oxidation heat production.

He does not deny that the body contains sufficient fat and proteid matter, by the oxidation of which this amount of heat can be produced, but he says it would require the destruction of one-third of these constituents of the body—a state rarely seen at the bedside or at the necropsy table. That this great loss of body tissues does not occur is further proved by the fact that there is a decided decreased excretion of nitrogen and carbon dioxide during the febrile period. On the other hand, if this increased heat production was the result of this greatly augmented oxidation of the body tissues, the excretion would have to contain a much larger amount of excreta *than is commonly found during a perfectly normal state of the system*. As this is not true, only one conclusion can be deduced, which is, that during all febrile conditions there is, instead of increased heat production, a state of decreased heat production to combat; that the apparent rise in temperature as recorded by the clinical thermometer is the result of a decreased production of heat in the body, associated with a decreased excretion of heat from the system, and an increased storage of the diminished amount of heat produced within the animal economy. Now granting this, Prof. Porter writes further, with reference to the cold bath treatment of fever. "If we have decreased heat production we certainly do not want to excite further abstraction of heat from the body, unless it can be shown that the cold bath augments heat production, increases the utilization of the food stuffs, and excites a more perfect secretory and excretory action, it certainly must damage still more the system when used in connection with febrile conditions, with our present knowledge of the pathology of febrile conditions, and the judicious administration of the therapeutic remedies at our command, few cases will be met with in which there will be an occasion to resort to the extreme cold baths." In the long discussion that followed the paper, five members took part. Of these, one expressed his belief in increased oxidation, but none ventured to argue that point. Two expressed their view that the best results of cold baths were due to the favorable impression they created on the nervous system. Another thought that the fact that heat production is less in fever, did not effect the fact that the body temperature is higher and that it leads to injurious consequences. Prof. Wilcox said his own connection with the cold water treatment had begun in 1881 and ended

in the next year, during which he had perhaps used it a hundred times. The bath did not reduce the temperature to any appreciable extent. In about 15% of all the patients there was a rise instead of a fall within an hour after the bath. However, the theory that the bath reduced the temperature had been *abandoned*, and the reason for this had been given at this meeting. The theory had then been propounded that the bath was a great nervous stimulant. It was and it was not. He would say that better stimulation would follow the administration hypodermatically of 1/20 of a grain of strychnine than from the bath. He had had opportunities within the last six or seven years to see the results of these baths in the practices of others, and he had noted that some of those who spoke most loudly in public in favour of the bath treatment often used all sorts of remedies in the latter part of typhoid fever. These advocates of the bath treatment would not treat the bad and protracted cases by these baths. He would treat typhoid on the surgical principles of cleanliness (antiseptics.)

Prof. Porter, in closing, said that evidence whether mathematical, theoretical, physiological or chemical, furnished absolute proof that the physician who was dealing with a febrile condition was dealing with a body which was producing less heat than normal. In all the years that he had practiced medicine he could recall having given only three cold baths.

My own fears of the treatment of fever by the external application of cold have arisen from several cases which have done badly under its use. And I may say that I have only employed the sponging with ice water, not the cold bath. In several cases of typhoid fever after the cold sponging and toward the third week, congestion of the lungs or pneumonia have occurred.

Two recent cases have especially impressed me. One was that of a young strong colored man who was nursed by the nurses of the Victorian Order. A week after the cold sponging had been begun he developed pneumonia which proved fatal, as I think it always is in these cases. Not long after, I attended a young strong married woman of Scotch parentage. I employed the cold sponging and not without misgiving. Soon she developed capillary bronchitis, and died. I am sorry that I have not accurate records of these and other similar cases.

It appears to me that if the use of the cold bath is contrary to the evidence of chemistry, it is also contrary to the theory upon which we still use hot applications. We use hot applications to withdraw blood from congested central organs to the surface where it is radiated. If

experience is worth anything hot poultices in pneumonia have helped to cure many a case, and if we had any theory right it has been that they benefited by inducing the blood to the surface. Now, the application of the cold bath must have directly the opposite effect of forcing the blood still more into the relaxed, paralyzed and distended blood vessels of the lungs.

It seems we can accomplish but little in the treatment of fever itself. We can help the secretory and excretory functions of the body, and also the digestive functions. In typhoid fever much can be done by intestinal antiseptics.

NOTE.—Two years ago Dr. A. Halliday read before this Society a paper giving the results of practical experiments of his own, to ascertain whether antipyrine in reducing temperature diminished oxidation. He did not satisfy himself that oxidation was diminished by it in medicinal doses. He found no methæmoglobin in the blood. Porter believes its antiseptic action is due to its dilating the surface blood-vessels—its action on the circulation.



Clinical Reports.

OPHTHALMIC CLINICAL CONTRIBUTIONS.

By DAVID WEBSTER, M. D., New York.

CASE I.—Glaucoma supervening upon neuroretinitis.

Mrs. Amelia M., aet., 38, came to my clinic at the Manhattan Eye and Ear Hospital on Dec. 17, 1886, complaining of blurred vision, a diagnosis of hypermetropia was made, and glasses + 1 D. were ordered, which gave her vision 20/20, each eye. She was advised to wear these glasses all the time. An ophthalmoscopic examination showed no intraocular lesion, but that each eye was hypermetropic about two diopters. She returned to the clinic eleven months later (Nov. 21, 1887) and the ophthalmoscope then showed that she had a mild form of neuroretinitis of the right eye. As a thorough investigation failed to reveal the cause of the disease, she was put upon small doses of the bichloride of mercury on general principles. On Feb. 2, 1888, although the vision was 20/20 in the eye affected with neuroretinitis as well as in the other, it was found that the swelling of the optic papilla had increased. She was then referred to Dr. H. N. Heineman, at the New York Polyclinic, for further investigation and treatment. Dr. Heineman made a diagnosis of gastro-hepatic dyspepsia, and treated her for the next two months with appreciable improvement in her general health; but, meanwhile, the vision of her right eye had deteriorated, and was now 20/50, (April 28, 1888). On May 1, 1888, the patient was referred to Dr. E. C. Seguin for his opinion as to brain disease. Having found no evidences of intracranial disease he first gave her mercury to the point of salivation, and then followed this up with iodide of potassium, gr. 70 t. i. d. This treatment was continued for five weeks. During this period the vision of the affected eye increased to 20/40. On July 28, 1888, the patient came to me complaining of severe pain in and about the right eye. The pain was not constant, but came on at intervals. I found the vision to be 20/30 with + 1 D. The anterior chamber was abnormally shallow, and the pupil was slightly dilated and markedly sluggish. The tension of the eyeball was considerably increased (+ 2). The ophthalmoscope showed pulsation of the retinal arteries, and the optic disk, instead of

being swollen, was moderately excavated. The visual field was contracted on the nasal side. On July 30, the patient was admitted to a bed in the hospital, and ether having been administered, I performed an iridectomy upward. Two days after the operation the patient complained of pain over the other eye, but this yielded to myotics in a few hours. The eye operated upon did well until the fourth day, when the patient reopened the wound by sneezing violently. The anterior chamber remained empty for four days, when under the use of eserine the leak was stopped. On Aug. 8, the anterior chamber was of normal depth, the vision was 20/30 and ophthalmoscope showed that there was no longer any pulsation of the retinal arteries. The patient was discharged on August 10, 1888, with the eye in a perfectly quiet condition, and having had no pain since the operation.

CASE 2.—Injury to an eye by the tip of a parasol.

W. R. H., aet. 59, was accidentally struck in the right eye by the tip end of one of the steel ribs of a parasol, Aug. 18, 1887. The injury was followed by pain which constantly increased in severity, and which interfered with his sleep. He bathed his eye with hot water, and by the advice of a friend, with iced milk. The eye grew steadily worse and became blood-shot. He came to clinic Aug. 21st., nearly two weeks after the injury. A diagnosis of traumatic iritis was made, and frequent instillations of 1% solution of sulphate of atropia were advised with the view of breaking up the adhesions. The vision was R. 20/100 with + 3 D., L. 20/50 with + 2.50 D. On Sept. 2, 1887, he had vision, R. 20/200 with + 3 D., and L. 20/20 with + 3 D. On Sept. 9th, when he presented himself at the clinic, he was suffering greatly from pain in the eye, and was therefore admitted to a bed in the hospital. The adhesions had been all broken up, so that the pupil was well dilated and circular. The tension of the eyeball was slightly increased. The eye was very red. Two leeches were applied to the right temple and there was some temporary relief. He passed a bad night, however, and an anodyne had to be given him to relieve the pain and enable him to sleep. On the night of the 11th., so severe was his pain that he was given two hypodermics of sulphate of morphia before he was anything like comfortable. Under the use of iced cloths and atropine, he from this time forth steadily improved, until on the 16th. he was discharged nearly well.

327 Madison Avenue.

MENINGITIS.—TWO CASES.*

By F. W. GOODWIN, M. D., M. R. C. S., L. R. C. P., (London,) Professor
of Materia Medica, Halifax Medical College.

On the first of April last, I was called to see W. C., aged 17. I found him with a temperature of 103.4°, pulse 110, suffering from very severe headache and sickness at the stomach. The fever soon declined from the effects of treatment, but altogether continued exactly three weeks. At intervals during the three weeks there was some delirium with attacks of excruciating headache. In the third week he became very much debilitated, paying no attention to anything, the headache disappearing somewhat. I then began to notice some symptoms of paralysis. There was ptosis of the right eyelid—though the pupils were normal and reacted to light. There was also facial paralysis on left side—his smile was confined to the right side. The left leg was also partially paralyzed, the patellar reflex being diminished. There was no anæsthesia. Later diplopia was observed which was very marked, apparently from paralysis of the fourth nerve—one image diagonally above the other.

After the third week his general condition began to improve but he continued to be attacked at intervals by atrocious headache and vomiting, when the mind seemed to waver a little. About six weeks ago he had his last attack of severe headache and vomiting. But he was very much emaciated and recovered very slowly. When he began to get about œdema of the left leg set in, which continued two or three weeks. The paralysis gradually disappeared,—the œdema being the last symptom. I saw the patient a few days ago and he was as well as ever. The patient was accustomed to drive a milk cart and was so engaged when he became ill. There was no near history of tuberculosis in the family. Other organs free from tuberculosis.

The treatment consisted at first of ice to the head, leeches and blisters behind the ears and drastic cathartics, (calomel and croton oil.) Mustard was applied to lower extremities and various parts of the body. While headache was severe I administered large and repeated doses of bromide in combination with the other treatment. After the third week I gave iodide of potash with maltine and cod liver oil and finally Fellow's syrup.

* Read at meeting of Medical Society of Nova Scotia, Truro, July, 1899,

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It Differs in its Effects from all Analogous Preparations; and it possesses the important properties of being pleasant to the taste, easily borne by the stomach, and harmless under prolonged use.

It has Gained a Wide Reputation, particularly in the treatment of Pulmonary Tuberculosis, Chronic Bronchitis, and other affections of the respiratory organs. It has also been employed with much success in various nervous and debilitating diseases.

Its Curative Power is largely attributable to its stimulative, tonic and nutritive properties, by means of which the energy of the system is recruited.

Its Action is Prompt; it stimulates the appetite and the digestion, it promotes assimilation, and it enters directly into the circulation with the food products.

The prescribed dose produces a feeling of buoyancy, and removes depression and melancholy; *hence the preparation is of great value in the treatment of mental and nervous affections.* From the fact, also, that it exerts a double tonic influence, and induces a healthy flow of the secretions, its use is indicated in a wide range of diseases.

NOTICE—CAUTION

The success of Fellows' Syrup of Hypophosphites has tempted certain persons to offer imitations of it for sale. Mr. Fellows, who has examined samples of several of these, FINDS THAT NO TWO OF THEM ARE IDENTICAL, and that all of them differ from the original in composition, in freedom from acid reaction, in susceptibility to the effects of oxygen, when exposed to light or heat, IN THE PROPERTY OF RETAINING THE STRYCHNINE IN SOLUTION, and in the medicinal effects

As these cheap and inefficient substitutes are frequently dispensed instead of the genuine preparation, physicians are earnestly requested, when prescribing to write "Syr. Hypophos. FELLOWS"

As a further precaution, it is advisable that the Syrup should be ordered in the original bottles; the distinguishing marks which the bottles (and the wrappers surrounding them, bear can then be examined, and the genuineness—or otherwise—of the contents thereby proved

FOR SALE BY ALL DRUGGISTS.

DAVIS & LAWRENCE CO. (LIMITED), MONTREAL
WHOLESALE AGENTS.

Now for the second case.

Mrs. S., aunt and neighbor of the above patient, aged 40 years,—watched with him one night during the latter part of the third week of the disease, when he was apparently very near death. As the patient was inclined to roll out of bed she lay down along side of him for some time, and in this close proximity had ample opportunity to inhale his breath. Just nine days after she watched with him, I was called to see her and found her unconscious. She had been vomiting and the vomited matter contained undigested food. At first I was inclined to think that the condition was due to the stomach. But in intervals of semi-consciousness she showed signs of suffering from extreme headache. There was slight spasm of the arms and disturbance of respiration. The consciousness gradually returned during the next few days. The temperature in her case was at first $101\frac{1}{2}^{\circ}$ and returned to normal as the consciousness came back. She seemed somewhat demented as she was recovering, but closer observation convinced me that *amnesia* was the principal trouble. She could not read. She said she could see the words but did not know what to call them. On being told, however, she immediately recognized them. On attempting to converse she seemed to have ideas but her power of expression was lost. On trying to talk she seemed constantly like one who for the moment forgets the name of some familiar person or thing, when he attempts to speak of it. This mental blank seemed constantly recurring to her. Her little children were teaching her over again to read. Even the names of some of the letters she had forgotten. There seemed to be no paralysis. At one time she said she saw two watches when I held mine before her eyes—but this symptom disappeared in a few days. Her eyes seemed as near as I could tell to act exactly in unison. I have known this patient for a number of years, and consider that she is far from being a hysterical person. She has now almost entirely recovered. There is no tubercular history in the family, and as in the first case no symptoms of tuberculosis in the other organs presented themselves. There was no herpes in either case. The treatment in the latter case was similar to that adopted in the former.

The question might arise as to whether these two cases were not simply la grippe. If they were, I never saw two cases like them. The head in each case was affected from the very start, and as a rule I believe, meningitis if it occurs in la grippe comes on later.

Neither patient complained of aching in the limbs. No other member of either household was ill for some time previous, during or since their illness.

I believe there have been during the last winter a great many cases of epidemic cerebro-spinal meningitis on this continent and I thought these might be two such cases. This disease is said to be due to the diplococcus pneumoniae, also called the pneumococcus, or streptococcus lanceolatus. Such cases are often associated with pneumonia, and herpes is associated with both.

Many cases of cerebro-spinal meningitis arise sporadically which are probably due to this germ—the same that gives rise to the epidemic form. The parts lying in the posterior fossa of the skull are generally attacked and thence the disease descends into the spine.

Dr. D. A. Campbell was called to the first case during a critical period of the disease, but through a misunderstanding he did not get there. In conversation with him about the case, he called my attention to the practice of lumbar puncture to draw off fluid from the arachnoid cavity for microscopical examination. This is now extensively done in some hospitals to establish the diagnosis of the cause of the disease in a given case. I should be slow to undertake this until I thoroughly understood its technique.

In conclusion I would like to ask the members of the society whether any of them have lately seen cases of meningitis that proved to be contagious or that gave symptoms of being caused by the pneumococcus.

(Since reading the above paper, the second case has continued mentally to improve. Had her eyes examined by a specialist and hemianopsia was found. This would to some extent account for the difficulty in reading. Patient's mental condition does not seem to me to be quite up to the normal standard yet. The full sight of the eyes will probably never be restored.)

TWO CASES OF "LA GRIPPE" WITH SYMPTOMS POINTING TO CEREBRO-SPINAL MENINGITIS.*

By M. S. DICKSON, M. D., Great Village, N. S.

On March 21st of the present year I was called to see E. B., aged 19 years, and J. B., aged 21 years, brothers, said to be suffering from a relapse of "la grippe." Both boys having arrived home in a delirious condition I could not get a very good history of their present illness up to that time. Their father told me that two weeks before they had had an ordinary attack of "la grippe," which had confined them to their beds for several days, the other members of the family having similiar attacks at that time. They had no medical attendance, but I have no doubt but that the old gentleman's diagnosis was correct. The boys recovered sufficiently to enable them to return to their work, which was chopping in the lumber woods. After working a few days they had to give up, and returned to the railway station nearest their home on the 20th of March and started to walk the remaining distance of four miles in a blinding snowstorm. They were, by the time they arrived at the station, in a semi-delirious condition, and the younger, E. B., gave out on the road. The elder reached home in an exhausted condition, and after being questioned about his brother, it was learned that he had given out by the road-side, and when brought home was wildly delirious. The following evening I was called in.

I will first give a description of the condition and symptoms of the younger, and refer first to those of the nervous system which were the most striking. There was headache of the most severe type, at first most marked in the frontal region, but later becoming equally severe in the occipital. Though delirium was so active at times that the pain in the head would be apparently forgotten in his raving, it would be as severe as ever on his partial return to consciousness, causing the patient to cry out as though with most excruciating pain. Though light, motion, or noise increased the severity of the pain, it was usually most severe in the early part of the night. Although apparently dreading any motion, he would at times become very restless and even try in his delirium to get out of bed. The head was thrown back, but not held very rigid at the time of my first visit on the 21st. At the

* Read at meeting of Medical Society of Nova Scotia, Truro, July, 1899.

time of my second and third visits on the 26th and 27th the rigidity was very marked. Lumbar pain was very severe when I first arrived in the evening, but had not been complained of earlier in the day. Lumbar pain continued throughout and was exaggerated by motion, but not by pressure along the spinal column. The hand slipped under the pillow would cause intense pain on making the slightest efforts to raise or move the head. There was no paralysis up to the time of my last visit to him on the 27th. Delirium was constant and at times violent, but for the most part low and muttering, with hallucinations of sight and hearing. Occasionally, when spoken to sharply several times in succession, he would answer questions quite rationally and distinctly. The eye symptoms were not important, the pupils were normal and reacted well and equally to light. Hearing was very dull. Insomnia was very persistent.

The temperature on the first visit was 106° F., on the 26th 104.2° F., and on the 27th 103.5° F. The pulse on the first visit was 120, on the 26th 109, and on the 27th 102 and irregular. It was small and wiry from the first.

Respiration was not much accelerated, but on the 26th and 27th it was of the Cheyne-Stokes type. Percussion and auscultation were negative.

Herpes developed early and was most marked on the lips and buccal surfaces with some spots on the chin and on one cheek. At my first visit there were bright red spots of various sizes on the face and body which did not disappear on pressure. They became much darker and less marked by the 26th.

Vomiting was a troublesome symptom for the first two days. The tongue had a thick yellow coating and was very dry at first, and in a few days became glazed, dark and fissured. The appetite was very poor. Constipation was marked at first, but a mild laxative produced quite a copious diarrhoea. There was never the slightest tenderness over the abdomen nor any tympanites.

The urine was about normal in quantity and contained traces of albumin.

Death took place on the 27th, nine days after coming home, the patient being comatose for about eighteen hours. Decomposition was very rapid; twelve hours after death it was very difficult to approach the corpse, which was quite black and offensive, and the skin would slip from the flesh on slight pressure.

The history of the older boy is very similar, but the temperature ran a much lower course, falling irregularly from 102.5° F. on the 21st. to 99° F. on the 27th, and rising again to 100° F. on the 30th, which was the last time I saw him. The pulse on the 27th. ran from 78 to 96, varying that much in a few minutes. It was small and wiry. Marked variation was noted right through his case, counting ten to twenty beats more at one time than it would ten minutes later. On March 30th, the day before death, it was intermittent.

The delirium in this case was of the low, muttering type right through.

The bright red rash was less marked than in his brother's case, but large blotches of a dark red colour developed on his back a day before his death.

Twenty-four hours before death the odour of decomposition was very strong, and by drawing the finger with firm pressure over the body the epidermis would tear and roll up like a piece of wet wrapping paper, while the slightest touch would leave a dark red mark. Death occurred on April 1st, eleven days after coming home.

In neither of these cases was there paralysis or very marked contractions. Though Kernig's sign was more marked in the elder brother's case, it was quite well marked in the other. In the former the legs could not be straightened much beyond a right angle when the patient was sitting up in bed. If, as is claimed, this sign indicates meningitis, we may ask: Had these boys la grippe, or did they only have meningitis, or cerebro-spinal meningitis? From what I could learn of the sickness they had early in March, I think they then suffered from that most protean of all disease, la grippe, and that their subsequent exposure to the hardships and insanitary conditions of lumber-camp life along with their tramp home in a snowstorm in their weak condition brought on cerebro-spinal meningitis as a complication.

Selected Article.

NOTES FROM PRACTICE IN THE ARGENTINE REPUBLIC.

BY F. G. CORBIN, M. D., (McGill, '90), Mendoza, Argentine Republic.

To start with, I am not a "scribbler," and am not going to pretend to be what I am not; my aim is simply to put in writing the histories of some of my cases which I, perhaps wrongly, consider out of the ordinary run, paying special attention to the practical side. I am not going to follow the dates, but simply pick out cases or series of cases here and there which to me seem fittest; above all, I intend writing out those in which I have been wrong in diagnosis or treatment. What is the good of only writing down the cream? One man's mistakes, confessed, may save the life of some poor human. Confession there will be, and perhaps my cases will be open to the stinging pen of the critic. Let my readers, too, remember, while reading these notes, that the difficulties under which I have often operated were at times so great that only one accustomed to them would have dared to interfere.

As some of my readers may remember, I left for this country immediately after graduating from McGill in 1890, and, owing to laws which do not allow foreigners to practise without first passing the corresponding examinations, I could not practise in any town where there was a received Argentine physician: I was forced to go to a place where there was no licensed doctor. I went to Patagones on the Rio Negro, a small town of three or four thousand inhabitants, including the smaller town of Viedma on the opposite bank of the river. Owing to the great distance and want of communication, these towns had then no received medical man.

About a week after reaching Patagones, a gentleman, well dressed and apparently well-to-do, walked into my office. He told me that for twenty years he had made it a practice to consult every new "medico" who came to the town; that they had all seen and prescribed for him, but that not one of them had been able to cure him. I naturally asked him what was the matter, and he showed me a long prepuce which was cracked on the surface over which the urine passed. I told him that I would cure it for him in a week and that it would never come back

again. He was very pleased and asked me for the prescription. I showed him a bistoury, and told him that that was the only receipt that would cure him, at the same time explaining to him the cause of his trouble and the proper way of curing it. He would have none of it, but wanted a salve or lotion. I told him that I did not want to be on the list of which he had just told me, and refused to give him a salve. Some days later I circumcised him with natural results,—radical cure, happiness, etc.

That small operation gained for me more than any other I have ever done; more reputation, more future operations, more fees, more everything. It was plain I knew more than any man who had been in Patagones for twenty years previously. I could not kill; if a patient of mine died it was because "God willed it," not from bad attendance, or from wrong diagnosis or treatment. This gave me courage; I began working at surgery, and have kept at it ever since. At present I hardly do anything else, and have gained a reputation, if I, myself, may say so. I will now relate another operation, done eight years later, which did the same for me in another part of the country, as the circumcision of Don G—— M—— did in Patagones.

FÆCAL FISTULA FOLLOWING PELVIC ABSCESS CURED BY OPERATION.

On January 13th. of this year I was called to see a Mrs. G., wife of a lawyer in Rio IV. Rio IV. is a good big town in the province of Cordoba, a day's journey from here by train. I happened to be there a couple of days on military business. Her history was briefly as follows:

Age 21 years, married twice, fairly good general health. After her first confinement, eleven months previously, she had had puerperal fever, and as a consequence an abscess of the broad ligaments (judging from what her medical man told me,) which was too high and too far out on the pelvic brim to be opened per vaginam. This abscess, the size of an orange, had been opened in the left inguinal region by Dr. Norona, who afterwards assisted me at the radical operation. A fistula resulted, for which she was taken to Cordoba, where she was treated by scraping the fistulous tract, and, later, burning it with nitrate of silver. She was sent home as well, but almost immediately the fistula opened again and she went to Buenos Ayres; to one of the best clinics there, to be treated. More or less of the same treatment again healed the sinus, and at the end of two months she again returned home considered to be all right. In a week's time the fistula had re-opened.

At the date on which I saw her, she had been home from Buenos Ayres about three months, and had a small fistula in the left inguinal region into which water, on being syringed, found its way into the rectum and was expelled in a few moments by the anus, proving without doubt the nature of the sinus. I proposed a radical operation, and consent being obtained, decided to operate next day, as my sojourn in Rio IV. was very limited. A dose of calomel was given, she was told to take only liquid food that day, and antiseptic cloths were applied to the abdomen. A clyster was given next morning, and, assisted by Dr. Norona and my soldier nurse who was with me, the operation was undertaken.

I first made an incision from the anterior superior spine of the ilium, of about five inches in length, in the direction of the symphysis pubis, going through all the coats of the abdominal wall. I found the omentum adherent all around the fistulous tract, which held a metal probe as a guide. After much trouble, I was able to clear this away and get down to the sigmoid flexure, which was firmly fixed by adhesions. These adhesions were broken down and the gut relieved, but not sufficiently to admit of its being lifted out of the abdomen. Boracic acid gauze wrung out of hot saline solution (six grams of sodium chloride to the litre) was packed in to prevent the small intestines from being cooled or soiled. I then made another skin incision, beginning and ending at the same points as the first, but running in a curved line half an inch below the opening of the fistula. This incision was dissected down in the same way as the first until I finally got the tract of the fistula in its whole length separated from the surrounding tissues. I next cut this off flush with the gut and removed the elliptical piece of skin, etc. The hole in the gut thus produced was about a quarter of an inch in diameter. First clamping the intestine on either side, I now cut out a ring of the degenerated bowel around this hole until I got into what I considered sound gut. The opening was now an inch in diameter in its long axis. I decided to simply stitch up this opening hoping, as I still hope, that the calibre of the gut would not be sufficiently reduced to produce any difficulty later on. I used Lembert's suture and silk No. 0, bringing up and covering over the wound with peritoneum. I thought it prudent to put in a gauze drain on account of there having been an escape of a few drops of pus when I cut off the fistula. The rest of the wound was stitched up in three layers, and my patient came out of the chloroform.

The next morning I left Rio IV., and for the rest of the history I am indebted to Dr. Norona, the resident physician. On the third day the gauze drain was removed, and there being a little pus, a fresh one was introduced. On the fourth day the temperature rose and, on removing the dressings, there was a slight discharge of fœcal matter. From this time on slight fever was noted and the dressings were changed twice a day, the bottom of the wound being dried with gauze each [time, until at the end of five weeks the opening had completely closed. I have seen the patient on two occasions since, in April and again in the last week of June, and she is quite well and without any sign of a return of the fistula.

NEPHRECTOMY WITHOUT A LIGATURE.

On February 25th I was called in consultation here (Mendoza) to see a lady, Mrs. A., 28 years of age, married six years, no children, who had been in bed for nine months. She gave me the following history :

Nine months before a swelling appeared in the right side, gradually became of an enormous size, and finally broke in the right loin, discharging at first watery pus, which later became much less fluid in consistence. Three months ago she began to lose the use of her right arm, especially of the shoulder muscles, which were greatly atrophied. Movement of the joint was painful and much limited. Near the end of the last rib there was a fistula which was discharging pus freely. On introducing a probe, I found it to be very deep and running in the direction of the anterior superior spine of the ilium, but I could not, as I expected, find an opening leading into the kidney. The following day I examined the ureters by Kelly's method. On the right side the catheter would not enter the ureter beyond a couple of inches, and no urine came away through it. I then felt sure, although I could not find the opening, that the fistula undoubtedly led to the kidney; and I decided to operate.

On February 28th, assisted by Dr. Goldsack, I introduced a grooved sound into the fistula, and splitting it up, soon found the opening into the kidney. On enlarging the wound, the kidney was found large and white, and on being incised, showed evidence of fatty degeneration, but little blood escaping from the cut surface of the organ. To get more room I cut away the lower third, after passing a Lawson Tait knot around it. Then, freeing the remainder of the kidney, I placed a ligature around the vessel and cut the organ away with scissors. I next introduced, guided by my fingers, a pair of scissors to cut the ends of the ligature which had been left long. By some mistake I cut the liga-

ture itself, and to my surprise pulled it away. To my greater surprise there was not any hæmorrhage at all; not a drop of blood came away. On investigation the artery was found to be completely obliterated. A nephrectomy without a ligature is, I think, rather rare.

I filled in the cavity with gauze and sewed up the wound, leaving a place for a gauze drain. Recovery was uneventful. The patient was up on the 23rd day, and the cavity had filled up by the end of the month, leaving only a skin deep fistula, which healed two weeks later.

This patient has gained some thirty pounds since the operation, and has gradually been recovering the use of her arm under treatment by massage and passive motion.

I have operated five times on the kidney, twice for stone, two nephropexies and the above nephrectomy. On again attempting the latter operation I would try the incision recommended by Langenbuch instead of the lumbar incision, which gives very little room. Had the artery not been obliterated in this case, it is doubtful if my patient could have withstood the hæmorrhage. The lumbar incision suits very well for nephrolithotomy and nephropexy.

INTERSTITIAL PREGNANCY MISTAKEN FOR A MYOMA UTERI—OPERATION —RECOVERY.

On June 24th I was called to see a woman supposed to be suffering from a fibroid of the uterus, and who gave the following history:—

S. A., aged 38, has been married 20 years, and is the mother of seven children, the youngest of whom is four years of age. Two years ago she began to suffer from metrorrhagia, the flow at times lasting from one menstrual period to the next. After lasting about a year the hæmorrhage suddenly stopped, and about this time she began to have severe pains in the abdomen and noticed a lump growing. In April she came in from the country to the native hospital here, and, when I saw her, was still complaining of pain, for which she had been given morphia continually since her entrance to hospital. There was great emaciation, probably partly on account of the morphia which she had been taking, but beyond this her general condition was good. The urine was normal. On examination, I found the uterus in a position of exaggerated anteflexion and a sound entered 8 centimetres. The tumor, which was about the size of an adult head and reached three inches above the umbilicus, was very hard, but free from nodules, and evidently fixed to the uterus, which moved with it. Pressure of the tumor had produced

constipation only relieved by clysters. I came to the conclusion that it was a myoma, probably submucous, and decided to do a hysteromyoectomy as described by Kelly in Volume II. of his Operative Gynæcology.

After a dose of calomel (0.50) and preparation of the abdomen, on June 26, assisted by my colleagues, Drs. Goldsac and Paladini, and my invaluable soldier-nurse, I opened the abdomen by an incision reaching from the upper margin of the tumor about three inches above the umbilicus to the symphysis pubis. I found the omentum adherent right across the tumor, in some places so firmly that it could not be separated by the fingers, but had to be ligated and cut. I then endeavored to lift the tumor out of the pelvis, but was unsuccessful, even with the help of a colleague's hand in the vagina; so, beginning on the right side, I tied and cut the broad ligament down to the uterine vessels, and then worked my way across between the uterus and bladder, pushing down the vesico-uterine peritoneum. I was now able to roll over the mass and then tied the uterine artery and cut through the cervix, leaving the stump. The left side was much more easily dealt with, simply rolling up the mass and putting forceps upon the vessels until everything was clear. All the vessels were now secured and the cervix stitched in the method described by Kelly. Over all, the peritoneum was now stitched from one side of the pelvic brim to the other by a continuous catgut suture covering in everything. I then drew down the omentum and put two catgut stitches in it, thus fastening it over the line of the peritoneal suture (as recommended by Forgue and Reclus) to prevent possible adhesions between the intestine and line of suture, and also to act as an absorbent for any liquid which might collect in the pelvis. The abdominal wound was closed without drainage in three layers, catgut being used for the peritoneum, wire for the muscle, and silk worm gut for the skin. The operation was finished in one hour and twenty minutes, much of this time being spent in freeing the adhesions of the omentum.

While turning out the tumour I had noticed that at one spot on the posterior surface it was quite soft, and thought at once of cystic degeneration. What was my surprise, however, on opening the mass, to find a placenta, dry and hard, and a little dried-up foetus, flattened out by pressure, measuring about five inches in length. On separating the uterus from the tumour it was seen that the ectopic gestation had taken place on the right side. On looking back over the history of the case now, I see that I might have suspected such an explanation of the symptoms, but the hardness of the tumour and its position nearly in the

middle line filling up the pelvis, pointed rather to the presence of a myoma of the uterus.

The woman made an uninterrupted recovery, the dressings not being touched until the eighteenth day, when the stitches were removed, and she left for the country on the 32nd day after the operation in perfect health.

A word or two about the technique in antiseptics. Permanganate of potash and oxalic acid are used, after a thorough scrubbing, for disinfection of the hands: all instruments are boiled for at least ten minutes in alkaline water (carbonate of soda): catgut is sterilized by boiling in alcohol under pressure: sponges are prepared after Kelly's method: silk, silver wire and silkworm gut are simply boiled with the instruments: as however, repeated boiling in the alkaline water weakens silk and silkworm gut, only sufficient for the operation in hand is put in. For ordinary work sterile normal saline solution is used for both instruments and washing out cavities. I, following Dr. O'Connor, have given up the use of iodoform. Picric acid, 3 to 5 grams to the litre of water, has taken its place and, I believe, to advantage. Strips of gauze soaked in this solution are used for packing suppurating cavities or applying to dirty wounds. The site of operation is prepared by scrubbing with soap and hot water, followed by a thorough rubbing with alcohol, and, if time permits, carbolic or sublimate fomentations are applied. Permanganate and oxalic acid complete the process. The secret of success is surgical cleanliness.—*Montreal Medical Journal*.

WYETH'S

Elixir Phos. Iron, Quinine and Strychnia.

Each fluid drachm contains two grains of phosphate of iron, one grain of quinine, and one-sixtieth grain of strychnine in simple elixir, flavored with oil of orange. ADULT DOSE.—One teaspoonful three times a day.

The preparation containing the above named ingredients constitutes an ideal tonic, and is especially adapted to those who have previously enjoyed robust health. It is rendered palatable and efficient with the use of only pure alkaloids of quinine and strychnine, excess of acid being avoided. Alternation with our beef, wine and iron is recommended, for the reason that sensitive patients are rendered extremely nervous and "fidgety" by the long continued employment of strychnine.

Please specify WYETH'S in prescribing.

WYETH'S

ELIXIR GENT. with TINCT. CHLOR. IRON.

Each dessertspoonful contains ten minims of the officinal tincture chloride iron. Four grains of quinine sulphate will dissolve in an ounce of the elixir, without an addition of any acid, the solution being beautifully clear. If a larger quantity be prescribed, the usual amount of acid per grain must be added. Dose.—Adults, one dessertspoonful; children, one-half to one teaspoonful.

The combination of gentian with iron in this form supplies a simple bitter with an active hæmatinic, free from the styptic taste of iron preparations in general. It can be taken in small doses, by delicate females and children, without derangement of digestion or subsequent constipation, and will often be found invaluable in overcoming malarial cachexia, given in combination with quinine and alternated with arsenical preparations.

It is especially indicated to correct relaxed conditions of the gastro-intestinal tract, whether or not associated with anemia.

Kindly designate WYETH'S in prescribing.

WYETH'S

Elixir of Phosphorus.

Each fluid drachm contains one-hundredth grain of Free Phosphorus.

Wyeth & Brother's elixir of phosphorus is prepared with great care, and will prove efficient in the treatment of the limited number of cases in which this remedy is specially indicated. It will be found of service in all low conditions associated with profound depression of the nervous system, such as the later stages of pneumonia and influenza, and also in the hypostatic congestion occurring in typhoid fever and other protracted disorders. It is likewise well adapted to the treatment of certain neuralgias, paralyzes, insomnia and impotence. The most satisfactory results follow its exhibition in small doses not too frequently repeated, but care must be exercised in selecting an active preparation.

In addition to the elixir, Messrs. Wyeth & Bro. manufacture a number of pills containing phosphorus in combination with other medicaments, descriptive circulars of which will be sent to physicians on application.

DAVIS & LAWRENCE CO., (LIMITED.)

AGENTS, MONTREAL.

WYETH'S ELIXIR TERPIN HYDRATE

— AND —

ELIXIR TERPIN HYDRATE with CODEINE.

“The Hydrate of the Diatonic Alcohol Terpin.”

This new official is composed of a mixture of rectified oil of turpentine, alcohol and a lesser quantity of nitric acid. It is officially described as “colorless, lustrous, rhombic prisms, nearly odorless and having a slightly aromatic and somewhat bitter taste.”

Terpin hydrate was first physiologically investigated by Lepine in 1885, who found it to act both upon the mucous membranes and nervous system in a manner similar to the oil of turpentine. It has since been used in chronic bronchitis, and in advanced stages of acute bronchitis, especially where the secretion is free, also in chronic cystitis and gonorrhœa.

Dose from 2 to 3 grains from four to six times per day.

Each fluid drachm contains one grain of terpin hydrate. At a temperature of 55 degrees or lower there may be a slight crystalline deposit which will redissolve when warmed but therapeutic value is not impaired.

Since the issue of our circular a few years ago, drawing the attention of the profession to the value of terpin hydrate as a therapeutic agent in the treatment of bronchitis, bronchial catarrh, asthma and like affections of the throat and respiratory organs the success of this preparation has reached far beyond the most sanguine hopes of its many supporters. We believe the unqualified statement of that distinguished authority Lepine, that “it is the best expectorant in existence” has been fully substantiated by those who have prescribed it.

We also prepare an elixir of terpin hydrate combined with codeine; each teaspoonful containing

Terpin Hydrate	2 grains
Codeine Sulphate	$\frac{1}{2}$ grain

This combination has proved to be most acceptable, embracing the expectorant and calmative properties of these two most valuable remedies. The experience of those who have already used this latter elixir has declared it to be eminently successful in allaying the distressing cough following influenza and other bronchial affections, without disturbing the stomach by creating nausea or loss of appetite; nor does it arrest the secretions, cause constipation, headache or other derangements.

JOHN WYETH & BROTHER,

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DAVIS & LAWRENCE CO., Limited, Montreal,

General Agents.

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Editorial.

ONCE MORE TUBERCULOSIS.

The NEWS has been so insistent upon the question of the care and cure of the tuberculosis, that we almost fear that by our continual coming we will weary our readers. But the publication of the report of Dr. Farrell, Canadian delegate to the World's Congress on Tuberculosis, held in Berlin last May, again brings the subject prominently before us, and we feel that the excellence of the report merits for it more than a passing reference. Moreover, it is due to Dr. Farrell, who has long manifested a practical interest in the prophylactic as well as the therapeutic aspect of tuberculosis, to have it said of him that the compliment paid him by the Dominion government, in selecting him as their representative at the great Congress, was well deserved, and that his report proves the wisdom of the selection.

From the tone of the report we judge that Dr. Farrell is substantially in accord with the policy of the NEWS in respect to tuberculosis. Our policy is not Utopian, but it requires state control—an insistence upon proper observance of proper laws framed to meet the case. We advocate the compulsory examination of every citizen for evidence of tubercular disease at least as often as once in every two years. We *insist* upon the necessity for control of the disposition of sputum, for the systematic inspection of foodstuffs likely to be infective, and for the establishment of sanatoria. We are gratified to have the support of Dr. Farrell in our contention for these necessities.

The report deals systematically with all the work taken up by the various speakers. The statistics, the relative frequency in the different professions and occupations, the relation between the disease in the lower animals and in man, and the causal association of the tubercle

bacillus, are all referred to. The superinfection by the pus organisms in the later stages of the disease does not escape notice, and the opinions of numerous authorities on the prevention of the disease are set forth. Heredity, infection, marriage; the prevention of the disease in factories, in the crowded dwellings of the poor, in hospitals; the disposition of sputum, the inspection of milk and meats; the precautions to be taken by those in attendance on the tuberculous—all these receive brief attention. But the major portion of the report is devoted to the subject of treatment.

Space does not allow as full a review of the report as we fain would give, but we cannot refrain from quoting several sentences, taken from different parts of the report.

"It can be stated without fear of contradiction that if, as a result of education, persuasion or legal enactment, all expectorated matter from tuberculous patients was thrown into a vessel containing a small quantity of five per cent. solution of carbolic acid or any other effective germicide, the number of cases of consumption existing in this country could be reduced over one-half within five years."

* * * *

"It is now clear that we must deal with this disease as an infectious one, just as we now deal with smallpox or diphtheria. We may not need to isolate a case of consumption, in all its stages, as completely as we isolate these diseases, but now that we know the source of infection, since science has proved the sputum from the diseased lung to be almost exclusively the origin of the infective matter, stringent measures should be taken as soon as possible by governments, boards of health, and sanitary authorities to prevent the wholesale poisoning of the people which is constantly going on, more particularly in the vicinity of cases of tuberculosis."

* * * *

"In considering the means to be taken to stamp out tuberculosis let us start with this axiom: *No tubercle germ, no consumption. An unfavorable soil for the growth of the germ, no consumption.*

"Next to the destruction of the bacillus the most necessary point to be learned by the public is the danger to which they are subject, if a good standard of health is not maintained."

* * * *

"The point to be kept prominently before the public is that *tuberculosis is infectious. In most cases in which many members of a family are attacked and die of the disease, it is not on account of inheritance, it is due to an infected house and to contact.*

"The necessity for special sanatoria treatment can no longer be looked upon as the view of a limited number of authorities; there is now a consensus of opinion among medical men that tuberculosis cannot be treated successfully in private houses. It is difficult to do so among those who are well housed and comfortably off, but it is almost impossible among the poorer classes, so that there are now being established, in all countries which have given attention to the subject, special sanatoria for this purpose."

* * * *

"I will conclude with the hope that the Dominion Government, in concert with provincial and municipal authorities, will see the pressing need there is, both for humane and economic reasons, to begin such a campaign against tuberculosis as will stamp it out of Canada in a few years."

The report has been written for circulation among all classes, and has been made as free as possible from technicalities. The style is terse and clear and consequently attractive, and we have no doubt, but that the report will receive the wide distribution and the careful and general reading which it deserves. In the interests of the public health we trust that it will.

* * * *

In this connection it is gratifying to learn that the Halifax Board of Health has taken action. They are about to distribute printed circulars giving in simple language, instructions, which, if acted upon, we believe, will aid materially in limiting the prevalence of tuberculosis.

✻ ✻

PRACTICE IN THE ARGENTINE REPUBLIC.

On page 424 of this issue we publish a very interesting article by Dr. F. G. Corbin, taken from the *Montreal Medical Journal*. Dr. Corbin is a son of J. G. Corbin, Esq., of Bedford, and at one time student in the office of Dr. Farrell.

Society Meetings.

ST. JOHN MEDICAL SOCIETY.

Dr. J. H. Scammell, President, in the chair.

Nov. 1st, 1899.—A paper entitled "Gastric Ulcer in Some of its Aspects," was read by Dr. J. W. Daniel.

Gastric ulcer is more prevalent than commonly supposed. Ewald claims that 50 per cent of the population suffers from this affection, and that 50 per cent of the supposed medical cures return. While the cause is uncertain, hyperacidity and hypersecretion of the gastric juice are important factors—most cases show an extensive acid secretion. Cases may occur leading even to perforation, in which the disease has been wholly unsuspected.

The important symptoms are vomiting, pain, hæmorrhage, tenderness, pallor and constipation. Vomiting is frequently seen and the time of occurrence in relation to food varies. Pain is not always in the region of the ulcer, but may be in the back, chest, shoulder or other situations. It may be increased or relieved by pressure, or it may be entirely absent. Hæmorrhage occurs in about 75 per cent of all cases and may be the first symptom to cause suspicion of gastric ulcer. Fatal hæmorrhages have been observed to be confined almost exclusively to the male sex. As a rule it is not the violence or amount but the repetition of hæmorrhages that kills. As regards treatment, there is no medical specific. Alkalies are useful to overcome hyperacidity, magnesium hydrate being very serviceable, while rectal feeding is of great benefit.

The symptoms of perforation are sudden onset of pain, shock, rigidity of abdomen, tender spot over stomach, diminution of liver dulness, and presence of free fluid in the abdominal cavity. It is important to differentiate the condition from colic and appendicitis. The treatment should be immediate operation. In cases of gastric ulcer with severe and frequent hæmorrhage, operation is also advocated; the stomach is opened, the bleeding point located and controlled. Two cases of gastric perforation were related.

Dr. Daniel concluded his paper by stating that many cases of supposed simple dyspepsia were probably cases of gastric ulcer, the real

condition not being recognized from the mildness of the symptoms, and further that perforation from gastric ulcer may occur where no ulcer is suspected.

Dr. Jas. Christie exhibited a man showing marked swelling of the neck, face and chest, with dilatation of the superficial veins of the chest. There was dizziness and shortness of breath. The condition was thought to be produced by the obstruction of the circulation, due to malignant disease or aneurism.

Nov. 8.—Dr. G. A. B. Addy read a paper entitled “Remarks on three Methods of treating Typhoid Fever.”

The methods referred to were symptomatic, antiseptic, and hydro-pathic; with anyone of these forms of treatment about 85 per cent. of cases recover. The advantages of hydrotherapy were pointed out as well as the inefficiency of antiseptics.

A general discussion followed, in which reference was made to the recent outbreak of typhoid fever in St. John and to the relative value of the various modes of treatment.

Nov. 15.—Dr. J. R. McIntosh, Vice-President, in the chair.

The subject for the evening was a paper by Dr. T. D. Walker, on the London and Berlin hospitals. Reference was made to various hospitals and the work done at these institutions, such as the London hospital and University College hospital. At the Portland Road hospital, the treatment of ulcers by the use of oxygen was observed; excellent results are reported in the cases of chronic ulcers and lupus. Bergoni's operation for removal of the upper extremity with the scapula was described. In this operation the middle third of the clavicle is first removed to allow ligature of the subclavian vessels. Speaking generally of the London hospitals, reference was made to the buildings being old and the operative technique not all that was desirable. The anæsthetic in general use is ether given with a Clover's inhaler.

In Berlin, at the Charité, excellent X-ray work was seen. In cases of fracture, after application of splints, the limb is radiographed and the position of the bones ascertained. Olshausen in the gynæcological clinic has abandoned the vaginal route in hysterectomy; Landau, however, pursues this method and uses very large and heavy clamps for controlling hæmorrhage. The work of Von Bergman and Engleman was also referred to and some remarks were made on German instruments.

Nov. 22.—Dr. J. H. Scammell, President, in the chair.

Dr. McIntosh exhibited a case of empyema of antrum and demonstrated the condition by an electric lamp in the mouth. The condition was produced by a carious tooth.

A microscopic slide of the bacillus of anthrax was shown by Dr. G. A. B. Addy. The specimen was obtained in this province, the disease having occurred in some cattle.

A note on the investigations carried on up to the present to determine the nature and action of antitoxin was read by Dr. Ellis.

A resolution was passed deploring the loss to the scientific world caused by the death of Sir. Wm. Dawson.



NOVA SCOTIA BRANCH BRITISH MEDICAL ASSOCIATION.

Dr. E. A. Kirkpatrick, President, in the chair.

Nov. 15th, 1899.—Dr. Jones exhibited an apparatus for modifying milk for infant feeding—a graduate beaker devised by Dr. Emmet Holt, and explained its use.

References to infant feeding were made by Drs. D. A. Campbell, Chisholm, Doyle, Farrell and Goodwin.

It was decided to have a discussion upon infant feeding at a later date.

Dr. Farrell showed several specimens which had been removed at recent operations.

The discussion on "Tuberculosis" then took place.

Dr. Farrell, in opening, referred to the importance of applying the term tuberculosis to all diseases associated with the tubercle bacillus, in order to impress on the public their common origin. He pointed out the necessity for the education of the people concerning the infectiousness of this disease and the importance of its prevention. The curability of the disease was spoken of and the important influence of the open-air treatment. He urged the importance of a sanatorium being provided for these cases.

Dr. Hattie spoke of the etiology of tuberculosis and the presence in many advanced cases of mixed infections.

Dr. Murray dealt chiefly with the institutional treatment of pulmonary tuberculosis, with special reference to the importance of strict and careful supervision. It was important for patients to lead the highest possible hygienic life. This was attained by life in the open air,

rest or graduated exercise and over-feeding. Dr. Murray suggested the formation of a society for the prevention of tuberculosis.

Dr. D. A. Campbell referred to the general harmful effect of mixed infection, particularly in internal organs. The disease was undoubtedly curable, though treatment by private practitioners had not been so far very satisfactory. He gave the history of three cases of undoubted cure, which had occurred in recent years in his own practice. The institutional treatment was important, because of the generalship and the reciprocal influence of patients.

Dr. Ross spoke of the good results of mixed infection that often occurred in cases of tuberculosis of the skin.

Dr. Murphy pressed the importance of removing tubercular glands.

Remarks were also made by Drs. Black, Jones and Goodwin.

The President supported the idea that a public meeting should be held with the object of enlightening the people on the important subject of tuberculosis.

Drs. D. A. Campbell, Murray and Jones were appointed a committee to deal with the question and report at next meeting.

Nov. 29th.—The report of committee appointed last meeting was read, which was favorable to holding a public meeting after the beginning of the new year.

A committee to carry out the meeting was appointed, consisting of the President, Drs. Jones, Silver, Sinclair, Murray and Cunningham.

Dr. M. A. B. Smith then read a paper on "Pyrexia; its Pathology and Treatment." (Published on page 409 of this issue.)

Dr. Goodwin thought that the danger of causing congestion of the lungs by the use of the cold bath, as spoken of by Dr. Smith really existed. He did not favor its use in lung disease. But he said after the application of the cold bath the surface of the body should be well rubbed.

Dr. D. A. Campbell believed there was over-production of heat in febrile processes, in spite of Dr. Smith's views, which he said were speculative and probably fallacious, as they were contrary to the views of accepted authorities. He was satisfied with the evidence of clinical experience which was all against chemical antipyretics. He believed great benefit resulted from the outward application of cold.

Dr. Jones referred to the beneficial effect the cold bath had on himself when afflicted with typhoid fever. He thought when Dr. Smith's views became more mature he might bring them before the Society.

Adverse comment on Dr. Smith's views was also made by Drs. Curry, Murray, Cunningham and Major Clements, R. A. M. C.

Dr. Smith, replying—as he explained, especially for Dr. Jones' benefit, mentioned that the argument was, he thought, simple and logical. Only one half as much food was taken in fever as normally to produce heat. Frictional heat was the same. Increased oxidation, granting it existed, would use more fuel than would be used to maintain the normal temperature. The end products, nitrogen and carbonic acid were diminished in fever. More heat from increased oxidation could not be got from the tissues nor anywhere else. Therefore, there was not increased oxidation in fever, but diminished elimination. The idea was that the oxidation processes as well as other processes such as digestion were in abeyance. The probable condition of Dr. Jones' nerves and the fact that the bath was admittedly a nervous stimulant, would explain the good effect he described himself as having felt from it. He also thought if the cold bath were used, the rubbing as mentioned by Dr. Goodwin was very important.

Dr. Goodwin read some interesting notes on work in some of the London hospitals.

Comments were made on Dr. Goodwin's notes by different members.



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

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

LACTOPEPTINE TABLETS

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Book Reviews.

THE SURGICAL DISEASES OF THE GENITO-URINARY TRACT, VENEREAL AND SEXUAL DISEASES. A Text-book for Students and Practitioners. By G. FRANK LYDSTON, M. D., Professor of the Surgical Diseases of the Genito-Urinary Organs and Syphilology in the Medical Department of the State University of Illinois; Professor of Criminal Anthropology in the Kent College of Law; Surgeon-in-Chief of the Genito-Urinary Department of the West-Side Dispensary. Fellow of the Chicago Academy of Medicine; Fellow of the American Academy of Political and Social Science; Delegate from the United States to the International Congress for the Prevention of Syphilis and the Venereal Diseases, held at Brussels, Belgium, September 5, 1899, etc. Illustrated with 233 engravings. $6\frac{1}{2} \times 9\frac{3}{4}$ inches. Pages xvi-1024. Extra cloth, \$5.00, net. Sheep or half-russia, \$5.75 net. THE F. A. DAVIS Co., Publishers, 1914-16 Cherry St. Philadelphia.

In the preface, Dr. Lydston says:—"In view of the cordial manner in which my various contributions to the subjects embraced in this volume have been received by the profession, I have felt that the publication of a more comprehensive treatise hardly requires either apology or explanation."

The writings of the author have always been read with considerable appreciation by the reviewer, so that the publication of Dr. Lydston's book was received with more than ordinary interest. There is something so frank in his style which cannot but appeal to the reader even though some of his teachings are not accepted by other recognized authorities in the same line of work. It is only fair to admit, however, that some of the ideas heretofore expressed by the author have lived to prove their correctness and converted the sceptical to his outspoken views. Every topic of importance that has any connection with the subject is given as much space as its importance warrants. It is only necessary to refer in this connection to the first chapter which deals with "Genito-Urinary and Sexual Hygiene," and the second with "Urinalysis in its Surgical Relations." The chapter on "Gonorrhœa" (in the male) occupies forty-seven pages, this article necessarily being much the same—with a few important references to new drugs and methods of treatment—as his contribution in the "American Text-book of Genito-Urinary Diseases, Syphilis and Diseases of the Skin," published last year. Hydrostatic pressure as the most satisfactory method of flushing the deep urethra, without the use of tube or catheter, is referred to—this being advocated first by the author some years ago, the value of which can be highly commended from experience, by the reviewer.

The important subject of stricture takes up ninety-three pages, and it is safe to say that no abler contribution on this topic has been written in the English language. We see no reference, however, to Poncet's operation recently advocated for extensively infiltrated strictures.

In chronic cystitis the author particularly recommends, as the most reliable urinary antiseptic, a combination of oil of eucalyptus and salol, when the stomach will tolerate it, ten minims of the former and ten grains of the latter being administered in capsule. Urotropin is also spoken of as valuable, but in Dr. Lydston's opinion is inferior to the combination given above.

Space will not permit us to refer to other chapters of interest and value, for in fact all we have perused are such.

The print and binding are up to the usual standard of the publishers while the numerous illustrations are admirably executed.

As a valuable guide and a most readable book we can strongly recommend it to the profession.

OPERATIVE SURGERY.—By JOSEPH D. BRYANT, M. D., Professor of Principles and Practice of Surgery, Operative and Clinical Surgery in the University and Bellevue Medical College, etc., etc., etc. Third Edition, volume I. With 749 illustrations, 50 of which are coloured. Published by D. APPLETON & Co., New York.

All who devote attention to surgical procedures and who have in any way come under the influence of Dr. Bryant, will heartily welcome the third edition of his book on Operative Surgery. The first volume of the new edition has just come from the publishers hands, and at once takes hold upon the affections. It is beautifully printed and is replete with illustrations which themselves teach. Not only has the work been modernized in the matters of technique, etc., but it has been greatly extended and embraces a terse and practical consideration of the advance which has been made in surgical science and practice since the appearance of the second edition.

The first chapter deals with general considerations, particularly the preparation of instruments, dressings, room and patient for operation; the administration of anæsthetics, general and local; the description and uses of instruments; antiseptic and aseptic methods, etc. Then follow chapters devoted to the control of hæmorrhage; the treatment of operation-wounds; the ligation of arteries; operations on veins, capillaries, etc.; operations on the nervous system; operations on tendons, ligaments, fasciæ, muscles and bursæ; operations on bones; amputations; deformities; plastic surgery. The various operative procedures are concisely

but very clearly described; the dangers to be avoided and the opportunities to make mistakes are all carefully pointed out; and the statistics of each operation are furnished. While the author shows no tendency to multiply words, he has yet succeeded in making his book very pleasant reading.

As should be, a critical perusal of the work reveals omissions, but we have not noted any which could be regarded as essential, and we feel that the author has shown excellent judgment in the selection of his material. We have no hesitation in recommending the work most highly, as being peculiarly adopted to the needs of those engaged in surgical work.

Matters Personal and Impersonal.

The marriage of Dr. J. A. Sutherland, of Springhill, to Miss Christina, daughter of Simon Chisholm, Esq., took place at St. George's Church, River John, on the 6th inst.

Dr. J. G. McDougall, of Amherst, was married on the 9th inst. to Miss Emily Jones, one of Ottawa's most popular young ladies.

Dr. M. D. Morrison, of Old Bridgeport, C. B., has also joined the army of benedicts, having been married on the 20th inst., to Miss Katie, daughter of Norman McDonald, Esq., of Sydney, C. B.

The News extends its cordial congratulations to the different couples.

Dr. W. Bruce Almon has started practice in this city, having opened an office at 166 Hollis St.

Dr. Atkinson, of Baie Verte, has been seriously ill at the Victoria General Hospital with typhoid fever, but we are pleased to learn that he is now improving.

The death of Dr. H. H. Mudd occurred at St. Louis, on the 20th ult., in the fifty-fifth year of his age. Dr. Mudd was one of the most esteemed medical men of St. Louis, and was Professor of Clinical Surgery in the St. Louis Medical College. Two of his best contributions are those on "Fractures" and "Dislocations" in Park's Surgery.

The Antikamnia Chemical Company, with their customary forethought and enterprise, have issued the fourth series of Skeleton Sketch Calendars, by that able and now lamented caricaturist, the late Dr. Cruzius. The set for 1900 is fully as interesting as the others published in previous years.

The next meeting of the Medical Society of Nova Scotia will be held at Amherst on July 4th and 5th, 1900. Dr. James Bell, of Montreal, has kindly consented to read the Address on Surgery.

We regret to announce the death of Dr. Foster MacFarlane, of St. John, which took place on the 14th inst. An extended obituary notice will be published in our next issue.

SANMETTO IN ANEMIC UNDEVELOPED YOUNG WOMEN.—I have used sanmetto with profit in a case of a young woman who was troubled with a very irritable bladder and urethra caused from an excess of uric acid crystals in the urine. The sanmetto accomplished what I did not expect. The mammæ had never developed very much, nor the chest and shoulders. She was also quite anemic. I gave her a bottle of sanmetto with no apparent improvement except toward the last she felt a little more vitality. I then procured another bottle at the drug store here and gave her about half of it. There is now marked improvement in her general health, the mammæ are about the former size; her shoulders and neck are becoming very much more plump and her chest is so much broader that she can scarcely wear the clothing worn before. She is looking very much better. But nothing seems to dissolve the uric acid crystals as yet.

F. E. DOANE, M. D.

Kansas City, Mo.

URIC DIATHESIS.—Gave to a man with frequency of micturition, pain in back, and bloating of stomach and bowels; with rheumatic pains in limbs; sleepless and nervous; with full feeling and eructations after meals, Lithiated Hydrangea (Lambert's), in doses of two teaspoonfuls after meals, and the following:

R	Potassii bromidi	ʒ	ij	
	Extr. cas. sag. fl.	f	ʒ	iss
	Vin. kola	f	ʒ	ij
	Tinct. cinchon. eo.	q. s.	ft.	f ʒ iv. Misc.

Signa. One teaspoonful, in water, before meals, and two teaspoonfuls before retiring.

He improved as if by magic; bloating, full feeling, eructations and all pain disappeared; and there is no undue frequency of micturition.

Cleveland, Ohio.

CHARLES H. SPRINGER, M. D.

WINTER COUGHS—GRIPPAL NEUROSES.—That codeine had an especially beneficial effect in cases of nervous cough, and that it was capable of controlling excessive coughing in various lung affections, was noted before its true physiological action was understood. Later it was clear that its power as a nerve calmative was due, as Bartholow says to its special action on the pneumogastric nerve. Codeine stands apart from the rest of its group, in that it does not arrest secretion in the respiratory and intestinal tract. In marked contrast is it in this respect to morphine. Morphine dries the mucous membrane of the respiratory tract to such a degree that the condition is often made worse by its use; while its effect on the intestinal tract is to produce constipation. There are none of these disagreeable effects attending the use of codeine.

The coal-tar products were found to have great power as analgesics and antipyretics long before experiments in the therapeutical laboratory had been conducted to show their exact action. As a result of this laboratory work we know now that some of them are safe, while others are very dangerous. Antikamnia has stood the test of exhaustive trial, both in clinical and regular practice and has been proven free from the usual untoward after-effects which accompany, characterize and distinguish all other preparations of this class. Therefore antikamnia and codeine tablets afford a very desirable mode of exhibiting these two valuable drugs. The proportions are those most frequently indicated in the various neuroses of the larynx as well as the coughs incident to lung affections, grippal conditions, etc.—*The Laryngoscope*.

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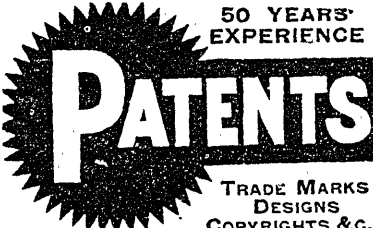
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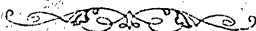
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