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Ontario Medical Journal.

SENT FREE TO EVERY MEMBER OF THE PROFESSION IN ONTARIO
AND BRITISH COLUMBIA.

R. B. ORR, - - - - - EDITOR.

All Communications should be addressed to the Editor, 147 Cowan Avenue, Toronto.

VOL. II.]

TORONTO, MAY, 1894.

[No. 10.]

Contributions of various descriptions are invited. We shall be glad to receive from our friends everywhere current medical news of general interest. Secretaries of County or Territorial Medical Associations will oblige by forwarding reports of the proceedings of their Associations.

Physicians who do not receive their Journal regularly, or who at any time change their address, will please notify the editor to that effect.

Editorials.

COUNCIL MEETING.

This month, which ushers in the summer, and is looked forward to by all for its pleasantness and beauty, is, at the present time, the last one in the year of the Medical Council of Ontario. In the early part of June, another and final session of the present body will be held, and all medical eyes are watching for its doings with great interest.

There are many things we would like to see, but it is not our province to dictate to the Council—rather may we outline the probable work which will in all likelihood be undertaken. The first, and probably the most important, to be dealt with will be the subject of "Contract practice," both with regard to its effect on the general profession and on the deliberating body itself. The importance is demonstrated by the large amount of correspondence carried on in the columns of this journal, and the general sentiments, as a rule, against the work so ably expressed there. Most writers condemn but suggest no remedy, and in this case we presume the Council is looked to for a solution. Under the present circumstances, we can hardly see how they can deal with it other than by a committee to investigate the condition of affairs, with orders to report to the incoming Council of

1895. Some may argue that members of the committee may not be members of the new Council; but that has no effect whatever, a committee-man being eligible for his position until replaced or the committee dissolved. The advisability of the report being held over will be easily comprehended through the fact that the general profession will have a stronger voice than at present.

The committee to suggest a remedy for the evil so-called will be called upon to exercise a great deal of thought, founded on the experience of many. They will have to be very canny, so as to keep in touch with both the profession and the general public. Some years ago a commission headed by the late Dr. Fulton went through a lot of evidence, and then found it impossible to do anything. One of the great troubles is both the legislative and the people's fear of close corporations, the reception of the Pharmacy Bill being quite strong enough to see which way the wind blows.

As medical men we are strongly against lodge work, and would like very much to see it either done away with or remedied in some way which would make conditions more favorable to ourselves than they are at the present time: but as rational human beings we see no remedy now with present temper of the people. Still we sincerely hope that our executive body will see their way through it.

The by law for the coming elections and the appointment of returning officers will be a necessary item: also, the report of the Discipline Committee dealing with the cases of Drs. McCullough, McBrien and Wilson. The precedent of the action in the case of Dr. McCully may be followed out, as the result has been excellent.

The renewal of the contract with the ONTARIO MEDICAL JOURNAL will be a topic of some interest, and without boasting we certainly think we have carried out our part to the full letter of the law. When we say we have supplied a good medical paper, giving free room to all the medical profession in reasonable bounds for the airing of their opinions, we are not giving our own thoughts but the result of the general expression of our readers.

Some men, rather finicky, or in fits of spleen, have objected to the style of advertising. If we needed any defence we could easily give a very good one. Without entering into the matter we might say that the *British Medical Journal*, which is considered the criterion in ethics, gives exactly the same class as we ourselves do in our advertising pages. As a matter of fact we have been just a little too particular for our own good in that line, as many times we have refused ads. which would pay well, but the matter did not please us.

The general work will be on the same lines as heretofore, and we look to find able expositions, of the different courses adopted.

PREVENTION OF CONSUMPTION.

The generous offer of Mr. W. J. Gage, the publisher, of Toronto, wherein he donated \$25,000 towards the founding of a hospital for consumptives, in High Park, the only stipulation being that the city grant a site and erect a building to cost not less than \$50,000, cannot be too highly commended. It is an offer that the city should immediately accept, the infectiousness of phthisis being so firmly established.

The diffusion of tuberculous dust is proven to be the principal means by which the disease is carried from man to man, and the necessity for isolation of advanced cases, and the education of the people of the necessity for the conscientious and persistent use of disinfected spitting cups, and of

various easily burned substitutes for handkerchiefs, are facts that should convince the city council of the urgent necessity for such an hospital. We cannot too strongly emphasize the prominence of the bacillus and the importance of dealing with the sputa and preventing diffusion of tuberculous dust. It is right to isolate, so far as possible, the hopeless consumptive, and to enforce such measures of cleanliness as should prevent those going about from infecting their neighbors.

Consumption is a disease of degenerate tissue in a degenerate race, the degeneration being entirely due to the entrance of a micro-organism with which the germicidal action of the blood is unable to cope. So that with proper isolation, improved sanitation, and thorough disinfection, the next century will recognize phthisis as a disease of the past.

SCIENCE OF BACTERIOLOGY.

Since the discovery by Koch, in 1882, of the bacillus tuberculosis, the study of bacteriology has rapidly become one of the most important, not only in the scientific, but also in the medical world. It has come to be looked upon as playing a most prominent part, both in the production of disease and in putrefaction, and in the everyday processes of fermentation and some chemical changes which hitherto were supposed to depend on very different causes. In consequence of this, study has been raised to the dignity of a science, and its ramifications have become so numerous and widespread, that many of the other ologies and even some of the arts have been freely brought into the service of one or the other of its branches.

The study of bacteria remained for many years in the hands of botanists, with the occasional intervention of scientific medical men, who made guesses at the casual relationship between certain bacteria and some infectious diseases.

In the last ten years, however, owing to the vast improvements that have been made in the methods of cultivations, and especially in the method of obtaining pure cultures, most valuable information, as to the functions and biological chemistry of these minute specks of vegetable protoplasm, has been rapidly accumulated.

The various nations of Europe have been so impressed with these facts that they have established state laboratories for the study and practical application of this important subject, and we regret that Canada is so far behind the smaller states in Europe, that she entirely ignores the importance of such a step. Had such an institution as exists in various parts of Great Britain been in existence, and men at its head possessing the confidence of the British Government, the embargo would never have been placed on Canadian cattle, and tuberculosis, as it existed in the Ontario Model Farm, would have been speedily eradicated.

EDITORIAL NOTES.

Now that small pox is so prevalent in Chicago, it is incumbent upon the Health Boards all over this province to exercise the closest care and watchfulness to prevent the appearance of it in this province.

At no time since the Medical Council was established was there so much interest taken in Council affairs as at present. This argues well for the new Council, and without doubt will be in the interest of the profession at large.

There was no attempt made during the past session of the Local Legislature to interfere with the Medical Act. It is unwise either for the Council or the medical profession to appear too frequently before the House asking for amendments to the Act.

The returns of the Spring Examinations of the College of Physicians and Surgeons will be published on May 31st. The students have done much better this year than in former ones. The stringency of the Council Examinations have stimulated the schools to better work, and the result is a superior graduating class.

Two decades ago bacteriology was unknown, its field a fallow waste, its results unprophesied. Today all over the world bacteriological laboratories exist in which thousands of ardent workers are holding out to the world the bow of promise and the hope of future science.

The American Government have at last recognized the fact that it is necessary to establish a National Bureau of Public Health, and the bill at present before both legislative branches at Washington is one which, if it becomes law will be of inestimable value to their nation.

During the past month the detective of the Council has been busy at work, with the result of many prosecutions. At the present time there is no Province in Canada or State in the American Union so free from quacks as this province, and we sometimes fear the profession at large does not appreciate the large outlay necessary in connection with this department, and the good work that is being done, more, perhaps, in the interest of the laity than the profession.

At the nineteenth annual meeting of the United States Hay Fever Association, Dr. S. S. Bishop, of Chicago, obtained the prize for the best essay on the subject of Hay Fever, proposing the theory of uric acid origin, with salicylate of soda for treatment. One year previous to the reading of this essay, Dr. Shawe Tyrrell, of Toronto, read a paper before the Ontario Medical Society, entitled "A Predisposing Cause of Hay Fever," which was afterwards published in the Canadian journals, setting forth the uric acid origin of the affection, and its treatment—a proper diet and soda salicylate.

British Columbia.

Under control of the Medical Council of the Province of British Columbia.

DR. MCGUIGAN, Associate Editor for British Columbia.

BRITISH COLUMBIA MEDICAL COUNCIL.

The annual meeting of the British Columbia Medical Council took place at Victoria, on Tuesday May 1st.

The following officers were elected for the current year: President, Dr. J. M. Lefevre, Vancouver; Vice-President, Dr. John A. Duncan, Victoria; Registrar, Dr. G. J. Milne, Victoria; Treasurer, Dr. J. M. Lefevre; Associate Editor of the ONTARIO MEDICAL JOURNAL, Dr. W. J. McGuigan, Vancouver.

Dr. Milne, the popular Registrar of the Council, entertained the members and a number of prominent gentlemen, practitioners, newspaper men, etc., at his palatial residence, "Pinchurst," on Wednesday evening, May 2nd. It was a great success, and will long be pleasantly remembered by those who participated in it.

THEN AND NOW—A RIP VAN WINKLE EXPERIENCE

To the Associate Editor for British Columbia.

SIR, You ask me to give you some account of my visit to the scenes of my childhood and youth in 1892-03. I have not thought that there was anything specially interesting in that trip except to myself. However, it is the individual experiences and inferences drawn from them that mould the sentiments of mankind. Besides, I do not like to refuse one whose uniform kindly deportment towards me has placed me under obligations, though I think you will be sorry you gave me the invitation.

It is necessary to state the fact that I have been engaged in the practice of medicine and surgery, barring interruptions, for nearly thirty-five years. The interruptions, however, run up into the millions, as I was a medical "misfit" from the start.

I soon discovered that the amount of business depended much more on matters outside of the profession than inside. Amongst these stand prominently, ability to run some organization, personal adaptation, skill in the confidence trick, etc., etc. So, after three years' experience in a town in Canada West, I resolved to try my luck in the gold mines of British Columbia.

I could give you an account of many adventures on the way to and all over this coast since '62—I came with an overland party through the wilds of British America—but this would be out of place in a medical journal.

When I commenced the practice of medicine, I need not tell the old practitioner that blood-letting, salivation and violent purgation were included in the means thought necessary in the battle with disease. Persons in health were being bled in the spring as a prophylactic.

When practising in Honolulu a few years ago, I complained of the frequent drenching rains,

when I would be informed that I was on the dry side of the island, and so I learned that the treatment mentioned was on the wane. What must it have been when it was at its height, when Washington and Byron were slaughtered? But notwithstanding the quite vigorous sentiment in favor of this sort of practice, I did not adopt it, and my patients did not die, as they should have done had they been more considerate and respectful towards the medical fashion. I always have thought it was very mean of them.

Neighboring doctors refused to consult with me on common grounds, such as surgery, because of my heterodoxy. But there is always danger of being run over when one places himself in opposition to current sentiment which, to this day, is considered to be the same thing as truth. It has never been considered right not to walk on an old and beaten path, no matter how many have been proven to lead in the wrong direction. It was not easy to make headway against the old family doctors who had such a good knowledge of their patrons' constitutions. This had special reference to the amount of medicine they could take without fatal results. Great attention was given to finding the maximum dose. My attention was directed in the opposite direction, and I had the idea, bad boy that I was, that it was bad enough for the patient to be attacked by the disease without being attacked by one or more doctors also.

Since then this pulling-down treatment has been largely superseded by the pulling-up treatment, of which a man by the name of Chambers was the greatest exponent. And now it is all germicidal, and instead of patients, the doctors are killing microbes.

As your space is limited, I must condense what I have to say of my visit.

The experience of Rip Van Winkle was repeated. Thirty years transformed the child into the middle-aged woman, who could not recollect me, and the middle-aged into the full of years. Many dead; everything changed; I was a stranger.

During my stay in Toronto, my native place, I visited the city hospital, and saw various operations under the antiseptic plan. I will only venture one criticism. I thought and think that the patients were kept unnecessarily long under the anesthetic. No attempt apparently was made to expedite matters.

I missed the old-fashioned tourniquet, and the old talk about sanious or "laudable" pus. It is not considered laudable. It seemed, to have pus at all.

I now hied me away to Cleveland, Ohio, where in the long ago I imbibed the heretical medical views which saved me from the beaten track. I found a large city instead of a small one. I could not find even the old college building. Nearly all the faculty were dead—only one remained to greet me. Instead of one heterodox college, with perhaps fifty students, there are two each, with about 125 students. None of these students are taught to use stimulants, or sedatives, or narcotics, etc. The old polypharmacy has long been shelved, but otherwise no difference could be seen from the ordinary.

A letter to Prof. Biggar, once an Ontario boy, opened the way for me. The Professor is an A.M. of Victoria University. One of these colleges became his *Alma Mater*. Formerly in the chair of general surgery, he is now in the field of gynecology. I saw him perform cœlotomies unto a surfeit. The last I saw was his 300th or thereabouts. His mortality has been about one in fourteen. He is a *gentleman*.

I was looking for something new. I found it, or it found me. It was orificial surgery. There is a chair devoted to it. An enthusiastic doctor from Sandusky held forth for an hour or so in place of the regular incumbent. He dwelt on the anatomy of the lower outlets and their numerous reflexes (the upper orifices are deemed comparatively unimportant), first, however, reminding the young doctors of the great advantage of being able to cure cases in which all others had failed. The various surgical procedures were explained, and many of which, however, were new. The operations on the uterine os and cervix included the usual repair of lacerations, dilatation and the too fashionable curetting, the latter being most safe when preceded and accompanied by dilatation and drainage. Incision of the male meatus, *a la Ots*, and prepuce is doomed if it goes behind the glans with anything of a snap, not to mention phimosis.

I heard the phrase "hooded clitoris" for the first time, and of phimosis in the same locality. The same treatment is applied as in the male, with results at least encouraging. The clitoris should

not be overlooked. But the greatest fountain of baneful reflexes is held to be the outlet of the bowel, and in addition to the usual treatments for fistula, the thorough dilatation of the sphincters alone, or followed by the "American operation," is the sovereign remedy for a large class of obscure and hitherto incurable diseases, or a big percentage of them, including insanity. This operation is similar to the Whitehead or English operation, but superior to it. This article is already too long to describe it now. It is done sometimes for merely constitutional effects.

The doctor so accurately described symptoms of which I had complained for many years, that I came near having the thing done for me then and there. I did have it done eventually, although I had no local trouble but an inveterate twenty-year-old pruritis. The pruritis is cured, and on my return home everybody pronounced me twenty years younger. It has been of immense benefit generally to me. Here, dilatation is the greatest of all remedies for chronic constipation, and, making some allowance for the claims of some of its advocates, I am satisfied that the operations referred to, barring indiscriminate womb curetting and circumcising, embody a very great advance in surgery. Dilatation should always be performed slowly with a bivalve speculum.

Before going home, I visited Prof. Pratt's sanitarium in Chicago, devoted exclusively to these matters. Everybody confirmed the good opinion I had formed of the treatment. Prof. Pratt, who was professor in one of the homœopathic colleges (five in Chicago, and 600 students) of Chicago, an Consulting Surgeon to Cook County Hospital, is the originator of the treatment. In addition to the "American," I saw him liberate a hooded clitoris, removing smegma, and for a case of retroversion of the uterus, cut down on the round ligaments, pull in or out the slack, cross them in front, and secure them until the wounds were carefully closed, then excise all outside. I remarked (I am of Hibernian descent) that in anteversion I supposed he would merely cut the ligaments, when the uterus would bound back to its place. I saw him perform the "American" also in a case where the mere removal of piles did not prove sufficient.

As I understand it, the thing needed to remove

all reflexes is the liberation of the filaments of the nerves bound firmly by more or less plastic exudations and undue contraction of the sphincters and other sphincter muscles. Dilatation of the sphincters is claimed to be the most potent resource in chloroform narcosis.

Another new thing to me was the attendance of the many lady students in the colleges I visited, at all the lectures and clinics, including the male venereal and the orificial and why not?

And then the ophthalmoscope, the otoscope and the laryngoscope, and other things are all new since I went to sleep by turning my back on civilization thirty years ago. And surely there must have been an immense increase in the numbers of the worm-like appendage of the cæcum. New ones. "Hence hangs a tail." Does it become "hooded," or need circumcision, or curetting, or dilating, or the "American"?

After an absence of eight months, I hied me to my home by the Western Sea.

E. STEPHENSON, M.D., M.C.P.S. Ont.

Prince Edward Island.

DR. R. MACNEILL, Associate Editor for Prince Edward Island.

HIGHER MEDICAL EDUCATION MISCONSTRUED.

The *Arena*, a monthly magazine, published in Boston, in last February's issue contains an elaborate article on "The Menace of Medical Monopoly." The writer evidently thinks it is a *squelcher*, and, so far, he has displayed considerable ability in evading the real issue. Higher medical education does not give or aid a monopoly in any sense. The writer ignores the rights of the public and the state. The state has an undoubted right to exercise police powers, and to demand when one dies, proof that he is dead and the cause of death. The proof is invariably a medical certificate. Is it unreasonable on the part of the state to require that the author of that certificate should possess certain qualifications? We think not, and that it is right and proper that there should be one standard of medical education, and every man who desires to practise the medical profession should come up to the standard. It is not a class law, nor is there any comparison between the standard

and the "religious hierarchy" of the Dark Ages, neither is it despotic. Mr. Flower, in his article, starts from false premises—he argues that a man cannot take any medicine but what is ordered by an authorized doctor, and quotes the case of his wife where a layman ordered *raw oysters* and *capsicum*. The liberty of the citizen is not interfered with in what they eat or drink, and higher medical education does not restrict anyone from buying anything they know how to use. But the liberty to buy what you please and do what you please are two different things. The idea that anyone who prescribes *oysters* and *capsicum* should have the liberty of styling himself a doctor, and cry out despotism, if required! Before he can assume that title, he must possess a certain standard of qualifications. Nay more, in view of the prevalence of quackery, the state has the undoubted right to require state qualifications as the legal right to practise.

If everyone had the liberty to sell what food and drinks they pleased, great injury would result to the public health, hence the state restricts articles that are injurious or adulterated. The liberty of the subject comes in here equally as well.

As a matter of fact, higher medical education does not create a monopoly, but it requires a better article, and in view of Mr. Flower's own statement of his experience concerning the various differences or mistaken opinions in the diagnosis of his wife's case, it is the best proof, eminent and all as the men may have been, that there was some defect in their training and medical education: and had they weighed the case they would have discovered that it was one of the innumerable nervous manifestations which has been the opprobrium of the profession in all ages. She must have been one of that class, or *oysters* and *capsicum* and *Christian so-called scientists* would not have succeeded in curing her. Anything that makes a *dominant impression* may effect a cure in these cases, which a very ignorant person may practise and succeed with on another ignorant person.

Jugglery of any kind succeeds in some cases where downright straightforward honesty may fail to make an impression, but we would be sorry to take the stand in this enlightened age that free scope should be given to this sprout or offspring of the Dark Ages.

Notwithstanding the eloquence of the *Arena* article, sixteen of the most enlightened physicians of the United States have taken up the standard of state qualifications for all; New York and Pennsylvania are among the number, and now the law is that "in all cases a foreign physician is required to take an examination before one of the state boards before he can be legally licensed." The clause in the New York law permitting the endorsement of licenses from other state examining boards, applies solely to other states in that country, and is at present inoperative, as no state maintains in all respects the requirements fixed by the New York law.

If a doctor from Prince Edward Island were to move from here to the State of New York, although legally qualified in this province for twenty years, he must take an examination before he can be a legal practitioner there. New York has the undoubted right to take this stand, and we have the undoubted right to require also that all New York and all other physicians take an examination before our state boards before they can be legally licensed, and our standard in medical education is higher than that of New York.

Let no man therefore take up the false cry of monopoly in this matter. Improvement in the quality of the article cannot be called class legislation: and mighty as the article of the *Arena* appears, it hits away and beyond the mark, and misconstrues entirely the great object and aim of higher medical education.

Original Communications.

MISTAKES IN PRACTICE.*

BY DR. GEO. HODGE.

It is often said, and I believe truly, that we learn more from our mistakes than from our successes. This being so, I should now be fairly well learned, as I can look back upon the past and readily recall many, too many, of them. As experience, often dearly bought, on the part of the doctor and patient is our best guide amidst the pitfalls that surround us, I think it a profitable task to go over

the ground of our past experiences and gather up the lessons taught us by our failures and mistakes.

Mistakes may be divided into two classes, viz., avoidable and unavoidable. I wish to-night to speak of the former class only, and in doing so it will be necessary for me to use the personal pronoun "I" more frequently than I otherwise care to, as I draw almost exclusively from my own experience.

I believe that avoidable mistakes are for the most part due either to carelessness in the examination of the patient or to our approaching the case with a pre-conceived opinion as to what is the matter, and thus we shut our eyes to facts which would be patent enough if we brought an unprejudiced mind to the case.

During the early years of my practice, I was called to attend a young man suffering from pneumonia. He was very ill and at the end of the time when convalescence usually commences, the temperature, instead of becoming normal, kept up: the cough, instead of disappearing, continued and was dry and barking: the lung, instead of clearing, remained dull. These symptoms, with the physical signs that must have existed had I looked for them, were surely enough to make me suspect the true nature of the case: however, I looked upon it as a case of consolidation of the lung following pneumonia. An old practitioner was called from a neighboring town. In consultation he agreed with me that it was a case of consolidated lung and attributed the cough to an elongated uvula which he promptly removed, without, however, affording any relief to the cough. I never even suspected what was the matter with this patient till he fell into the hands of another practitioner, who was fortunate enough to diagnose the case as one of *empyema*. An operation was suggested and readily agreed to by his friends, with the result that the patient immediately after the operation began to improve and soon regained his former state of health. At the time I felt very much crestfallen on account of this error, but I have since then learned that there is no more common source of error than the subtle development of *empyema* after an acute illness. I have more than once had a sort of satisfaction in finding that others make this same mistake, and I cannot but think that two of this society who

* Paper read before the London Medical Society, April 9, 1894.

have for years been in the enjoyment of large practices, and who at one of the meetings of this society, when the subject of Empyema was up for discussion, stated that they had never had a case of empyema in their practices, must have probably more than once made this same mistake.

A few years after the case above related, I was asked by a doctor in a town in which I then lived to look after his patients during his absence from town for a few weeks. Among other patients was a child aged two years, who had had an attack of measles. The child did not convalesce well, but continued feverish, had a dry hacking cough, and became very much emaciated. The friends were told that the child had phthisis, and that he would not recover. When I first called to see the child I asked the mother to strip him. To see the child stripped was almost to make a diagnosis. One side of the chest was bulged and immovable. Physical examination revealed dulness, absence of respiratory murmur, etc. I aspirated the child's chest for a few times at intervals of about a week, drawing off considerable quantities of pus at each operation, and when the doctor returned, to his astonishment and chagrin he found his patient almost completely well.

I have within the last two years seen two cases in consultation: both had suffered from pneumonia, and instead of convalescing as these cases usually do, they remained feverish, were breathless, especially on exertion; had dry, hacking cough, and on examination had all the physical signs of pleural effusion. In both cases the real condition was unsuspected till suggested by myself. Both were cases of empyema: both rapidly recovered after operation.

Some few years ago a young man came to my office complaining of pain in the epigastrium and loss of appetite. Without an examination I took it for granted that he was suffering from dyspepsia, and prescribed accordingly. In about a week he returned, saying he was no better, but weaker. I never questioned the diagnosis made at the first visit, but I thought I had prescribed the wrong remedy: consequently I changed the prescription. A few days later his father came to see me, and said, "David is no better: he is steadily growing worse: unless you can do something for him, I fear he will not recover." I visited the young

man at his home, found him up and dressed, but so breathless that he could scarcely walk across the floor. As I looked at him, it flashed across my mind there was something wrong with his chest, and I then did what I should have done when he first visited me—stripped him. A few minutes' examination readily convinced me that one side of his chest was full of fluid. I returned next day and drew off eighty ounces of serum with the aspirator. If I had kept the motto, "Strip him," before my mind, I could not have fallen into this error. No longer than last week I would have made precisely the same mistake had I not remembered the motto, "Strip him."

I commenced the practice of my profession in a malarial district: nearly everyone suffered from ague. I was myself no exception to the rule. A young man on one occasion visited me, and complained of suffering from recurring chills and fever. I at once jumped to the conclusion that he had ague, and prescribed quinine. He returned a few times, reporting himself on each occasion no better. Notwithstanding this, I continued the quinine. Deriving no benefit from my treatment, he consulted a doctor in a neighboring town. I met his sister one day, and enquired as to the condition of her brother, remarking at the same time that I had not seen him lately. "Oh," said she, "you did him no good and he went to see Dr. K., who tells him that he is far gone in consumption." I felt humiliated, but tried to make myself believe that Dr. K. either was mistaken or trying to make a "mountain out of a mole hill." However, as the young man died shortly afterwards, I was forced to believe the mistake was mine, not Dr. K.'s. Had I remembered the motto, "Strip him," and acted upon it, I might have saved myself this error. For a long time I thought that no person but myself ever made such a dreadful error. However, I find that Dr. Osler in his "Practice of Medicine," says: "In Philadelphia it was very common to have patients sent to the hospital supposed to be suffering from malaria, who had well developed signs of phthisis.

Failure to examine the urine often leads to errors both in diagnosis and treatment. To illustrate: A couple of years ago I was called to see a gentleman who gave me the following history: He had been ill for several months, during which

time he had been under the care of Dr. — (now deceased). He complained of nausea, pains in various parts, particularly in occipital region of the head, weakness, etc. Notwithstanding treatment, his symptoms continued unabated. One day as he was in a neighboring town, he happened to meet a doctor with whom he was well acquainted. The doctor friend remarked that he (the patient) was not looking well, put his finger on his pulse, and at once asked him if his doctor had examined his urine. He said, "No." Said he, "When you return home, ask him to examine your urine." He did so, and to the astonishment of both doctor and patient, the urine was found to contain a considerable quantity of albumen, casts granular, hyaline, etc. From a case such as this we may learn to have the motto, "Examine the Urine," ever present to our minds. May we not also learn the importance of the pulse as a factor in the diagnosis?

Another common source of error is pain in the lower extremities, due to pressure in or about the pelvis. The pain is described as neuralgic, while its true source is unsuspected. A couple of examples of this occur to me. A doctor who enjoyed a large and lucrative practice, and very deservedly so, diagnosed a case of disease of the sacro-iliac synchondrosis as sciatica, because the pain was referred to the course of the sciatic nerve. How a gentleman of his varied experience and shrewdness could have made this mistake in the face of other symptoms that were present, is to me a mystery. He saw the patient several times, and never even suspected the true nature of the case till a short time before death.

A few years ago I was asked to see a case in consultation. The patient was a woman who had been confined some weeks previously. For some time she suffered excruciating pain in one leg. Her medical attendant had diagnosed sciatica. When I saw her, she had a high temperature and other marked constitutional symptoms. The leg was flexed on the thigh, and the thigh on the abdomen. Movement of any kind caused severe pain. This was a case of pelvic cellulitis, which ultimately proved fatal.

In both of these cases the mistake was quite unjustifiable, and cannot be accounted for, except by the grossest carelessness on the part of the medical attendants, as in professional attainments

and experience they were much above the average practitioner. The lesson to be learned from these two cases is the importance of determining in every case of pain in the course of the sciatic nerve, whether or not it is primary or secondary to some affection of the pelvis or the cord itself. Still another source of error of diagnosis is to be found in the detection of infectious diseases.

No doubt there are a certain number of doubtful cases about which the most careful practitioner cannot be confident. Errors of diagnosis do not, however, always occur in difficult cases.

During my attendance at the hospital last winter a great many cases were sent in certified as diphtheria, and were accordingly sent to the infectious ward. Quite a proportion of these cases were suffering only from follicular tonsillitis, and should never have been sent to an infectious ward. Occasionally a much more serious error is made, viz., treating a mild case of diphtheria as one of follicular tonsillitis; consequently the patient is not isolated, and other members of the family frequently contract the disease, which in them might assume a much more malignant type than in the one first attacked.

Let us learn the lesson that where there is the least room for doubt in any infectious disease, we should always isolate the patient till such time as doubt no longer exists.

Another common and dangerous mistake is to call epidemic rose rash scarlet fever. Children are thus supposed to have had scarlatina; subsequently all necessary precautions are not taken to prevent the recurrence of this disease. I have frequently heard of children having had second attacks of scarlatina, but I have never yet in my own practice seen a case of true scarlatina which has been followed by a second attack.

In a short paper such as this I cannot hope to do more than mention a very few mistakes. Did time and opportunity allow, I might prolong this subject almost indefinitely, but I do not wish to be tedious, and therefore must close; but before doing so I would like to call your attention to a couple of errors that are probably not so common.

The diagnosis, "worm fever," is frequently made by old women, but I can scarcely think it is ever now made by practitioners. I can well remember having made this diagnosis more than once, not that it really satisfied me, but because I was ignor-

ant of the real nature of the cases, which I am now convinced were nothing else than tubercular meningitis.

Another favorite diagnosis in my younger days was "bilious fever." Looking back upon the past I can recall cases of what I now believe were pneumonia, without distinct symptoms and signs, that were called bilious fever.

About six years ago I was called to see a young woman who had the day before been at a neighbor's house helping with pig-killing. She ate heartily of the fresh pork, and was soon after seized with vomiting. She felt so ill that she had to be driven to her own home. When I saw her the following morning she was vomiting occasionally, and complained of pain in the head. Prior to this she had been in the enjoyment of excellent health. I diagnosed her case as a bilious attack brought on by eating too freely of the fresh pork: gave her a purgative and something to settle her stomach. I visited her the next day and found her no better. I continued visiting her daily for the next three or four days without any suspicion that my diagnosis was not correct. The persistent vomiting and pain in the head, even without the presence of the other symptoms, which must have existed had I taken the trouble to look for them, should at least have made me suspicious of my diagnosis. About the fifth day symptoms arose which so obviously pointed to meningitis that I could not longer close my eyes to the true nature of the case. Within twenty-four hours the patient was dead. An earlier diagnosis in this case would not have likely changed the result: it would, however, have saved my reputation with the friends.

The one great lesson that I would desire to impress from this brief review of past experience is greater care in the examination of our cases.

THE PATHOLOGICAL AND CLINICAL FEATURES OF ATROPHIC RHINITIS.*

BY MR. WYATT WINGRAVE, LONDON.

INTRODUCTION TO DISCUSSION.

At a recent meeting of this Association it was my privilege to demonstrate some histological investigations concerning the disease commonly known as "atrophic rhinitis." Through the cour-

tesy of your Council I am now enabled to amplify that communication by dealing with its clinical and pathological aspects.

The selection of a disease with whose existence we are only too familiar, perhaps, demands some justification or apology. As I cannot justify its choice by presenting you with any brilliantly novel observations or discoveries, I can simply plead the importance of the subject, and express a hope that by your discussion more light may be thrown upon a disease regarding which at present our literature reveals an apparently hopeless tangle of conflicting views and contradictory interpretations.

It is not my intention to trouble you with an exhaustive chronological or critical review of all that has been written upon the disease, but to give you the results of a personal investigation into upwards of sixty cases, many of which, through the courtesy of my colleagues, I have been able to examine systematically and watch during the last year or two. Although sixty may seem a small number, they represent a careful selection, as I have rigidly excluded all those which appeared of a doubtful nature.

Definition.—Without prejudging the appropriateness of the name, atrophic rhinitis may be defined as a progressive and persistent form of dry rhinitis, characterized by a shrinking of the mucous membrane, which tends to invade contiguous chambers, and is accompanied by the formation of crusts with more or less fetor of a special character.

Nomenclature.—*Ozaena*, dry catarrh, foetid coryza, cirrhotic rhinitis, and punaisic represent only a few of the names which are in use, and more or less indicate the nature of the disease and the ingenuity of the writer. Although they are all more or less defective and misleading, instead of busying ourselves in coining new names, we can, I think, more profitably devote our attention to a consideration of the pathological and clinical details, so that certain features may be selected as characteristics and constants of the disease. Until then, it may, perhaps, be more expedient to provisionally retain the term "atrophic rhinitis."

Histological Features. The difficulty of obtaining material for microscopical examination is obvious, for few cases are found in the *post mortem* rooms of our special department. My histological examinations have, therefore, been confined to portions of tissue removed from living patients, by means

* Read before British Laryngological Society.

of the snare, in a large proportion of the cases seen. I will briefly summarize and discuss the most prominent and constant features which were present.

They may be conveniently arranged under the following headings:

1. Transformation of the columnar ciliated and special olfactory cells into stratified squamous epithelium.
2. Disappearance of the hyaloid basement membrane.
3. The presence of special hyaloid bodies and pigment masses.
4. Changes in the glands.
5. Changes in the lymphoid tissue and blood-vessels.
6. Changes in the bones.

All these conditions were present in degrees proportional to the intensity of the disease in every well-marked case; I shall, therefore, consider them as the histological constants of atrophic rhinitis. Although transformation of the surface epithelium and many of the other changes may occur *separately* in various diseased states of the nasal mucous membrane, *collectively* their significance is of the utmost weight in identifying the specific nature of the process.

It has been observed by Bosworth* that these epithelial cells may become active inflammatory corpuscles, but I have not found any evidence to justify such an assumption.

The disappearance of the hyaloid membrane is very constant and characteristic, for in other forms of rhinitis it generally remains intact.

Perhaps the most striking and interesting feature is the presence of hyaloid bodies, which increase in number with the duration and severity of the disease. They consist of small, refractive, rounded, homogeneous masses, imbedded for the most part in the interlobular tissues of the glands and in the adjacent lymphoid tissue, but are also seen amongst the surface stratified epithelium. In the early stages they exist as small spheroidal masses about one two-thousandth of an inch in diameter, gradually increasing in size to about one eight-hundredth of an inch. At a later stage a complete change can be demonstrated—they seem to break up into

minute refractile bodies, resembling spores embedded in a transparent matrix.

In some places they are apparently encapsuled, whilst in others they are free. I have never satisfied myself of their nucleation, for whilst they readily take up rubin and orange they resist hæmatoxyline and other nuclear stains. The granular stage is well demonstrated by means of osmic acid and gentian violet.

What is their nature? Until consulting Burnett's "System of Diseases of the Ear, Nose and Throat," I was unable to find any reference to their existence. Under atrophic rhinitis, Fraenkel* describes homogeneous round and oval bodies, consisting of broken-down cells and nuclei, which he regards as the result of retrograde cell metamorphosis. These are doubtless similar to my hyaloid bodies, but I cannot agree with his interpretation, for they bear very little resemblance to broken-down cells, and I find no vestiges of nuclear particles. Stepanow† (Moscow) has described hyaloid bodies in polypi, rhinoscleroma, and adenoid growths, which he attributes to the action of bacilli, believing that their production is a process which presents too great a propagation of bacilli.

These bodies I have also seen, but they differ entirely from those of atrophic rhinitis, being concentrically laminated, staining differently, and are similar to the laminated corpuscles which occur pathologically in thyroid growths, and normally in thymus gland as Hassell's corpuscles.

Fat globules are also described by many writers, but these bodies are not fatty, since they do not give the characteristic reaction with osmic acid, and they are insoluble in ether. They are not composed of amyloid substance (lardacein), since they give negative results with methyl violet and similar stains. They are very suggestive (in their earlier stages) of myelin masses so often seen in preparations of nerve tissues after treatment with alcohol; but their presence in such large numbers, and subsequent granular changes, sufficiently negatives this interpretation. One feature is, however, very remarkable and suggestive, viz., their strong resemblance in staining reaction to the substance which

*Burnett's "System of Diseases of the Ear, Throat and Nose," Vol. I., p. 675.

†*Journal of Laryngology*, Vol. V., p. 322.

* "Diseases of the Nose and Throat," Vol. I., p. 166.

constitutes the hyaline basement membrane everywhere underlying the surface epithelium in the normal state, but which in this disease disappears.

With regard to their parasitic nature my investigations at present do not permit a decided expression of opinion, although several friends, whose biological experience is greater than mine, have expressed themselves in favor of that view.

Pigment masses are not constant in their appearance: they occur for the most part in irregularly-shaped clusters, sometimes enclosed in branched connective tissue cells, at others blocking the lumen of the capillaries, and distributed both superficially and deeply.

Changes in the Glands. The gland changes vary in degree, from a simple cloudy swelling of the secretory cells, with blocking of the lumen, to a complete disorganization of the acini by ingrowth of small cell inflammatory tissue. The duct epithelium apparently resists these changes until very late, excepting in those instances in which the ducts were distended by plugs of laminated keratin masses. Most writers refer to these cell changes as being fatty in nature; whilst confirming this in a few instances, careful examination showed that mucoid and keratinoid degenerations occurred much more frequently. The plugging of the ducts bore a strong resemblance to the comedones of sebaceous glands.

Changes in the Lymphoid Tissue and Vessels.—In every specimen the lymphoid tissue gave distinct evidence of change. In early stages the corpuscles were numerically increased, whilst in later stages they diminished in numbers but increased in size with absorption of the reticulum—in fact, presenting the appearance of granulation tissue, such as occurs in lupus, and, like it, invading other structures and undergoing subsequent sclerosis.

The capillaries, which normally present long loops reaching to the hyaline membrane, became entirely obliterated. The cavernous spaces became less distended, and finally atrophied, due to diminished blood supply, induced by a general interstitial fibrosis, and in some cases a process of slow endarteritis obliterans in their afferent vessels. I could not observe any decided active changes in the arterial walls; they seemed to be undergoing a process of atrophic stenosis.

This vascular atrophy and perversion of gland function are greatly responsible for the altered secretions, but a most significant feature is the disappearance of the lymphoid tissue.

Changes in the Bones.—I have entirely failed to demonstrate any histological changes which might be considered specific. The walls of the bony cancelli in advanced cases were decidedly attenuated, even more so than what would be considered normal to the patient's age, and the osteoblasts were few and flattened. Osteoclastic absorption was well shown in early cases, but not excessively. When the disease occurs in early life it must obviously interfere with the proper growth of the turbinal bones; it is, therefore, not surprising to find them smaller than natural, but this diminution must not be attributed at any time to rarefying osteitis, nor must rarefying osteitis be considered necessary to atrophic rhinitis.

Too much stress has been laid upon the simple presence of osteoclasts as indicative of a particular morbid process. These periosteal and endosteal changes are simply part and parcel of a normal osteoporosis or cancellation, a process essential to the development of these and other bones. It is only when the osteoclastic changes become excessive that they justify a morbid attribute.

Many writers explain the bone atrophy as the result of pressure from the drying crusts, like a collodion film, whilst it has been suggested by Zaufal* that it is the result of a congenital defect, and has an important causal relation to the disease in question.

Considering the nature of the changes occurring in the soft tissues, it would be surprising if the bones did not give indications of a diminished blood supply; but this atrophy presents the features of a passive rather than an active process, occasionally producing patches of bare bone.

Relation to Lupus.—Spencer Watson† has advanced the view that there is a very close analogy between atrophic rhinitis and lupus non exedens, and that they may both be due to a common bacillus. That they probably possess a few features in common may be correct, but the suggestion of a common origin in a particular bacillus requires

* "Aerzte corresp. für Böhmen," 1874, Nos. 23 and 24.

† "Diseases of the Nose," 1887, p. 85.

some substantiation ere it can be accepted, even admitting that lupus has a specific organism.

Atrophic rhinitis, like lupus, is undoubtedly a spreading disease—it may extend to all the accessory and adjacent cavities, it may even involve the larynx, but it has never crossed the muco-cutaneous boundary. It occurs, like lupus, chiefly in patients who are the subjects of a tuberculous or strumous taint, and it tends to persist, but not to kill. In its fundamental histological features—the presence of small cell tissue of a low type—it resembles lupus and tubercle, but it does not ulcerate spontaneously; its end is sclerosis.

Lupus has been described as an attenuated form of tuberculosis. Are we, then, to consider atrophic rhinitis an attenuated lupus? There is certainly a sufficient resemblance between these diseases, both histologically and clinically, to justify further investigation.

Rhinoscleroma - Rhinoscleroma, albeit an extremely rare disease in this country, having some resemblance to atrophic rhinitis in its histology, demands a short notice. Its essential feature is the presence of slowly-growing, small cell tissue, containing, according to Cornill,* small, highly refractive, hyaline bodies. It tends to spread in all directions, including skin, tongue and larynx, but does not ulcerate. In the hands of Frisch and Stepanow it has afforded positive results to cultivation and inoculation experiments.

Incidental Pathological Changes.—The most strikingly uniform incidental change observed was the disappearance of lymphoid structures. In fifty-six of sixty cases the faucial and pharyngeal tonsils had entirely disappeared, whilst in the remaining four they were very small. The lingual tonsils were equally diminutive, for in all well-marked cases the pharyngo-glossus was perfectly smooth. This shrinking and disappearance of lymphoid structures is, I venture to submit, a significant feature of the disease, and has something more than a mere coincidental relation to the intra-nasal changes.

In most cases the teeth were more or less decayed.

The thyroid gland could not be distinguished by palpation in twenty-eight cases, but in two instances it was distinctly enlarged and resilient.

Whilst conjunctival complications were not observed, non-suppurative middle-ear disease occurred in eight cases. (Wyss found ear trouble in forty-seven cases out of sixty.)

In ten instances bare bone was distinctly felt on probing the anterior ethmoidal cells.

Anæmia was well marked in twenty-seven cases.

Etiology and Pathology.—However interesting the local changes may be, the origin of atrophic rhinitis must not be considered solely upon evidence afforded by them: it is perhaps expedient, therefore, that I should first put before you the question, Is the disease *atrophic rhinitis ab initio*?

It would be tedious to quote all the different views which have been advanced in answer to this question, but so many writers of eminence have expressed themselves in such definite terms that, by way of illustration, I must draw your attention to one of the most recent articles.

In Burnett's "System," J. N. Mackenzie* unhesitatingly answers this question by a negative. He considers that atrophic rhinitis "always appears as the sequel of a pre-existing catarrhal inflammation," and that the rapidity with which it sometimes passes from the hypertrophic to the atrophic form is, in all probability, proportional to the presence of some constitutional taint, such as syphilis.

Although we not infrequently may see a well-marked atrophic process at work in one nostril, coincidentally with distinct prominence of the turbinal in the other nostril, this does not necessarily imply that atrophic rhinitis is always preceded by true hypertrophic rhinitis. What we see in such a case is the early inflammatory thickening, which, here, as elsewhere, is so frequently the preliminary thickening of a sclerotic process. There is a wide histological difference between this enlargement and that of cavernous or erectile hypertrophy, which Mackenzie holds to be the constant and necessary antecedent to the atrophic changes. Most careful cross-examinations have only afforded me a preliminary history of nasal obstruction with profuse catarrh in three instances, and histologically I have entirely failed to trace the changes which Mackenzie describes as connecting degener-

* Burnett's "System of Diseases of the Ear, Nose, and Throat," Vol. I., p. 672.

* *Progrès Médical*, 1883, p. 857.

ative cavernous dilation with the specific atrophic changes, and I cannot believe that atrophic rhinitis is the result of a badly treated catarrh.

Of course there are other varieties of hypertrophic rhinitis, such as the mucoid, glandular, etc. But what is the usual termination of these conditions? The erectile form, if slight, usually subsides, but if severe and persistent, owing to actual atrophic mucoid degeneration of the muscular walls of the spaces, it develops into what I have described as turbinal varix,* and is eventually removed under the varying disguise of polypus or angio-myxoma. Should it be chiefly mucoid its localized exaggeration becomes an ordinary mucoid polypus; if glandular, it becomes cystic. But I cannot understand how any ingenuity can trace any of these conditions, step by step, into the conditions which constitute atrophic rhinitis.

If this distension and subsequent sclerotic obliteration of the venous spaces is the *fons et origo* of the disease, how can the presence of atrophic rhinitis be accounted for in situations where no erectile tissue is even found? The disease is not confined to the turbinal bodies, but spreads to every adjacent structure excepting the skin.

Drake and others† have advanced the view that it arises as a chronic purulent inflammation of the accessory sinuses, whilst Gottstein holds that deficient development of the turbinal bodies is responsible, since it is followed by abnormal patency of the cavities.

Whilst admitting that a simply *dry* or pseudo-atrophic rhinitis may follow a catarrhal state, it must not be confused with this particular disease, and whether atrophic rhinitis is a specific disease *ab initio*, or is the result of a series of hypertrophic events, I leave for your discussion.

There can be but little doubt that constitutional influences are often important factors, although Bosworth denies any connection between this disease and tubercle or scrofula.

In thirty-seven cases I obtained a definite family history of phthisis; one was attributed to small-pox, one to erysipelas, five were associated with acquired and inherited syphilis, whilst a large

number gave a family history of suppurating glands in the neck, and personal history of persistent anæmia.

Alcoholism has been credited with a causal relation; this I cannot verify.

Whether there is or is not a special diathesis, apart from tubercle or struma, I will not venture to advance.

I will now proceed to a clinical analysis of my sixty cases.

1. *Age of the patient when first seen.*

From ages 14 to 20 years.....	21
“ “ 20 “ 30 “	23
“ “ 30 “ 40 “	8
“ “ 40 “ 50 “	5
“ “ 50 “ 60 “	3

It will be seen that the majority of cases presented themselves between puberty and thirty, but these figures are, however, of much less importance than the following, which show, as far as I was able to gather with the most careful questioning, the *age at which the disease was first noticed* i.e.

2. *The date of commencement.*

From 1 to 5 years.....	2
“ 7 “ 9 “	4
“ 12 “ 15 “	28
“ 15 “ 30 “	19
“ 30 “ 53 “	7

These figures indicate the age of puberty as being most frequently either the real commencement of the disease, or at all events the period at which it was first appreciated by the patient or her friends. These figures practically correspond with Greville Macdonald's,* who gives seventeen as the average age for the appearance of the disease.

3. *Sex of patient.*—There were forty-nine females and eleven males.

4. *Sexual functions.*—In females it was the exception to find them not suffering from leucorrhœa or amenorrhœa, and in every instance the nasal phenomena were intensified at the menstrual flow. In two cases the disease was actually dated with the menopause, whilst more than half the number associated the commencement of the trouble with the establishment of the catamenia.

5. *Family history and heredity.* As previously

**Journal of Laryngology.* Vol. VII., p. 177.

†Burnett's "System," Vol. I., p. 677.

‡"Diseases of the Nose and Throat," Vol. I., p. 168.

*"Diseases of the Nose," p. 136. 1890.

mentioned, I obtained a definite history of consumption in thirty-seven cases, and of abscesses in the neck, eighteen. The evidence of a constitutional taint is therefore strong, although in eighteen cases I could get none at all.

Several cases bearing unmistakable local evidence of syphilis I excluded. In eight instances there was evidence of atrophic rhinitis in other members of the family, and three volunteered the information that their mothers suffered with the same complaint.

6. *Occupation.* The employments were so varied that I need only remark that the greater number consisted of girls belonging to the hard-working classes, and were engaged in warehouses and shops under varying degrees of unhygienic surroundings; still several belonged to the well-to-do middle class.

7. *Fætor.* With regard to fætor, whilst in fifty-eight cases it was more or less obvious to the observer, in about half that number it was appreciated by the patient. The intensity seemed to vary with the extent of the disease and the amount of crusts, but in those cases in which the accessory sinuses were involved it was always more persistent in spite of treatment. In those cases associated with bare bone I could not detect any difference in its nature. It was always worse during menstrual flow. With regard to its origin, I will ask your indulgence for a few remarks.

The mucous membrane of the nostrils is a transformed epidermal structure, derived originally from an involution of the buccal epiblast. Hence the surface epithelium (excepting the olfactory cells) and the glands originate in common with the epiderm and its appendages.

During atrophic rhinitis in the stratification of the surface epithelium we find a structural reversion to the primitive type, and in the gland epithelium we find the establishment of a perverted function--in other words, the nasal mucous membrane becomes converted into a cutaneous structure, with a corresponding change in secretion.

Cutaneous secretions vary in odor with their source and with the individual. Compare the characteristic smell of the feet with that of the axilla and the preputial glands. Even the ear is the seat of a similar fætor due to intra-tympanic

accumulation of epithelial masses and secretions (cholesteatomata).

The nasal glandular secretions are, with those of the cutaneous glands, equally liable to putrefactive decomposition; they all give rise to peculiar odors, and they are all exposed to the influence of the same micro-organisms. Bromidrosis and rhinal fætor have a close kinship, and it is in this kinship that I venture to suggest is to be found an explanation for the peculiar odor in atrophic rhinitis.

8. *Olfaction.*—Complete loss of smell occurred in only thirty cases: in the remainder the sense varied in degree with the extent of the disease and the locality invaded. Anosmia in most instances was gradual in its onset, but in not a few it was one of the first symptoms, parosmia often preceding it.

9. *Nature of the Crusts.*—Microscopical examination of the crusts afforded but little evidence of value. Staphylococci and an occasional diplococcus and leptothrix were the most prominent bacteria. One point, however, I was fully satisfied upon, viz., that the discharge was not pus, for pus cells were rarely present, the organized cells being epithelial squames and some multi-nucleated lymphocytes.

Bosworth persistently applied the term "mucopurulent to the crusts. This certainly requires justification, for the elements of pus are wanting, and there is no granulation surface for its production.

Chemically they contained mucin, keratin, a small proportion of serum, albumen and a trace of sulphur.

10. *Supra-Nasal Pain.*—From the frequency of the occurrence of pain over the bridge of the nose and at the "back of the eyes," I am inclined to consider it an important diagnostic element—especially when observed late in the disease, and when the accessory sinuses were involved. It was present in thirty-eight cases.

11. *Disappearance of the Tonsils.* As already mentioned, the faucial, pharyngeal, and lingual tonsils presented well marked atrophy, a condition which (as far as I am aware) has not been recorded. This, I think, is an important point in diagnosis, and occurring with lymph atrophy in the nostrils

may throw some light on the pathology of the disease. In fifty six cases the tonsils had entirely disappeared.

12. *Thyroid Gland.*—With the exception of two cases, as far as I could judge by palpation, the thyroid showed distinct indications of atrophy. In those two exceptions it was very prominent and soft.

13. *Complexion.*—Statistics with regard to complexion, involving so many sources of error, can have but little value. Numerically the dark skins were in excess of the fair.

14. *Typical Facies.* I observed twenty cases in which that which is usually accepted as the typical cast of features was present, viz., the tilted and open nostrils, depressed and widened bridge, with general diminutiveness of the organ.

15. *Relation to Infantile Suppurative Rhinitis.*—Bearing in mind Bosworth's assertion* that atrophic rhinitis is a sequel to post-nasal troubles in infancy, I carefully cross-examined every case, with the view of establishing the truth or the reverse of this view. I only found four examples in which there was a reliable history of a prolonged nasal discharge in early life: The difficulties in obtaining reliable information of this nature I know are great, consequently the evidence must be accepted with reserve; still, whenever it was practicable, I made direct inquiries of the parents themselves.

With the exception of one case of measles, and one of small-pox, I was much surprised to find no association with the specific fevers, neither could I find any evidence of association with suppurative ethmoid troubles.

Diagnosis.—The diagnosis from all other varieties of dry rhinitis will depend upon the presence of the foregoing conditions *collectively*. *Separately* they may be of little value, but it is upon a due consideration of *all* these changes that differentiation is based. Apart from the classical signs, I need only emphasize the *spreading* nature of the disease and the uniform disappearance of the tonsils.

This, gentlemen, is my case for atrophic rhinitis as a specific disease. I have endeavored, by an analysis of sixty cases, to verify or to disprove

many of the facts upon which specialist writers have based their views. With many of the facts I wish for a much closer acquaintance. Of novelty I may have afforded you little, either in substance or interpretation, therefore I trust that by your greater experience you will filter the good from the bad, and that the many deficiencies will be supplied by your discussion, thereby affording a sounder appreciation of not the least important of our nasal diseases.

Dr. WOLKES said he had listened with great interest and instruction to the excellent paper just read. There were some points which were brought out more clearly in it than had been apparent to him previously, possibly because he had not given so much attention to the microscopy of this particular phase of the disease as he had done to the hypertrophic form of it. On the subject of the particular name accorded to this disease by the writer of the paper, he would offer a mild criticism, which, inasmuch as he had been adjudged a sinner in the matter of nomenclature, he might, perhaps, be allowed to do. The term "rhinitis," as applied to any localized affection of the nose, he objected to, as if it meant anything at all it denoted an inflammation of the entire nasal organ, being derived from the Greek *ῥίσις* a nose. "Atrophic" rhinitis, therefore, means a wasting inflammation of the nose as a whole, a description which did not apply to the disease under discussion. It was clear, even from the paper just read, that the affection was a form of inflammation of the turbinal bones, more especially those of the ethmoid, the cells of which latter bone were, besides, almost invariably implicated in it. It was, therefore, an "ethmoiditis," and displayed all the changes in the arteries, blood sinuses, and bone seen in other forms of ethmoidal disease, as he had described them: only the nyxomatous developments were lacking, the fibroid elements from which these were derived undergoing atrophy instead. From the point of view, therefore, of securing by means of its nomenclature a definite description of the disease, he thought the term "atrophic ethmoiditis" distinctly preferable. He would abjure the term "rhinitis" altogether, as conveying no idea of the particular locality of the nasal organ affected. While these were his views, he was prepared to admit they were all a good deal mixed on the

* "Diseases of the Nose and Throat," Vol. I., p. 162.

subject of the nomenclature of nasal disease, and, before attempting definite conclusions, it might be well to wait awhile, and let their ideas simmer down.

As regards the origin of the affection, he was disposed to agree with the author quoted in the paper, who regarded it as the outcome of a pre-existing hypertrophic inflammation. He had noticed a fact which had a suggestive bearing on this question. He had occasionally been consulted respecting children on whom he had operated for post-nasal growths, several years after the operation, because they had again become affected in the nose. This was not due to a recurrence of the growths, but to a hypertrophic inflammation of the middle spongy bones, associated with stuffiness, and with profuse and slightly offensive discharge. He regarded this condition, occurring under the circumstances mentioned, as a later manifestation of the same diathetic state as had in infancy induced the growths.

Granted such a diathesis, it was not unreasonable that it should evoke later manifestations, as the child grew up. It was well known to them all that even adults neglected in themselves what they called a "chronic cold," and in their children this neglect was general. So that it might easily be that adults who presented themselves with well-developed atrophic disease had long since passed through a hypertrophic stage. He had certainly seen a number of cases, chiefly in young adults, who when first examined presented what clinically was indistinguishable from hypertrophic disease, and who, while under observation, passed into the atrophic phase. He had shown one such patient among those illustrating the presence of necrosis, which he had exhibited that afternoon. The history of this case showed that the disease commenced in childhood.

There remained the question as to what constituted the determining factor which should decide whether an inflammation of the ethmoid region of the nose should assume the hypertrophic or the atrophic phase?

When he published his first comments on the affection in 1887 (*vide* "Polypus, etc., associated with Ethmoiditis," p. 26, *et seq.*), he expressed the opinion that this determining element consisted in the possession on the part of the patient of an

enthetic heredity —*i.e.*, in the atrophic or ozæmoid cases. His subsequent experience tended to support this view, and one frequently saw in the teeth, eyes, and other regions confirmatory evidence to this effect. He thought the description of the pathology of the disease given by the author unique, and its scientific value proportionately great, because it would now be possible with the microscope to accurately differentiate this disease from any other.

He doubted, however, whether this research would prove of much service, either therapeutically or clinically. They could not always scrape off pieces of mucous membrane, and treat such specimens microscopically, as, besides the special knowledge necessary, such a proceeding required considerable preparation, and the devotion to it of much time. Fortunately, the very distinctive clinical features of the disease made its diagnosis easy, apart from pathology.

Finally, he wished to insist on the great importance of recognizing the necrosis, the presence of which, in his opinion, constituted the element of persistency of the disease. He had been able to do this in every case but one which had come under his observation. He was glad to note that the writer of the paper had recognized this necrosis in considerably more than a third of his cases. The fact that it was often concealed within the ethmoid cells added, no doubt, to the difficulty of discovering it, but the necessity for doing so, with a view to its elimination, was essential to the radical cure of all ozæmoid affections of the nose.

DISCUSSION.

Mr. LENNOX BROWNE, with all respect to Dr. Woakes, could not agree that his suggested alteration in nomenclature was an improvement; for the term rhinitis was generally supposed to be restricted to intra-nasal structures alone, and not to the nose as a whole, and seeing that rhinitis referred to an inflammation of other parts than the ethmoid bone, he could not allow that the term ethmoiditis was preferable. Mr. Mayo Collier had anticipated the speaker, in suggesting disorder of the sympathetic system as a primary etiological factor in the production of atrophic rhinitis, for as to diathesis the older writers spoke of struma and scrofula as constitutive factors; but, as had been

advanced by the speaker in several editions of his book, these terms merely represented an inability to form healthy blood corpuscles—in other words, a feeble vaso motor.

He had been struck by the original observation of Mr. Wingrave, the truth of which would be at once recognized—as to the disappearance of all tonsillar and glandular tissues in the disease under consideration. This, taken in connection with the circumstance that in a certain proportion of cases there was thyroid enlargement, materially strengthened the opinion that inherent vaso-motor debility was at the root of the disease. The experience of the writer of the paper, that there was a ponderable proportion of cases which occurred at the onset of menstruation, was not in accord with the speaker's, or at least the circumstance was misinterpreted: for, on the contrary, in the majority of the cases the menstrual epoch was inordinately delayed, and that might be the reason that the symptoms were most intense at the period of puberty, in other words, when the turbinals should be at full development. As time went on, the symptoms, especially that of factor, were intensified. A far larger number of cases occurred in early childhood than Mr. Wingrave's tables showed, and the discrepancy was probably due to the fact that the patients came earlier under notice in private practice, whilst those now under consideration were all hospital cases.

With regard to the relation of atrophic to hypertrophic rhinitis, the speaker could not agree with the views of Dr. Woakes, that the former state often preceded the latter, and on this point, Bosworth, who held that atrophic never followed hypertrophic changes, was probably as much in error as Metell Macdonald and Nolan Macdonald, who in agreement with Dr. Woakes, favor of the opposite sequence.

It is quite true that there is a form of atrophic rhinitis which follows hypertrophic rhinitis, and may even consist of an absolute atrophy, but this is not the case under consideration. It is, I believe, well to stick to the notion of hypertrophic rhinitis as a distinct form of disease, and to apply the term atrophic to a part of the atrophic rhinitis which is characterized by arrested development, and the variety of rhinitis that arrested development regulated the glandular changes, is the most serious to beget. Still, the speaker was of

opinion that syphilis was only an exceptional factor in the causation of the disease.

Finally, Mr. Wingrave had alluded to the specific fevers as rare excitants of atrophic rhinitis. The speaker had seen one case in which, after an attack of typhoid fever, marked improvement resulted, an exceptional experience not without parallel in connection with disease in other regions of the body.

Mr. LODGE, jun., said he was personally indebted to the author for his very admirable paper, the anticipation of which was one of the principal reasons that had led him to come from Bradford. None of them could dispute the author's histological description, because the sections were there under the microscope for all to examine and control. The histological details might, he thought, be accepted as correct. For people in his own position, however, the great difficulty was as to treatment, and he would like to have an expression of opinion from the meeting as to the best method of treatment, especially as the author had omitted to deal with this important division of his subject at the length it deserved. He had had a case during the last six months, in which he had tried every thing he knew of or that he had read about, but the patient did not get any better. He had tried touching the ozeme spots with trichloroacetic acid, galvano-cautery, Gottstein's plugs, and the usual antiseptic douches. No bare bone, such as Dr. Woakes described, was found in any of his cases. It was a typical case of atrophic rhinitis. He had tried ureting, because in the *Ontario Medical Journal* of last year the disease was attributed to a microbial affection of the glandular elements. This certainly seemed to do more good than anything else. The author said that he had found no evidence of the pharyngeal tonsil remaining, but in another case of his own one could see the remains of the pharyngeal tonsil, it was on the posterior wall with granulated tissue upon it, and he removed it by cauterizing with Gottstein's curette, apparently to the great benefit of the atrophic rhinitis.

Mr. METELL said there appeared to be four theories advanced. (1) A special diathesis, (2) micro-organisms, (3) vaso-motor changes, and (4) necrosis. He did not believe there was a special diathesis. He had seen, in a family of children, "bottle" tip under precisely similar conditions, one

suffer and all the others escape. The rôle played by micro-organisms must be left undecided for the present. It was not at present as probable a theory as the one promulgated by Mr. Mayo Collier. He had never detected necrosis in typical cases of atrophic rhinitis.

Annual Examinations.

TORONTO UNIVERSITY.

The following fifty-six gentlemen having completed their course of study, and successfully passed the necessary examination, will receive the degree of M.B.:

L. Agnew, W. H. Alexander, W. A. Ball, J. Becket, W. L. Coulthard, G. M. Ferris, L. O. Frost, E. B. Fisher, A. E. Gardner, E. D. Graham, G. B. Gray, W. A. Hackett, R. G. Laycock, K. C. McIlwraith, J. W. McIntosh, H. MacLaren, J. Park, G. D. Porter, H. H. Sinclair, F. W. Smith, J. Stenhouse, W. Stephen, F. W. Stockton, T. Wickett, H. L. Reazin, D. J. Armour, W. B. Boyd, J. Ball, B. Campbell, F. Coleman, W. E. Crain, J. Crawford, J. D. Curtis, H. A. Cuthbertson, J. W. Lord, A. Galloway, A. B. Greenwood, H. Guelph, N. M. Harris, R. H. Hastings, T. C. Hodgson, H. A. Johnston, A. H. Jones, J. A. Lawson, R. M. Lipscomb, D. A. McClenahan, W. J. McCollum, J. F. McKee, J. R. Mencke, H. N. Rutledge, J. P. Sinclair, C. E. Smyth, N. C. Wallace, R. B. Wells, J. A. White, F. H. Whiteclaw.

Medals.—Faculty gold medal, W. J. McCollum; first faculty silver medal, H. N. Rutledge; second faculty silver medal, W. E. Crain; third faculty silver medal, H. A. Johnston.

Scholarships.—Third year—first and second scholarships divided between M. Currie and A. K. Merritt; second year—first and second scholarships divided between W. Goldie and E. L. Roberts; first year—first scholarship, J. H. Elliott; second scholarship, A. H. Addy.

George Brown memorial scholarship in medical science—in order of merit—W. E. Crain, C. E. Smyth, J. D. Curtis, R. B. Wells, W. J. McCollum, J. Bull.

Of the third year, 38 passed, 1 starred. Primary, 2 passed, 5 failed. Second year, 54 passed, 4 starred, 11 failed. First, 54 passed, 9 starred, 6 failed.

Meetings of Medical Societies.

CANADIAN MEDICAL ASSOCIATION.

The dates for the meeting of the Canadian Medical Association have been fixed for August 22nd and 23rd next.

The people of the Maritime Provinces, generally, and the profession of St. John, N.B., particularly, are noted the world over for their hospitality; hence, the members of the Association are looking forward with a great deal of pleasure to the meeting in St. John this summer.

At first sight people in this province might think the trip will be an expensive one, but we have made enquiry and have been informed that, taking Toronto as a starting point, the round trip can be made for less than thirty dollars. Of course if a large number signify their intention of going to the meeting, it might be possible to get the fare materially reduced.

We are sure the Secretary, Dr. Starr, of Toronto, will be glad to learn of any who contemplate the Eastern trip this year, for it will materially assist him in making arrangements with the railways.

LONDON MEDICAL SOCIETY.

To the President and Members of the Ontario Medical Council.

GENTLEMEN,—The London Medical Society hereby appeals to the Medical Council to devise, if possible, some means of abolishing or restricting the system of contract or lodge practice.

This society, in common with the profession in general, recognizes the necessity of some steps being taken to check this evil. The Medical Council has rendered valuable service in protecting the profession and the public from *unlicensed* practitioners. There has, however, grown up within the ranks of licentiates themselves this pernicious system which is making greater inroads upon the field of regular practice than all forms of quackery combined, and this society but voices the current sentiment of the profession in condemning the system, and appeals to the Council as the guardians of the profession to adopt some means of abolishing or minimizing the evil.

The Society begs to offer the following suggestions:

1. Apply for legislative authority to prohibit

contract practice. With the prevailing contract rates at \$1.00 and \$1.50 per member, this prohibition might be shown to be in the interest of the public as well as the profession, inasmuch as indifferent service is a natural result of inadequate remuneration: or

2. Apply for legislative power to fix a minimum tariff of contract rates. A Toronto medical journal, in December, 1893, claims, on the authority of a distinguished actuary, that the proper remuneration for contract practice in Canada is \$4.00 a year per member: or

3. Apply to the Legislature for power to frame and enforce a code of medical ethics, with a view to control the evil: or

4. Address an appeal to every registered practitioner to discountenance the system. The influence of such an appeal coming from the representative body of the profession would tend to bring the practice into disrepute.

Signed on behalf of the London Medical Society.

J. H. GARDNER, M.D., *President.*

OCTAVIUS WELLS, M.B., *Secretary.*

London, April 6th, 1894.

TORONTO ALUMNI DINNER.

The Annual Meeting and Dinner of the Medical Alumni of Toronto University will be held on the evening of Convocation Day, June 10th, at the Royal Canadian Yacht Club. The meeting proper will be at 7.00 p.m., and the dinner at 7.30. The price of the tickets has not yet been settled, but it will not be more than \$1.25.

ONTARIO MEDICAL ASSOCIATION.

Programme of the 14th Annual Meeting, to be held in Toronto, Jun. 6th and 7th:

THE PRESIDENT'S ADDRESS—

L. McFarlane, Toronto.

DISCUSSIONS.

"Some Remarks in the Treatment of Chronic Diseases," J. E. Graham, Toronto; R. W. B. Smith, Seaforth; R. H. Preston, M.P.P., Newboro'. "Treatment of Strangulated Hernia," J. Wishart, London; F. W. Strange, Toronto; R. Whiteman, Shakespeare; G. S. Rennie, Hamilton. "Use of Strychnine in Ordinary Practice, with

Special Reference to Pneumonia and Chronic Heart Disease," J. H. Duncan, Chatham; J. T. Potheringham, Toronto; A. C. Gaviller, Grand Valley. "Placenta Prævia," J. Algernon Temple, Toronto; A. McKay, M.P.P., Ingersoll; J. H. Burns, Toronto; G. T. McKeough, Chatham.

SYMPOSIUM.

"Influenza: Its General Features," L. M. Sweetnam, Toronto: "Its Nervous Phenomena," S. Lett, Guelph; "Its Thoracic Phenomena," C. Sheard, Toronto; "Its Digestive Phenomena," J. S. Harrison, Selkirk.

PAPERS BY GUESTS.

"Cancer of the Breast in its Clinical Aspect," J. Hingston, Montreal.

PAPERS BY MEMBERS.

"Atrophic Rhinitis," J. Price-Brown, Toronto; "The Contagiousness of Diphtheria," J. R. Hamilton, Port Dover; "The Artificial Feeding and Care of Infants," J. W. McCullough, Alliston; "Placenta Prævia," J. Campbell, Seaforth; "McGill's Operation for Prostatic Enlargement" (with cases), A. McKinnon, Guelph; "The Photography of Pathological Specimens," N. A. Powell, Toronto; "Treatment of Consumption," E. Herbert Adams, Toronto; "Law vs. Theory in Therapeutics," G. M. Aylesworth, Collingwood; "Inflammation of the Frontal Sinus," F. N. G. Starr, Toronto; "Cholecystotomy," R. Whiteman, Shakespeare; "Cephalematoma," E. Bromley, Bright; "Hip-joint Disease: Diagnosis and Treatment," W. W. Bremner, Toronto; "The International Congress of 1894," E. E. Kitchen, St. George; "Uncured Gonorrhœa: Causes and Sequences," E. E. King, Toronto; "Placenta Prævia, with Hydatids," A. Bethune, Seaforth; "Paralysis Agitans," E. H. Stafford, Toronto; "Treatment of Morphia Poisoning by Permanganate of Potash" (report of experiments), Graham Chambers, Toronto; "Headache," D. Clarke, Toronto; "Report of Cases of Abdominal Section" (with remarks on same), H. Meek, London.

Papers are also promised by: G. W. Fox, New York; A. B. Welford, Woodstock; J. M. Cotton, Lambton Mills; R. King, Peterboro; G. A. Bingham, Toronto; L. Brock, Guelph; W. J. Gibson and J. E. Eakins, Belleville.

Correspondence.

The Editors do not hold themselves in any way responsible for the views expressed by correspondents.

COUNCIL ELECTIONS.

To the Editor of ONTARIO MEDICAL JOURNAL.

SIR, The report of a recent meeting of the medical profession of the Burlington and Home Electoral Division, which appeared in your last issue, has left the impression in some quarters that I am not a candidate at the ensuing Medical Council elections.

What I said, in effect, was that my time, being fully occupied with my professional duties, I had not intended to be a candidate, but after learning that steps had already been taken to bring out a representative in Hamilton, my friends here and throughout the Division expressed a strong desire that I should again be a candidate, and that it was in response to that request I was in the field.

While the report contains other matter suitable for criticism, I desire simply to correct the impression which the report has conveyed, and to state definitely that I am a candidate for the representation of the Burlington and Home Electoral Division at the ensuing elections.

Yours truly,

GEO. M. SHAW.

Hamilton, April 24th, 1894.

SHOULD THESE THINGS BE?

To the Editor of ONTARIO MEDICAL JOURNAL.

SIR, -With this caption you call attention to the habit of newspapers in describing, to the great glory of the operator, some skillful (?) operation, and to the "album" of celebrities with pictures of medical men, as well as to the custom of even city papers in publishing cuts of local doctors. Certainly these things should not be. A physician should quietly settle down with a neat, modest door-plate. He should wait until he starves, or till the Spirit moves patients to come: on no account should he ever refer to his success or permit his friends to do so. Even a card in the local paper is an abomination. The chief reason why these things should not be, is that it infringes

upon the rights of these demigods who, covered with glory, lead in the profession. Their reputations were God-given, and not obtained by the bragging of their friends in public and in private. Above all, "these things" infringe upon the rights of the professors in medical colleges. It is part of their duty to scatter announcements with addresses, specialties, etc., by the ten thousands, not only in their own city, but all over the country. It is no doubt for this that we elect them to positions of honor among us. To be sure, they get out of it money, first, from patients thus directed to them; second, from students' fees, and, third, from consultations from their young graduates. No, Mr. Editor, nothing should be that competes with this divine right of medical schools. To be sure, these "ads" of theirs spoil many a good farmer and good mechanic, making poor physicians out of them, and so many! No; let us honor these college dons, and scorn the rascals whose names get in the country newspapers.

Respectfully,

G. R. CRUICKSHANK.

Windsor, May 3rd, 1894.

TREATMENT OF DIPHTHERIA.

To the Editor of ONTARIO MEDICAL JOURNAL.

SIR, -One can scarcely take up a monthly medical publication but he will find something on the treatment of diphtheria, and in offering you my contribution to the literature on the subject, I do so very reluctantly. Yet, as the method I have persistently pursued during the last ten years in treating this disease has given me nothing but good results, perhaps it is my duty to the profession to offer it for their consideration.

When called upon to treat this disease, I prescribe for a patient between four and ten years the following mixture:

R Pot. chloratis	ʒi.
Tinct. ferri mur.	ʒi.
Liq. atropiæ B.P.	℥ ii-iv.
Glycerin	ʒiv.
Aquam ad.	ʒiv.

℥ Sig. ʒi. every hour, each dose to be preceded by a copious draught of water; no water to be given for fifteen minutes after taking the medicine.

Milk, having a tendency to adhere to the fauces and pharynx, and in some way causing the membrane to spread, is absolutely forbidden till the throat is clean. After thirty-six or forty-eight hours, if the swelling of the tonsils and glands of the neck is subsiding, the atropia may be discontinued, or given in smaller doses, and the iron increased. But the atropia should not be discontinued too soon. Children can take it in the doses given for four or five days without any other effect than dilatation of pupil and slight dryness in the throat.

I use no spray or application to the throat.

If the nose becomes involved, I syringe it twice daily with perchloride solution, 1-2000 or salt and water. But if the patient will not permit this to be done quietly, it should not be done violently. In lieu of the syringing, the nurse may apply the solution to the nasal cavities on absorbent cotton frequently.

The diet should consist of beef tea, chicken broth, whiskey, water and fruit, especially pineapple. If the patient asks for a crust of bread, let it be given him.

To summarize :

1. Give the patient plenty of good water every hour or oftener, just before giving the medicine.
2. Give the patient no milk till the throat is clean.
3. Do not exhaust the patient by trying to spray or make applications to throat and nose.
4. Support the patient with alcohol, if necessary, from the very beginning of the treatment.

Yours truly,

J. BAUGH, M.D.

Hamilton, April 24th, 1894.

WHAT ARE MEDICAL ETHICS?

To the Editor of ONTARIO MEDICAL JOURNAL.

SIR, Much has been written recently in medical journals as to the demoralizing effect on the integrity of the medical profession by doing "lodge practice," "making it convenient to have all operations done by a surgeon reported in all the local papers (unknown to the surgeon?)," "the appearance of the photograph of the *leading physician* of the place with a subjoined 'ad' in

the 'Rogues' Gallery' of the Dominion," etc. No doubt all these cases are breaches of the rules of medical ethics. Much of the writing on this subject has been in a general way. I deem it more practical to get at individual cases.

About a year ago I determined to take a trip to England with the sole object of visiting the hospitals of London. I expected to be absent about five or six months, and as I lived in a small country village where two doctors had appeared to be a necessity, for the convenience of the community, I desired to get a *locum tenens* during my absence. As that was the time of the year at which the medical colleges had set free their new-fledged graduates, I wrote the dean of one of those colleges to see if he could recommend a suitable man for the summer. I received correspondence from a number whom the dean had referred to me. I engaged one of them for the term of my absence. It was suggested to me to stipulate that he should discontinue practice on my return. I replied that if there was one single man in the profession so dishonorable as to stoop to that, I would not bind him, but would give him an opportunity of showing his inner nature. Well, true enough, that one man amongst the 2,500 medical men of Ontario was the one I had the lot to engage, for on my return he opened an office almost within a stone's throw of my door, and had the temerity to tell me that he did not think that he was straining the relations existing between us, or acting unprofessionally in so doing. It may be that I am over-sensitive in the matter because personally affected, but I hope this will elicit an expression of opinion from some of the members of the Discipline Committee of the Medical Council or from you, Mr. Editor, as editor of the official organ of the profession of Ontario, and if my opinions are too far-fetched, I am willing to submit to your ruling. If I have not been used unprofessionally, then to my mind medical ethics are a misnomer, and the practising of those means mentioned at the beginning of this article sinks into insignificance in comparison. Is this a sample of the manhood of recent graduates? I verily believe we cannot take this case as a criterion.

I am,

W. NEWELL.

Wyoming, Ont., May 8th, 1894.

DISTRICT ASSOCIATIONS.

To the Editor of ONTARIO MEDICAL JOURNAL.

SIR, -In response to an invitation issued by Drs. Ruttan and Day, a number of medical men of the Fourteenth Electoral Division met on Thursday evening, March 29th, at the Huffman House, Belleville, for the purpose of organizing a District Medical Association and adopting a tariff of fees. The following officers were appointed: President, Dr. A. Ruttan, Napanee; Vice-President, Dr. McKenzie, Trenton; Secretary-Treasurer, Dr. Bowerman, Picton. Executive Committee: Drs. Eakins, Thornton, Kidd, Macaulay and J. S. Sprague.

A. C. BOWERMAN,
Secretary.

Picton, April 23rd, 1894.

Book Notices.

The Popular Science Monthly for May shows a greater diversity than usual in its pages, fit articles being given for all scientific turns.

"Guests of the May flower," an entomological paper followed by "Frost forms on Roan Mountain," beautifully illustrated; "Cause and effect in Education," and "Religious belief as a basis of Morality," with "Economic uses of non-edible fish," and "The sleep of mollusks" as counterfoils. The photograph and sketch in this number is of Sir Joseph Henry Gilbert, the ancient scientist and fellow-worker of Sir John Lawes.

Probably the chapters of most interest are those continued through as "New Chapters in Warfare of Science," by A. D. White. That of this month is on the theological and scientific theories of an evolution in animated nature.

Essentials of Nervous Diseases and Insanity.

Their symptoms and treatment. A manual for students and practitioners. By JOHN C. SHAW, M.D., Clinical Professor of Diseases of the Mind and Nervous System, etc., etc. Second Edition. Revised. Forty-eight original illustrations. Price \$1.00. 1894. Philadelphia: W. B. Saunders,

The study of diseases of the nervous system, the great bug-bear of most students in medicine, will be greatly facilitated by the use of this volume.

The facts given are accurate and concise, and easily acquired on reading.

While not approving of these question compends, as a rule, we must make an exception of this one, not only on account of its matter but also because of the reference given at the end of each description to large works.

The Medical Annual. The edition of 1894 is worth reading. Each contributor has been selected with special reference to his familiarity with the subject, and through many of the articles can be seen a pleasing individuality, which is much more acceptable to the average reader than the too liberal quotation which tends to confuse and fatigue, rather than to instruct. The scientific excellence and practical value of many of this year's contributions to the *Medical Annual* make it a volume of equal importance to the active practitioner and to the student.

The excellent plates, which are expressly prepared to illustrate and verify the descriptions, are also worthy of special notice: among others, we may mention those which accompany Dr. Shaw's valuable communication on the "Expression of the Face as a Means of Diagnosis in Cases of Insanity."

Carveth & Co., Parliament Street, Toronto, are the agents for Canada, and well deserve an order. Price \$2.

Essentials of Practice of Pharmacy. Arranged in form of questions and answers, prepared specially for pharmaceutical students. 2nd Edition. Revised by LUCIUS E. SAYRE, Ph.C., Professor of Pharmacy and Materia Medica of the School of Pharmacy of the University of Kansas. Price, \$1.00. 1894. Philadelphia: W. B. Saunders.

This work is published by the well-known house of W. B. Saunders, Philadelphia. It is neatly bound and well printed. The selection of type used is excellent, enabling one to refer to a given subject in the minimum of time.

The author has well named his work. It contains, in concise form, much knowledge which he who builds solidly must thoroughly understand. While it may be to some few a twice-told tale, it is certainly an excellent work of reference for all, and should be in the hands of every employee, assistant and apprentice.

Mathews Medical Quarterly. A journal devoted to diseases of the rectum and gastro intestinal disease—rectal and gastro-intestinal surgery.

At last the series is complete! We now have a journal for every specialty. The work in the hand of *fate* seems to be to outline new specialties rapidly enough to supply the demand, and *fate* does her work well. Indeed, medical science is making such rapid strides, and new specialties are cropping up so fast that one must be a ravenous reader in order to keep abreast of the times. We prophesy for the *Quarterly* a large circulation, the progressive specialist cannot well afford to be without it, while many general practitioners with a leaning toward rectal and gastro intestinal work will find in it a trusty friend. Long may it live, and if disaster should come, let us hope it will not be "*Rect*" "*al*" at once.

The Maryland Medical Journal has always been a welcome guest. Since our last issue it has undergone a great transformation and comes to us in an entirely new form. Evidently, having taken a place in the front rank of journalism, it intends to keep it. We wish the managers all success in their new venture.

AN EPITOME OF CURRENT MEDICAL LITERATURE. MEDICINE.

A New Method for the Detection of Tubercle Bacilli in Sputum.—In the examination of sputum for tubercle bacilli, Ilkewitch (*Centralbl. f. Bakt.*, February 5th, 1894) employs the centrifuge. The following preparatory measures are taken: Sputum 15 c.cm.; distilled water 20 c.cm.; and 8 to 12 drops of a 30 per cent. solution of caustic potash are well mixed with a glass rod in a porcelain capsule, and the mixture is heated until vapor forms. When the sputum is quite dissolved, a little casein (no specific quantity) is added: under the combined influence of heat, stirring and caustic potash (one or two drops of the above solution) this also dissolves, and the translucent fluid becomes of a milky color. It

is then poured into a test tube, and a few drops of acetic acid are added, until the first signs of clotting of the albumen appear. The mixture is now poured into a small brass cylinder (the simple apparatus used by the author is figured), and this is submitted to the action of the centrifuge for five or ten minutes. The deposit which has formed at the bottom of the cylinder is now collected and rubbed between two slides. The two preparations, when dry, are fixed in the flame as usual, stained after Ziehl's method, and examined under an oil immersion lens without a cover slip. In this procedure, all the bacilli present in the sputum are carried down with the clotted casein, and the entire solid material is deposited at the bottom of the cylinder by the action of the centrifuge. Compared with the ordinary method for the examination of tuberculous sputum, this plan has the advantage that a larger amount of material can be examined in a shorter time. The author refers to cases in which he has been enabled by this means to detect tubercle bacilli in the sputum when none could be found after repeated examination by the ordinary method, and when the clinical signs were insufficient to justify the diagnosis of phthisis. —*British Medical Journal.*

Two Cases Illustrating the Difficulties in the Diagnosis of Gastric Ulcer.—The following two cases are of interest, inasmuch as they are examples of the difficulties which beset the certain diagnosis of some cases of stomach pain. Both occurred recently, and were sent to Colwyn Bay with the diagnosis of gastric ulcer, in each case made by more than one practitioner of standing, and at different periods in their course.

Miss X., a thin anæmic lady of about twenty-six years of age, with a strong family predisposition to tubercle, gave the following history:—Till five years ago she was well and strong but then, after exposure to cold, developed an intestinal affection, passing blood, mucus and membrane in the stools. Since then she has been troubled, more or less constantly, with attacks of sickness and abdominal pain, associated with constipation. About a year ago she suffered from severe epigastric pain, coming on immediately after food and lasting some hours, and at the same time often vomited blood (one or two tablespoonfuls, the

mother says), always first thing in the morning, and with great relief to the pain. She was then under one of the leading physicians in Brighton, who diagnosed gastric ulcer. After a few weeks she recovered, but has since had frequent attacks of more general, "grinding" abdominal pain.

When first seen, she gave a history of having been attacked, on getting out of bed in the morning, with severe epigastric pain, "like a knife running through her." She felt sick and faint and then vomited, with immediate relief to the pain. The vomit consisted of about three drachms of dark fluid blood, having a curious sickly odour like that of liquor amnii. On examination very marked tenderness was noted in the epigastrium, so severe that the slightest pressure recalled her attention when she was engaged in answering questions. The abdomen was resonant all over, not tender elsewhere than in the epigastrium, and not distended; and no intestinal movements could be seen. The heart, lungs, and liver were normal. The case was therefore diagnosed as one of gastric ulcer, and the patient kept in bed on a fluid diet.

Three days later, while straining at stool during the night, she was seized with severe stabbing pain in the epigastrium, and a general abdominal pain of a grinding nature. Vomiting began, a prolapsus ani came down, and she fainted. When seen the pulse was rather weak and about 120, and the temperature 100. An injection of morphia was given, and a little weak brandy and water, with good results. The next morning she was much better, and, the bowels not having been moved for four days, a large olive-oil enema was given, which brought away large masses of hard motion having a foul odour, and was followed by almost complete relief of the symptoms.

An examination of the rectum showed a prolapsus ani and a retroverted uterus, which were replaced.

Further olive-oil enemata brought away more foul motions, and as there was still some griping, five grains of calomel were ordered and salol capsules (gr. v. ter die).

Three days later all tenderness had disappeared, and the pain was but trifling, and of an aching character.

On examination of the nose, a small polypus was found in the right nostril, which seemed to

have been the cause of the hæmatemesis, and explains why it should have occurred only after the patient had been in the recumbent posture all night.

The diagnosis was therefore altered to gastro-intestinal catarrh, chronic constipation, nasal polypus, retroversion of the uterus, and prolapsus ani.

Mrs. Z., a thin, active lady of about twenty-six years of age, presented herself for treatment, complaining of excruciating epigastric pain, which she had had daily for four months, during which time she had lived on an exclusively fluid diet, but without relief. The pain generally came on immediately after food, occurred after every kind of food, and was accompanied by a feeling of fulness as soon as anything had been swallowed. It was of a sharp stabbing nature, limited to an area about the size of the palm of the hand, in the centre of which was a spot, the size of a shilling, where it was most acute, and from which it radiated: and it was associated with a similar pain a little to the left of the eighth dorsal vertebra. The epigastrium was acutely tender to pressure, even when the attention was directed to other matters. The tongue was clean and bright red at the edges, but constipation was troublesome. No history of vomiting, hæmatemesis or melæna could be obtained, and there were no signs of hysteria (contraction of fields of vision, hyperæsthesia, etc.). The patient was directed to rest both before and after every meal—advice which she had previously neglected and to take only small quantities of fluid food; and the following medicines were ordered: Hunyadi water every morning, Vichy water half an hour before each meal, and a mixture of bismuthi carb. and hydrocyanic acid immediately before meals.

Two days later the pain and tenderness had nearly gone, and at the end of three weeks, having been promoted, through scraped meat, meat-juice, etc., to a diet of fish, fowl and chop, she was quite free from pain.

The points I would especially call attention to are the curious coincidence, in the first place of a stomach pain, resembling that of gastric ulcer with vomiting of blood, followed by symptoms highly suggestive of perforation of the stomach: and the sudden and apparently permanent disappearance

in the second case of a very typical gastric ulcer pain. — ROBI. E. LORD, M.D., in *Manchester Med. Chronicle*.

Absorption of Salicylic Acid by the Skin and its Use in Acute Rheumatism.—Dr. Bourget (*Revista de Ciencias Medicas de Barcelona*, No. 24, 1893) concludes as follows:

1. Absorption of salicylic acid by the skin is very rapid and intense. The skin of youthful individuals is most absorbent, while persons with white skins are more so than those with brown or black.

2. The rapidity and intensity of absorption depends upon the vehicle in which the acid is dissolved. Fatty substances especially favour its introduction through the skin, while with vaseline or glycerine it is less.

3. The treatment of acute articular rheumatism by a salve of salicylic acid and turpentine is to be recommended. It is less serviceable in other forms of rheumatism, yet it might be of use as an adjunct in massage.

4. In gonorrhœal rheumatism it is inactive.

Diphtheria. *The Polyclinic* summarizes the treatment as follows:

1. Germicidal treatment, preferably by the use of strong hydrochloric acid, used early to be effectual: especially valuable in cases beginning on the tonsils.

2. Local cleanliness by the use of a weak antiseptic solution in the pharynx.

3. Nasal syringing with the same solutions in every case where there is nasal discharge.

4. Alcoholic stimulants begun as soon as the first systemic effects of the poison are seen, and in very severe cases pushed to the point of tolerance.

5. Calomel fumigations as soon as laryngeal symptoms appear.

6. Intubation in laryngeal cases not relieved by fumigation. — L. EMMETT HOLT in *Archives of Pediatrics*.

Jaundice and Emotional Disturbance.

Dr. E. A. Lubbock (Fulham Road, S.W.) writes: "On the evening of March 31st last I delivered a fragile, highly sensitive young lady (by no means hysterical, by the way), a primipara, of a stillborn male child. The 'waters,' I was informed, had

broken and escaped ten days previously. Delivery was instrumental, and was accomplished, while the patient was under chloroform, with some difficulty. Some thirty-six hours after, my patient, otherwise doing well, developed jaundice, which speedily became intense. There was no pain, no nausea, and the temperature was normal. The lochia were foul, otherwise there have been no troubles, and to-day, five days since its appearance, the jaundice is beginning to fade. Four of my medical neighbours whom I have asked have never seen a like case, neither has such a one been seen by my old teacher, a gentleman who has been for many years obstetric physician to one of the great London hospitals, so I venture to bring the case to your notice. Was the jaundice due to emotional disturbance? — *British Medical Journal*.

The Preparation of a Nutrient Medium for Bacteria From Eggs.

—Wesener (*Centralbl. f. allgem. Path.*, January 31st, 1894) gives a simple method of preparing from a hen's egg a solid, opaque nutrient medium for the cultivation of bacteria. Koch originally employed eggs for this purpose, directing that they should be boiled hard and then cut into two equal portions. The disadvantage of this plan is the want of uniformity in the composition of the medium (yolk in the centre, white of egg in the periphery). This Wesener overcomes by the simple expedient of mixing yolk and albumen by shaking the egg before boiling. At first a slight tap is experienced by the finger as the intact ball of yolk impinges against the shell, but presently this is no longer felt: it may, then, be concluded that the membrane investing the yolk has been ruptured. After a little further shaking, with the object of mixing the two constituents thoroughly, the egg is placed in water at 75 to 80° C. for one-half to three-quarters of an hour. It is then transferred to sublimate solution for cooling and for sterilization of the surface: on removal, after drying with sterilized wool, the shell and membrane investing the white of the egg are removed. The contents of the egg are now seen to be solid, and of a uniform golden-yellow color. Three or four slices are cut from the mass with a sterilized knife, placed in Esmarch's dishes, and sterilized as usual. Upon a nutrient medium so prepared almost all the well-known

fission fungi and yeasts grow well, and often in a characteristic manner. Wesener describes the growth upon egg of cholera and Finkler-Prior bacilli, vibrio Metchnikovii, typhoid bacillus, *B. coli communis*, streptococcus pyogenes, *B. diphtheriæ*, and other organisms. By some of the latter the medium is liquefied. Pigment-producing organisms grow well upon it. The slices of egg dry very slowly. Further advantages presented by this medium are its alkaline reaction, its richness in albumen, and the fact that it is unfavorable to the growth of moulds.—*British Medical Journal*.

Exalgin as an Anodyne.—In the *Lancet*, November 25th, Dr. Thomas D. Savill relates his results with exalgin given in various cases for the relief of pain of a neuralgic character. He finds that a convenient way of preparing it is to pour six ounces of boiling water on forty-eight grains of the salt, no separation occurring on cooling. One teaspoonful of this preparation contains one grain of the salt. From one to three grains were given every four hours, with relief of pain in each instance. No bad effects were noticed even in cases of phthisis or heart disease, and no symptoms of intoxication were seen in any case. He recommends that it should not be given when a febrile temperature is present, or in cases of constipation.—*Birmingham Medical Review*.

An Unusual Cause of Renal Hæmorrhage.—H. D., aged 36, laborer, shortly after lifting some pails of water on June 24th, 1893, was seized with pain in the right lumbar region and began to pass water of a dark porter color. On examination there was very decided fulness and marked tenderness over the region of the right kidney, and the urine on examination was found to contain a large quantity of blood. During the next week the symptoms remained unchanged, except that the amount of blood passed was distinctly intermittent in quantity. The microscope showed blood cells, large round and tailed cells, and ordinary squamous epithelium in great abundance. The symptoms seemed to point to malignant disease of the right kidney.

On July 6th, a fortnight from onset of the hæmorrhage, total suppression supervened, with

symptoms of uræmia, vomiting, muscular twitchings, and great drowsiness. Forty-eight hours later the patient died. He had been under medical treatment four months previously for chronic rheumatism. No disease of the kidneys at that time suspected.

Autopsy.—Both kidneys much enlarged, and their substance almost entirely converted into closely aggregated cysts. The right kidney was about the size of a cocoanut. A large hæmorrhage had taken place between the capsule and the kidney, dissecting off the capsule, and had burst into one of the cysts, which, in turn, had ruptured into the pelvis. The ureters and bladder were perfectly healthy.—WM. COLLIER, M.D., in *Birmingham Medical Review*.

A Case of Thrombosis of the Basilar Artery.—The patient, S. S., was admitted to the General Hospital under the care of Dr. Rickards on December 5th, 1893. He was then suffering from chronic bronchitis and cardiac dilatation, and was much cyanosed. Venesection was performed on the day following, twenty-one ounces of blood being abstracted, with considerable relief to the cyanosis and dyspnœa. The urine was acid and gave a light cloud of albumen on boiling; no casts were seen. During the following fortnight the condition did not vary to any extent, cyanosis being at all times a marked feature of the case.

During the morning of January 11th the patient was observed to be peculiar in manner and somewhat wandering. Shortly before mid-day he raised himself in bed and stretched across to the bed of the adjoining patient, a much greater amount of exertion than he had undertaken since his admission. About mid-day he suddenly developed convulsions and Cheyne-Stokes respiration. There was slight rigidity of both arms, with clonic spasms of the muscles of both arms and of both sides of the face; the convulsions being, however, most marked on the left side. The legs were not affected. The pupils were equal and reacted to light. The knee-jerk was present on both sides, as also were the superficial reflexes. One hour later neither superficial nor deep reflexes could be obtained. The patient was not insensible, being able to answer questions and to recognize people around him.

Venesection was at once performed, twenty ounces of blood being taken. No relief to the symptoms followed this treatment. As regards venesection, the idea was that the patient was suffering from ingravescent hæmorrhage, though the cardiac condition would certainly have favored thrombosis.

During the next four hours the condition did not change, except that the respiration became gradually more marked in type. The patient died six hours after the onset of the attack. Half an hour before death he became comatose, with flaccid limbs, the pupils being fixed and somewhat dilated.

The *post mortem* examination showed a considerable thrombosis of the basilar artery, extending also a quarter of an inch into the right posterior cerebral artery and less into the left posterior cerebral. The cerebral arteries were atheromatous and calcareous to a considerable extent. The heart was hypertrophied and dilated.—S. H. PERRY, M.B., in *Birmingham Medical Review*.

Treatment of Severe Chorea by Chloroform and Morphine.—A girl, aged 17, was admitted into the Leeds General Infirmary in November last with moderately severe chorea. She had a rheumatic history but no existing arthritis. The movements increased rather rapidly in violence, unchecked by chloral in frequent doses of twenty grains. Beginning with one-sixth grain of morphine hypodermically immediately followed by inhalation of chloroform for a few minutes, and gradually increasing the dose of morphine to one-half grain, always aided by chloroform, the movements were kept under control with the greatest of ease. The smaller doses produced sleep lasting only from one to three hours, the patient awaking no better; but after the half-grain dose she slept almost uninterruptedly for nine hours, and was then so greatly improved that she required no further medication except by the mouth—in fact, became an ordinary mild case, and left the hospital well in about six weeks.

With moderate doses of morphine there is often a delay of many minutes before sleep occurs; the inhalation of chloroform for two or three minutes produces immediate sleep, which is continued by the morphine. If necessary, the chloroform may

precede the injection of morphine.—T. CHURTON, M.D., in *British Medical Journal*.

Thyroid Extract in Washerwoman's Eczema, and as a Local Application.—S.H., aged 42, a washerwoman, was placed on the sick list on January 27th. The patient was suffering from an acute attack of typical eczema, of the impetiginous type, with intolerable itching and exudation. The legs and arms were chiefly affected. She was unable to stand or do her daily work. She was treated with the ordinary remedies for a week, and these failing to do her any good, I determined to give thyroid tabloids a trial.

On February 6th three tabloids were daily prescribed. The result was most gratifying. In twenty-four hours she began to peel, and when I visited her on February 9th the epidermic scales and crusts filled the bed and littered the floor. The patient expressed herself much improved by the medicine, and the soreness about her limbs had disappeared. The eruption still further yielded to treatment, and on February 12th she was able to attend at the out patient department practically convalescent.

This patient occupied a small room in a back court, the general surroundings being very unfavorable for a good recovery. I think the remedy undoubtedly had a curative effect in this case.

I have been trying thyroid extract lately as a local application, and have found the remedy useful in the following cases: (1) Unhealthy serpiginous ulcers, (2) open buboes of specific gonorrhœal origin, (3) Hunterian chancres, and especially chancroids, (4) for the cure of deep sinuses. The medicine proved serviceable combined with calomel and another sheep product—lanolin. Buboes and sores quickly took on a healthy action, and in some patients desquamation was noticed. The tendency to too rapid healing had to be obviated, for example, in discharging buboes. An elegant preparation has been made for me by Messrs. Burroughs, Welcome & Co., in the form of thyroid cream. This seems to be a very cleanly and emollient dressing, the lanolin acting as a preservative. I have already noted the benign influence of the tabloids in certain syphilitic skin eruptions.—J. D. MENZIES, Surgeon R.N., in *British Medical Journal*.

SURGERY.

The Treatment of Eczema of the Ear.

—A brief note in the *Journal de Medecine de Paris* for February 4th, 1894, gives the following directions: In moist eczema of this region, where the eruption is confluent and behind the ear or in the auricle, it is well to wash the parts with a very weak solution of bichloride of mercury, which should be warm. This should be done three or four times daily. After the parts are thoroughly disinfected, they may be dressed by an application of iodol, the auditory canal being closed by a pledget of absorbent cotton. This treatment is very useful in those cases where a discharge from the middle ear has produced irritation. In dry eczema in this region we may also use the mild bichloride wash, and follow it by an ointment composed of,—

R Iodol gr. xv.
Lanolin ʒi.

If the disease involves the external auditory canal, the disquamating epithelium should be removed by some absorbent wool twisted upon an applicator, and the canal anointed by,—

R Iodol gr. xv.
Paraffin oil ʒi.

The introduction of a tampon of wool will do much towards the keeping of the liquid in the canal. This dressing should be renewed night and morning. Often a cure results in a very few days.—*Therapeutic Gazette.*

An Anomalous Case of Stone in the Bladder in a Female.—F. B., aged 30, married ten years, had had five children. The last child was born twelve months before the patient came under my observation. It was suckled for two months only, but the menstrual discharge did not reappear until six months after this confinement.

Since six weeks after this confinement she had complained of passing a thick purulent-looking material with the water and the motions. There was pain during and after micturition, which continued for about half an hour. She had never passed any blood with the water. She stated that ten years ago the abdomen became much enlarged, but the swelling suddenly disappeared when an un-

usually large quantity of urine was passed. The first child was born eight years ago.

There was nothing to note about the abdomen. The cervix uteri, which was lying towards the left side of the pelvis, was much torn. In front of the cervix was felt a short ridge in the vaginal roof, and anteriorly this ridge terminated in a small nodule which was tender to the touch. The body of the uterus was slightly and uniformly enlarged.

The catheter was passed, and on being withdrawn impinged against a solid body, which proved to be a phosphatic calculus with a uric acid nucleus. The stone was embedded in a pouch of the bladder. The urine drawn off was muddy and offensive. It contained a large quantity of pus, and its specific gravity was 1023.

Remarks.—Ten years before this patient came under observation she had probably suffered from hydronephrosis, and it is quite possible that the calculus which produced this disorder was the nucleus of the stone removed from the bladder. Augmenting in size, it had probably lain during these years in a pouch or diverticulum of the bladder without producing any untoward symptom until the fifth parturition excited some inflammatory disturbance in the tissues which surrounded it.—JAMES OLIVER, M.D., in *British Medical Journal.*

Cancer of the Testicle. Poncet (*Lyon Med.*, December 31st, 1893) reports two cases of cancer of the testicle, both of which were accompanied by malignant enlargement of the supraclavicular lymphatic glands on the left side. (1) A man, aged 37, had suffered from malignant disease of the right testicle for eight months. The supraclavicular glands on the left side were the size of an orange. No enlarged abdominal glands could be discovered. The swelling in the neck was punctured, and a few drops of blood exuded. No other sign of secondary growth could be discovered. Castration was performed on the right side, and an attempt made to remove the supraclavicular glands. These, however, were the seat of a soft vascular encephaloid growth, and only two small glands could be removed. The wounds healed well at first, but on the ninth day a raised temperature was recorded, and there followed all the signs of a general cancerous infec-

tion, death taking place on the twentieth day after operation. At the *post mortem* examination there were found numerous secondary deposits. Some were in the root of the left lung, and from these there extended a thickened cord to the enlarged glands in the base of the neck, and along the posterior abdominal wall many masses were seen. On microscopic examination the tumor was seen to be a chondro-sarcoma. (2) A man, aged 20, had suffered from a round-celled sarcoma of the left testicle, which was removed at the age of 18. Fourteen months after this operation sarcomatous adenitis of the left supraclavicular glands appeared without any other neoplastic manifestation, and was quickly followed by generalization, which caused death four months and a half after the enlargement of the supraclavicular glands. Poncet thinks that in both these cases the mode of transmission of the sarcomatous material was by the thoracic duct, which receives the testicular lymphatics from both sides, and also those from the left supraclavicular glands. He advises that in all cases of malignant disease of the testicle which it is proposed should be submitted to a radical operation, a systematic examination of the supraclavicular glands of the left side should always be made. — *British Medical Journal*.

Healing of Tongue Bites. — This well-known accident is generally believed to be trivial as far as prognosis is concerned, and Berenger-Feraud* and Peltier† have shown, on the evidence of fourteen bad cases, that wounds of the tongue heal quickly. A piece of the tongue almost severed by the sharp incisors usually fails to slough away. Nevertheless, it is the duty of the attendant to be on his guard against injury to the tongue in any case of convulsions. Puerperal eclampsia is a very grave disease, and the obstetrician's attention is directed in most instances of this disorder, rather to the emptying of the uterus than to the protection of the tongue. Dr. Matthai, of Berlin, has recently shown that we must not rely too much on the evidence of Berenger-Feraud as to the healing of bitten tongues, whilst Professor Veit has brought forward a case where a wound of the tongue placed the patient in immediate peril. Dr. Matthai states

that a woman was admitted into the Berlin University Lying-in Hospital deeply comatose after twelve fits. The tip of the tongue, blue and swollen, projected from the mouth, but the assistants did not take steps to protect the organ. Delivery followed quickly on admission, and it was not till the second day, when the patient awoke from her coma, that a deep oblique wound was discovered, about an inch behind the tip of the tongue. A thin band connected the damaged part with the rest of the organ. That part became very putrid, and separated on the seventh day. Neither taste nor deglutition were affected after recovery. In Dr. Veit's case a pregnant woman, sleeping alone, had convulsions, and bit her tongue badly. Next morning she was found senseless and blanched, profuse hæmorrhage having occurred through injury to the lingual artery. She recovered. The point of the tongue did not slough off, but permanently lost all sense of taste. — *British Medical Journal*.

MIDWIFERY.

Menstruation in a Young Infant. — On February 20, 1894, I delivered Mrs. B. of a full-term female infant: well formed, weighing about seven pounds. On the 22nd the nurse noticed a sticky discharge oozing from the vagina of the infant to which she called my attention on the following day, when I found a small stain of mucus streaked with blood on the linen, and the labia minora were covered with a viscid mucous secretion. On the 24th I found on separating the labia quite a decided discharge, ʒiiss-ʒii of bloody mucus oozing from the vagina, which almost entirely disappeared on the following day. — FRED. W. THUM, M.D., in *Archives of Pediatrics*.

Pregnancy and Hepatic Abscess. — Chamberlent (*Arch. de Toxol. et de Gynec.*, December, 1893) relates a case in which a patient was delivered of her first child four years ago. There was central placenta prævia and fever in the puerperium. The temperature rose and fell very irregularly between 102° and 104°: but the patient was discharged "cured" on the seventeenth day. On December 14th, 1892, she was admitted into the Bordeaux Lying-in Hospital, pregnant nearly to term. The temperature was over 103°. The patient complained of severe pains in the right side

* *Gazette de Hopitaux*, Nos. 53 and 56, 1870.

† *Movement Medical*, No. 6, 1876.

of chest, which bulged, and resonance was diminished. Chambrelent diagnosed pneumonia. On December 15th a healthy child was born spontaneously. The mother died on the 17th. The liver was in a universally suppurating condition, looking like a dark broth. Chambrelent traced the liver complication to the first confinement, when phlebitis must have occurred and affected the liver. At the second labour germs remaining in the liver had been disturbed, and fatal complications resulted. Though the liver was almost destroyed, no uramic convulsions were observed. Coyne related a case, during a discussion on Chambrelent's clinical report, in which a man had pain in the right side of the thorax after a gunshot fracture of the arm. Three years later he died, and four abscesses were found in the liver, and a suppurating area in the lung. Uremia is often absent in very rapid attacks of hepatic abscess. Several other obstetricians doubted whether the abscess was chronic in Chambrelent's case.

Pregnancy after Ventrifixation.—Lohlein (*Deut. med. Woch.*, March 15th, 1894) says that ventrifixation has maintained its position as a method for maintaining the uterus in a forward position with moderate elevation which is at once reliable and unattended by unpleasant consequences. It is, however, indicated only when very considerable inconveniences are to be attributed to the abnormal position of the uterus. He reports two cases in which pregnancy occurred after ventrifixation: (1) A woman, aged 30, had ventrifixation performed in July, 1892, on account of prolapse: in December, 1893, she was delivered of a child; the involution of the uterus proceeded satisfactorily. (2) A woman, aged 35, had myomectomy performed in November, 1892: as the uterus was retracted, the bed of the tumor was stitched to the abdominal wall: five months later she had severe nausea and vomiting, and was found to be pregnant; the adhesions between the uterus and abdominal wall could be felt; subsequently she was delivered of a well-developed child, which, however, died shortly afterwards. The ventrifixation was undertaken here to guard against bleeding and the infection of the peritoneum, in addition to the above-named reason. This method has been of service to the author in

cases of the enucleation of large myomata. He cites a case in which a rapid pulse and raised temperature led him to reopen the abdomen, and he stitched the bed of the tumour to the abdominal wall with the best results. The indications for ventrifixation are thus not to be limited by any fears in regard to conception and gestation. The bands of adhesions take part in the involution just as the utero-sacral and broad ligaments do. Thus there is reason to believe that the fixation will still remain sufficient. In both cases there was marked nausea and vomiting during the early months of the pregnancy, severer than in previous pregnancies.—*British Medical Journal*.

Personals.

Dr. F. R. Eccles, of London, is away on a holiday. He will visit Baltimore, Washington and Philadelphia during his absence.

Dr. J. O. Orr has returned from England, and now resides at 337 Jarvis Street. He will devote himself entirely to the diseases of the respiratory tract and to bacteriology.

Dr. V. Sullivan, son of Senator Sullivan, of Kingston, is attending St. Mary's Hospital, London, England, while Dr. Acland Oronhyatekha is attending St. Thomas', preparing for the conjoined examination in June.

Dr. H. Hamilton is still in London attending the medical classes in several hospitals. He intends returning about the end of August, after his year's work in England and the continent, and settling in Toronto. He will be a valuable acquisition to the profession in this city.

Births, Marriages, Deaths.

MARRIAGE.

ROBERTSON—WILSON.—At Toronto, on Wednesday, May 2nd, by the Rev. W. F. Wilson, William Robertson, M.D., of Elora, son of the late Rev. William Robertson, Chesterfield, to Florence, daughter of the late Roger Wilson, of Barrie.

DEATH.

BULL.—On Wednesday, April 25th, at his late residence, "Elmsleigh," 131 Bloor Street West, Toronto, Edward Bull, M.D., in his 71st year.

Miscellaneous.

THE DOCTOR'S WIFE.—Our attention has been called by a distinguished member of the profession and an authority on life assurance to a paragraph in Henry Vizetelly's *Glances Back Through Seventy Years*. At page 415, Vol. I., after discussing the Rugeley poisoning case, Vizetelly writes: "Mayhew, besides interviewing Dr. Taylor, had conducted an inquiry for the paper at the principal life assurance offices with somewhat startling results. . . . That the dishonorable portion of the medical profession was largely mixed up with these frauds, and that most offices made it a rule never to insure the life of a medical man's wife." It may hardly seem necessary to take notice of this statement, unsupported as it is by any evidence, and we should have treated it with silent contempt had not our opinion been asked by one of the leaders of the profession. This being the case, we communicated with some of the leading actuaries of the day, and they all agree in affirming that they have never heard of any such rule, and that both now as well as in the

past the wives of medical men have just the same facility for assurance as the wives of other men.—*British Medical Journal*.

LANOLIN.—The Lanolin case before the Court of Appeal has ended in a decision upholding the patent of the Darmstaedter Lanolin Fabrik, and maintaining the injunction which had been granted by Mr. Justice Romer against an English firm for an infringement of it. It was interesting to find English judges discussing evidence on this question obtained from ancient authors such as Livy, Ovid and Dioscorides, but they all agreed that the wool fat of those days—the substance called "œsypus," as described by Dioscorides—was a very different material from that which we know under the name of "lanolin," as introduced by Professor Oscar Liebreich. What the ancients did was to get wool fat out of wool; what is done now is to get the substance called lanolin out of wool fat. As we all know, lanolin consists chiefly of cholesterin in combination with stearic and other fatty acids, mixed up with a certain quantity of water. The lye or liquor in which wool has

FOR INVALIDS.—Delicious Dishes made in a few minutes at a trifling cost.

WYETH'S LIQUID RENNET.

The convenience and nicety of this article over the former troublesome way of preparing Slip, Junket and Frugolac, will recommend it at once to all who use it.

WYETH'S RENNET makes the lightest and most grateful diet for Invalids and Children. Milk contains every element of the bodily constitution; when coagulated with Rennet, it is always light and easy of digestion, and supports the system with the least possible excitement. Price, 25 cents per bottle.

FERMENTATIVE DYSPEPSIA.

WYETH'S COMPRESSED TABLETS. * BISMUTH SUBGALLATE, 5 GRAINS.

DR. AUSTIN FLINT says:—"In nearly every case of functional dyspepsia that has come under my observation within the last ten months, I have begun the treatment by giving five grains of bismuth subgallate, either before or after each meal. I find it almost a specific in cases of purely functional dyspepsia with flatulence. Price, per bottle of 100, \$1.00.

WYETH'S COMP. SYRUP WHITE PINE.

A most valuable remedy in chronic or recent pulmonary affections of the throat or lungs—relieving obstinate coughs, by promoting expectoration—and serving as a cathartic in all bronchial or laryngeal troubles.

Each fluid ounce represents: White Pine Bark, 30 grs.; Wild Cherry Bark, 30 grs.; Spikemard, 4 grs.; Balm Gilead Buds, 4 grs.; Blood Root, 3 grs.; Sassafras Bark, 2 grs.; Morph. Sulph. 3-16 gr.; Chloroform, 4 mins.

Wyeth's Glycerole Chloride of Iron.

(NON-ALCOEOLIC.)

This preparation, while retaining all the virtues of the Tincture of Iron Chloride, so essential in many cases, in which no other Salt of Iron (the Hydrochloric Acid itself being most valuable) can be substituted to insure the results desired, is absolutely free from the objections hitherto urged against that medicament, being non-irritant, and it will prove invaluable in cases where Iron is indicated. It has no hurtful action upon the enamel of the teeth, even after long exposure. Each fluid ounce represents 24 minims Tinct. Chlor. of Iron.

JOHN WYETH & BROTHER.

Davis & Lawrence Co. (Limited), Montreal, - - - - - General Agents.

been washed by an alkaline solution is the basis from which it is obtained as a commercial product. This lye consists of water, dirt, soapy matter (that is, the glycerine fats converted into soap and glycerine by the alkali), and fat which is not combined with the alkali, and is not soapy (that is, the cholesterin fats). These constituents differ in specific gravity, and that of the cholesterin fats being the highest, the patentees are able by a centrifugal machine, like a cream separator, to separate these from the rest. The cholesterin fats so obtained then go through various processes of purification, and, being then kneaded up with a certain proportion of water, produce the material we know as lanolin. It had been contended that the thing patented was the use of the centrifugal machine, and that if the same separation could be obtained by a process of subsidence, by the action of gravity alone, the patent would not be infringed by so doing. The Court held, however, that the patent covered any mechanical method of effecting the separation at the stage indicated, even although it might not be done by the precise machine which was selected as the best. So there

was an end of that side of the case. It had also been contended, if it were not the particular method by the use of a centrifugal machine, but the whole process which was claimed by the patentee, that in that case the patent had been anticipated by the process described by Dioscorides. But the judges held that this old process did not produce lanolin but only wool fat; the separation, in fact, was not performed by it, and there was no anticipation.—*British Medical Journal*.

EMISTAXIS: The method of Dr. Rougier is to paint the spot from which the hæmorrhage seems to come with:

- R Collodion.....ʒiij.
- Acid. carbolic.....
- Acid. benzoic.....
- Acid. tannic.....aa gr. lxxv. M.

This preparation coagulates albumen instantaneously, and its use is not painful. The author also employs it after removal of adenoid tumours, tonsillotomy, etc.—*La Méd. Mod.*

SOMATOSE

A new Meat Extract in powder form, tasteless, and very concentrated.
Specially suited for Invalids.

MANUFACTURED ONLY BY

FARBENFABRIKEN, VORMALS FRIEDR. BAYER & CO.

ORIGINAL INVENTORS OF THE WELL-KNOWN REMEDIES

PHENACETINE=BAYER and SULFONAL=BAYER.

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WHOLESALE ONLY.

Sole Agents for Canada.

That an unwarranted substitution of one remedy for another is occasionally practised by some druggists there seems to be no question. That this is morally wrong, is equally true; but that it is frequently a crime, in the eyes of the law, and as such is punishable, seems to have been lost sight of by some of those who may practise it.

But the fact that such have enjoyed immunity from prosecution, is no guarantee that they can continue their speculation, even on a small scale, without detection and its consequences.

Frank A. Ruf, of the Antikamnia Chemical Company, has recently been in New York and Chicago, and states that he has made arrangements for a thorough system of investigation throughout the country, and that counsel has been employed to prosecute, both civilly and criminally, all who persist in furnishing a substitute as and for antikamnia.

The Antikamnia Company proposes doing this without vindictiveness, and indeed, with none but the most friendly feeling to the druggist. Even where a druggist has allowed himself to be persuaded into the practice, their first step will be to

confer with him in the interest of mutual protection. Following that, they propose, if necessary, notifying every physician in the city of the name and address of the offender, with the recommendation to avoid him if honest goods are desired. The substitute obtained by the investigators, together with the name of the dispenser, will be shown to the physician, thus protecting the honest druggist. The more flagrant cases will be given to their attorney for proceedings in law.

Mr. Ruf said in regard to the matter: "We are simply determined that the honest druggist shall be protected: that the physician and patient shall be protected, and lastly, that our own interests shall not be trampled upon." -- *Druggists' Circular*.

FOR PULMONARY TUBERCULOSIS.—

℞ Creosoti	}aa ʒij.
α-Naphthol		
Acidi arseniosi	 gr. ij.
Strychninae nitrat	 gr. j.
Atropinae sulphat	 gr. ʒ6.
Extracti gentianae	}	aa q.s.ut ft. pil. no. cxx. M.
Gummi arabic.		

S.—One from four to six times daily.—*Maximowicz*.

The Latest and Best.....

HAPPY RELIEF ABDOMINAL SUPPORTER

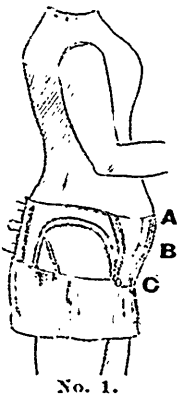
244 SPADINA AVE.,
TORONTO, April 7th, 1891.

I have used Mrs. Pickering's Happy Relief Abdominal Supporter in my practice, and have found it to give entire satisfaction. A patient who had suffered for many years from an enormous hernia, being almost disabled thereby, has found the most complete relief from its use, and is now able to perform her household duties. She had tried other supporters, without the slightest benefit.

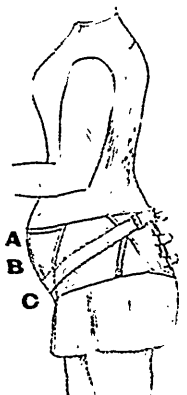
C. McKENNA, M.D.

Physicians or Patients—standing measurement, a perfect fit is guaranteed, measurements to be made directly around the body from A, B, C, also distance from A to Navel, and from A to C.

Prompt attention given to all orders. Liberal Discount to Physicians and Druggists. Price List and Circulars on application.



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Address,

MRS. F. L. PICKERING,

BOX 149,

BRANTFORD,

ONTARIO.

A CHINESE MEDICAL DIPLOMA.—“Dr.” Chan Quan Hing not long ago registered at Detroit, U.S., under a diploma from the Kwang Joie College, Canton. The following is a translation of the document: “Dr. Lee, Chief Examiner for the Government, second degree of the rank of wearing peacock’s feathers for special attendance at the Gong Wo College of Physicians and Surgeons. This certificate is for the examination in the practice of medicine as physician, that the practice of medicine may be promoted in order to guard and protect both the exalted and the lowly. Now the bearer, Chan Quan Hing, although young, has sufficient character and knowledge. He was examined at Kwang Joie College of Physicians by Dr. Fond. His learning entitles him to be a doctor, having passed the examination of the second grade of first degree of this College. I therefore encourage him and give him this certificate. He must be kind to the people, and use his knowledge to the best of his ability, doing nothing rash in his practice to render futile this examination of our College. This certifies that he may practise where he pleases in the gateways and

throughout the cities and the country. No. S.O.E., 362. First month and fifteenth day, seventh year of Kwang Shui, Emperor (1881).” *British Medical Journal*.

A TONIC MIXTURE:

R Wine of kola.
Wine of cinchona.
Wine of gentian.
Wine of colomba, of each . . . ʒviii.
Fowler’s solution gtt. x.
Tincture of nux vomica . . . gtt. v.

A wineglass-ful after each meal.—*Therapeutic Gazette*.

FOR DIABETES:

The *Journal de Medecine de Paris* for February 4th, 1894, recommends the following:

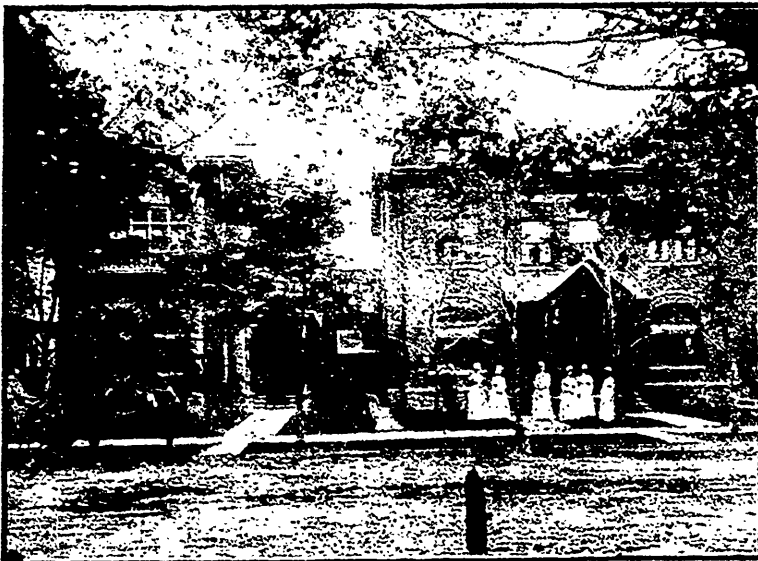
R Nitrate of pilocarpine gr. iii. $\frac{1}{2}$
Dilute alcohol ʒi.
Distilled water ʒss.

4 or 5 drops of this mixture may be placed upon the tongue two or three times a day.—*Therapeutic Gazette*.

ROTHERHAM HOUSE

Dr. Holford
Walker

Announces to the Profession, that having taken Dr. WILLIAM NAYLOR into partnership, it is their intention to enlarge the Hospital, to permit the admission of men. A separate building will be devoted to that branch of the work.



APART from the special work of Nervous and Surgical Diseases of Women, general non-contagious diseases of men and women will now be admitted. The application of the various forms of electricity is resorted to in all suitable cases.

Medical Men can obtain Nurses and Masseuses for outside work on application. * For Terms, or other information desired, address

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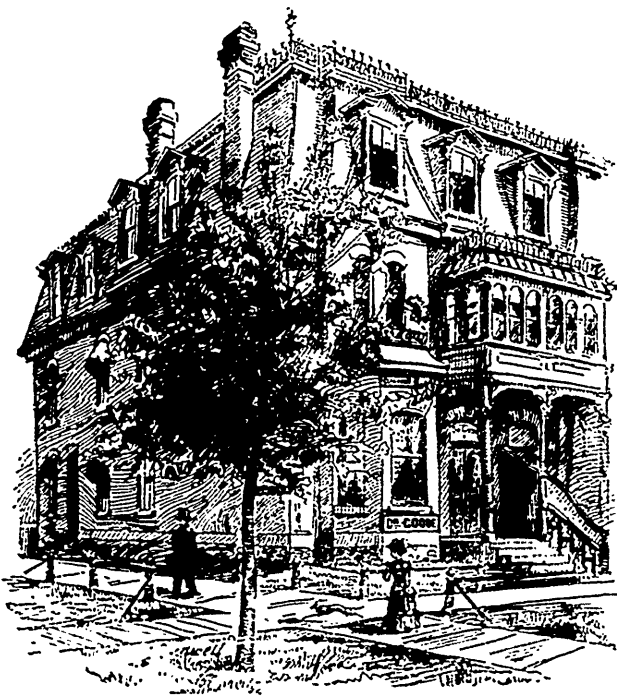
THE EDITOR OF "AN AMERICAN TEXT-BOOK OF PRACTICE." "In announcing the completion of 'An American Text-Book of Practice,' the publisher asserts that in this work *over 500 pages are from the pen of Dr. William Pepper*. This fact, from a purely mechanical standpoint in these days of enormous literary production, would not appear in itself to be matter for special comment, but when there is taken into account the Editor's busy life, it is a notable instance of the wonderful vitality and executive ability of an exceptionally gifted man."

"Dr. Pepper, who is a native-born Philadelphian, is perhaps no less widely known as a medical practitioner than as Provost of the University of Pennsylvania, and since assuming the administration of this venerable institution its interests have been more rapidly advanced than during any equal period of its history. The words of Governor Hoyt, addressed to Dr. Pepper at the time of his installation as Provost (1881), that 'the events of this day will affect your own and the *fortunes of the University of Pennsylvania*,' were singularly prophetic. An indefatigable worker, he has con-

ducted the affairs of the University with such remarkable tact that the various educational departments now aggregate thirty huge buildings and the institution commands an international reputation. But it is not alone as the chief administrative officer of the University that Dr. Pepper's influence is all-potent; he is connected with, and is especially active in various capacities in, many learned societies."

"Moreover, in addition to shaping and directing the general policy of the University, Dr. Pepper attends to a very large medical practice. He is recognized as the leading American authority on medical questions, his powers of diagnosis amounting almost to intuition. He was mainly instrumental in securing from the city of Philadelphia the gift of the site on which now stands the University Hospital, and he has always been an ardent supporter and a successful promoter of charitable works deserving public recognition."

"The question naturally arises, How does Dr. Pepper meet the exactions of all these engagements? The answer is, Simply by self-abnegation and by his mental adroitness, no opportunity being



Private Sanitarium ... for Inebriety

No. 1 Clarence Square, TORONTO, ONT.

THIS INSTITUTION possesses facilities for the successful treatment of the drink habit on modern principles.

It is situated on the corner of Spadina Avenue and Clarence Square, and facing a beautiful park; is only one block from street cars, only a short distance from the Brock Street boats, and five minutes' walk from Union Station. All the rooms are large, well furnished, and house is heated by furnace and gas.

The medical treatment is superintended by DR. GOODE, whose assistants are competent. As the residence of patients will be from three to four weeks, and as occupation or amusement is almost necessary, it will readily be seen that a first-class place where gentlemen may be treated in the city has great advantages over a like institution in the country.

lost—whether it be in his office or in his carriage responding to a business, a professional, or a social call—in formulating the duties of any function requiring personal attention. As an editor and writer, as Provost and practitioner, it may be inferred that the official demands on Dr. Pepper would preclude attention to the enjoyments of society; but in social as in public life he still finds time for interchange of civilities with a wide circle of friends, by whom he is highly esteemed not only for the brilliancy of his literary attainments and his gentlemanly qualities, but also for his congeniality as a friend and a companion.”

ACUTE CATARRHAL TONSILLITIS:

As a gargle:

- R Borax gr. xlv.
- Glycerin ʒj.
- Decoction of marsh-mallow ʒix. M.

Internally:

- R Salol gr. xlv ʒj.
- Mucilage of acacia ʒiv.

M. Sig. : Divide into 4 doses and take during the course of the day.—*La Riforma Med.*

“VIEWING THE BODY.”—Old customs, especially if supported by legislative sanction, are hard to kill, but it is likely that some remarks by Mr. Oliver Pemberton, F.R.C.S., the coroner at Birmingham, will have helped to drive a nail into the coffin of that particular meaningless and sometimes dangerous rule of “viewing the body” at public inquests. The case was a very unfortunate one: a poor girl who, in a state of delirium, had escaped from the local small-pox hospital, and had been drowned in a canal. Mr. Pemberton favored the carrying out of the law, but urged the necessity for its amendment. To prevent evil consequences in the case in question he had the corpse enclosed in a coffin covered with a glass lid, and laid in the open air. He stated, in addition that the member of Parliament representing Aston Manor had already given notice of his intention to raise the question in the House of Commons. As soon as Parliament finds time to attend to the matter we fancy it will have no difficulty in coming to a decision in accordance with the view so often expressed in the *British Medical Journal*, and now endorsed by Mr. Pemberton.—*British Medical Journal.*

MADAM VERMILYEA'S HEALTH CORSET

Read what a prominent Toronto Physician says:

“I have examined MADAM VERMILYEA'S PATENT SPIRAL STEEL HEALTH CORSET, and can recommend it without hesitation as being the **best Corset I have ever seen.** It is constructed on the hygienic and anatomical principles, and is a great boon to ladies.”

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ACTION OF SOMATOSE ON HEALTHY PERSONS.—

1. Experiment of twelve days' duration on a man, thirty-six years of age, of medium strong build, having a healthy gastro-intestinal canal. During the Somatose period a remarked N surplus occurred on the second day, on the fourth day there was N equilibrium. During the following meat period N surplus also ensued, but not as large as during the administration of Somatose. According to this experiment, Somatose is not only equivalent as regards the nitrogenous surplus to meat, but even somewhat superior.

2. The person experimented on was a moderately vigorous peasant boy, sixteen years old, who had suffered, although only at times, from constipation. Notwithstanding that the patient received in addition to the Somatose, only food whose percentage of nitrogen was at the lower limit of the albuminous requirements of the human body, there was a gain in nitrogen under nutrition with Somatose.

3. If, on the other hand, a person is in an especially good condition of nutrition, and, in contrast to the preceding case, consumes, further, more

nitrogenous substances (albumen), the nutritive value of Somatose is somewhat lower than that of meat, as was shown by a third experiment on the peasant boy mentioned above.

From this experiment it follows, moreover, that even under such conditions the utilization of Somatose may be considerably increased by diminishing the quantity of nitrogenous substances in the additional food. The absorption and assimilation of equal quantities of Somatose is twice as good when the percentage of nitrogenous elements in the additional food supply is reduced than under an albuminous diet.

On the ground of these three experiments on a healthy person, it follows:

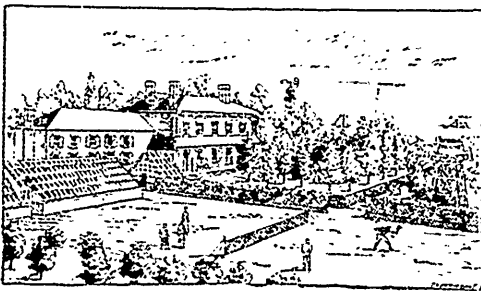
(a) Somatose is well borne, without producing diarrhœa.

(b) The absorption of Somatose N and its excretion in the urine is almost the same as that of N of meat.

(c) The assimilation of the preparation is more perfect if the supplementary food is poor in albumen. Under the use of 4.24 N in form of Somatose there was excreted in the feces, instead of

LAKEHURST SANITARIUM

OAKVILLE, ONT.



FOR THE TREATMENT OF

INEBRIETY

(Habitual and Periodical)

MORPHINE, and other

DRUG HABITS and

NERVOUS DISEASES

PHYSICIANS generally now concede that these diseases cannot be treated with entire success except under the conditions afforded by some **FIRST CLASS SANITARIUM**. Such an institution should be a valuable auxiliary to the practice of every physician who may have patients suffering from any form of these complaints, who are seeking not relief merely, but entire restoration to health. The treatment at **LAKEHURST SANITARIUM** rarely fails to produce the most gratifying results, being scientific, invigorating, thorough, productive of no after ill effects, and pleasant to the patient. The usual time required to effect a complete cure is four to six weeks.

LAKEHURST PARK is a well-wooded expanse of several acres extent, overlooking Lake Ontario, affording the utmost privacy if desired, and the surroundings are of the most picturesque description. The Sanitarium is fully equipped with every necessary appliance for the care, comfort, convenience and recreation of patients. Terms upon application to

C. A. MCBRIDE, M.D., MEDICAL SUPERINTENDENT,
OAKVILLE.

one-half, only one-eighth of the N quantity which, under the use of 8.48 N, remained unused in the intestines.

(d) The gain in flesh under the administration of Somatose is at least as good as under a meat diet.

ANTIPIRETTIC PILLS IN PHTHISIS.

- R Pulveris digitalis gr. i.
- Quininae hydrochloratis gr. iss.
- Pulveris opii gr ss.
- Misce et fiat pilula No. i.

S.—One to be given every six hours. —*Therapeutic Gazette.*

PYREXIA IN LA GRIPPE:

- R Tinct. digitalis ℥x.
- Tinct. aconiti ℥iiss.
- Liq. ammon. acetat ℥jiss.
- Aquae ad ℥viii.

S.—One tablespoonful to be taken directly, and repeated every hour until four doses have been taken: then every two, three, or four hours, as directed. —*Therapeutic Gazette.*

A PLEA FOR THE PIPE. In the discussion about "Puerperal Septicæmia," Dr. Barnes wisely lays great stress on the importance of a medical man disinfecting his breath, as well as his hands, and that he should, as a general rule, not drive about to see his patients in a close carriage, nor wear gloves in the summer, etc., etc. He, however, omits one important item—"a quiet smoke." Depend upon it, there is nothing like an occasional pipe (or cigarette), or even a fragrant cigar, for disinfecting the breath and destroying disease germs, to say nothing of a pipe soothing one's irritated nerves, especially at such a time as the present, when one is in attendance on so very many cases of this so-called, or rather *miscalled* "influenza."—W. I. HERVEUX BLENKARNE in *Medical Current.*

EXTERNAL TREATMENT FOR RHEUMATISM:

- R Salicylic acid.
- Lanolin.
- Essence of turpentine, of each, gr. xv.
- Lard ℥jiss.

—BOURGET.

THE ACID CURE.

HERETO our "Guaranteed Acetic Acid" has not been pushed in Canada, and consequently is not generally known. We wish now, however, to press it on the attention of the Medical profession. That "The Acid Cure" is deserving of study is sufficiently obvious from the subjoined professional notices which were published shortly after the Acid Cure was first introduced into America over a year ago. The "Guaranteed Acetic Acid" (Acetocura), is absolutely pure and will not injure the skin. To effect the cure of disease, it must be used according to our directions, which are supplied with every bottle. Our larger treatise, "The Manual of the Acid Cure and Spinal System of Treatment," price 30c., we will forward to any qualified practitioner for 35c.

TESTIMONIALS.

The late D. CAMPBELL, M.D., Edin., President, College of Physicians and Surgeons, of Toronto.

"I have used your 'Guaranteed Acetic Acid' in my own case, which is one of the forms of Asthma, and in several chronic forms of disease in my patients, and I feel justified in urging upon the medical profession an extended trial of its effects. I consider that it acts in some specific manner, as the results obtained are not only different, but much more permanent than those which follow mere counter irritants."

Extract from "The Physiological and Therapeutic Uses of our New Remedies." By JOHN RUCHANAN, M.D., Professor of Surgery, University, Philadelphia.

"New Cure.—'The Acid Cure' is attracting a great deal of attention at the present time in some parts of Europe. It has been introduced by Mr. F. Coultts in a very able Essay on the subject. He begins by stating that the brain and spinal cord are the centres of nerve power; that when an irritation or disease is manifest in any portion of the body, that an analogous condition of irritation is reflected to the cord by the nerves of sensation, so that in diseases of long standing there is a central irritation, or a lack of nerve power, and in order to reach all diseases it is necessary to strike at the original—the root of the nerve that supplies the organ diseased. . . . The Acid seems to stimulate a renewal of life in the part, then to neutralize the poison and overcome the morbid condition; in all diseases the Acid is potential, and as a prophylactic, never found to fail. As a preventive to disease, daily bathing the entire body with the Acid has been found to ward off the most pernicious fevers, infectious and contagious diseases, and is productive of a high grade of animal and mental life."

DR. J. T. COLLIER, Brooks, Maine, Oct. 26th, 1877, writes:—

"With regard to the 'Acetic Acid,' I have used it in my practice until I have become satisfied that it has a good effect, especially in Typhoid Fever and in cases of chronic complaints. I have no hesitancy in speaking in its favor."



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COULTS & SONS,

72 Victoria St., TORONTO.

"Doc." If it has been your misfortune to be called "doc." and if this recognition has become at all general among your friends you might as well move to some other place. A man may be called a thief, a liar and a dead beat, and yet he may prosper and live upon the fat of the land. But once let him be called "doc" and his professional success is at an end. We would prefer to spend a night in the station-house, so far as its effect on our professional success is concerned rather than to have our friends notice our approach by saying, "There comes doc." If a man calls you "doc" you need never expect a penny from him for any professional services you could render. His answer is sure to be, "All right, doc, in a few days that will be all right." "Doc" means disaster. "Doc" is the culmination of all calamity. "Doc" is a catastrophe given at one stroke. "Doc" is the warning that we have reached the extreme limit of our usefulness. "Doc" is the hand which points us to the next town. Shun it, my young friend, as you would flee from a Kansas cyclone or a prairie-fire. Knock the man down who first dares speak it to

you, and call upon the whole medical profession for vindication of your righteous deed.—*The National Medical Review.*

BLISTERS OF THE FEET.—In the German army the following application is employed for the rapid cure of blisters of the feet incident to long marches:

R Black soap 52 parts.
Water 27 parts.
Vaseline 15 parts.
Oxide of zinc 6 parts.
Essence of lavender, enough to perfume.
—*Therapeutic Gazette.*

INSOMNIA OF CHILDREN:

R Chloralis gr. ij.
Tr. moschi,
Tr. valerianæ aa gtt. xx.
Aqueæ dest. ʒ j.

M. Sig. Inject the entire quantity into the rectum, and if necessary, the dose may be repeated if sleep does not ensue in the course of two or three hours.—*Ex.*

RELIABLE AND PROMPT

Two Characteristics that Commend SCOTT'S EMULSION to the Profession.

THERE ARE MORE THAN TWO—but the fact that this preparation can be depended upon, and does its work promptly, covers the whole subject.

Physicians rely upon **SCOTT'S EMULSION OF COD LIVER OIL WITH HYPOPHOSPHITES** to accomplish more than can possibly be obtained from plain cod-liver oil. They find it to be pleasant to the taste, agreeable to the weak stomach, and rapid of assimilation. And they know that in recommending it there is no danger of the patient possessing himself of an imperfect emulsion. **SCOTT'S EMULSION** remains under all conditions *sweet* and *wholesome*, without separation or rancidity.

FORMULA: 50% of finest Norwegian Cod Liver Oil; 6 grs. Hypophosphite of Lime; 3 grs. Hypophosphite of Soda to the fluid ounce.

SAMPLE of Scott's Emulsion delivered free to the address of any physician in regular practice.

Prepared by **SCOTT & BOWNE, Chemists,**

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