

The Canada Lancet

VOL. XLVIII.

TORONTO, JANUARY, 1915

No 5.

EDITORIAL

MEDICAL RECIPROCITY WITH BRITAIN.

“By a practically unanimous vote the Ontario Medical Council recently agreed on the motion of Dr. A. T. Emmerson, Goderich, Ont., to affirm the principle of reciprocity between Britain and Ontario on the basis of the medical registers of Ontario and the medical registers of Great Britain and Ireland.”

Thus on 22nd December, 1914, what we have long contended for became an accomplished fact. A doctor holding a qualification to practise in Britain may now register in Ontario, and vice versa. It must be taken for granted that the General Medical Council in Britain is jealous of the standard of the medical practitioners there, and will see to it that they are competent, so far as the tests of written and practical examinations can determine. It is safe to assume that any medical men who come from Britain to practise in Ontario will be able to give a good account of themselves.

In like manner, the standard in Ontario for many years has been a high one. We have stood by the Ontario Medical Council at all times in every legitimate effort to raise the tests that had to be passed to secure a license to practise. Britain need have no misgivings in registering any one holding an Ontario qualification.

Thus Prince Edward Island, Nova Scotia, New Brunswick, Quebec and Ontario are in line on this very important matter. The four Western Provinces of Manitoba, Saskatchewan, Alberta and British Columbia have yet to join with their sister provinces. It is to be hoped that the day will not be long postponed when they will cast in their lot with the majority. The vision for the future is an Empire-wide profession.

In Canada, after a long and arduous struggle we have attained to the goal of a common medical standard and have now a Dominion Medical Council; and already the good results are abundantly in evidence. But the still larger outlook is that of such a standard for all parts of the Empire as would be acceptable in all other parts. Let the time soon cease when the words of Shylock will be true:

"I will buy with you, sell with you, talk with you, walk with you, and so following, but I will not eat with you, drink with you, nor pray with you."

DR. BELAND IN BELGIUM.

Dr. Beland, who was married in July at Cappellem, near Antwerp, to a Belgian lady, had just started on his honeymoon trip when war broke out. He was then in France, and at once decided to return to Belgium, where he volunteered his services for hospital work. He, with others, was put in charge of the Dawson Memorial Hospital, an English hospital in Antwerp.

Dr. Beland's first experience was the care given by him day and night to General French's soldiers. He witnessed the coming of the German troops into Brussels. During the bombardment of Antwerp he remained at the hospital, going every second day to Cappellem to his wife's residence. When the white flag was hoisted on the cathedral in Antwerp his wife and step-daughter fled to Holland, to Bergen-op-Zoom. Dr. Beland and the Mayor remained alone in the village and received the first German officers on their way to Antwerp.

The interview, it is stated, was very interesting. Dr. Beland's charming manner quite captivated the Germans. The officers begged him to harangue the fugitive women, children and old men, and to persuade them if they returned home they would not be molested. In French and in English, from his doorstep, Dr. Beland addressed the crowd. They numbered about 4,000. Many of them followed his advice, but others went to Holland, some nine or ten miles away. Since then Dr. Beland has returned to his hospital, where his work has been highly appreciated by foes as well as friends.

Dr. Beland is a prominent French-Canadian doctor, and was for a time a member of Sir Wilfrid Laurier's Cabinet. Canadians, English-speaking as well as French, feel proud of his splendid achievements during the war.

NEED FOR MEDICAL SUPPLIES.

A distressing lack of medical supplies for the wounded of the battlefields of Europe is shown by appeals received by various relief organizations here and by the tremendous orders received from the warring nations by American manufacturers of such materials.

Reports received at Red Cross headquarters from nurses attached to some of the hospital units sent to Europe by that organization show

that the supply of absorbent cotton, bandages, gauze, anæsthetics, iodine, and alcohol and similar necessities are utterly inadequate.

Servian hospitals ran short of anæsthetics three weeks ago and surgical operations there have since been performed while wounded were still conscious, according to Red Cross reports. Many deaths from shock of operations are reported. From nurses in French hospitals come such statements as "bandages, medicines and ambulance necessities are like the treasures of kings. Gauze and anti-tetanic serum are very difficult to get, and cotton is disappearing." It is also reported that there is a great shortage of surgical instruments in the field hospitals behind the armies.

"This country does not know the awful needs of medical supplies in Europe," said Cranton Brenton, New York war relief director of the Red Cross, recently. "Imagination cannot exceed the horrors resulting from the lack of them. We are doing all we can, but there is a great and pressing need of money to purchase these supplies."

In a war so vast as the present one it is impossible to cope with every need. The area covered and numbers engaged are so great that it surpasses anything known in the world's history. Nevertheless, all should give what assistance they can to mitigate the sufferings of those who are called upon to serve at the battles' fronts.

THE BELGIAN DOCTORS.

Every day brings fresh accounts of the terrible sufferings of the Belgians, and the conditions of the doctors of that country are deplorable in the extreme. If ever there was an opportunity for the medical profession throughout the world to vindicate its title to the noble profession, that opportunity has now come in the opening it affords of rendering help to their war-stricken confrères in Belgium.

The members of the medical profession in Britain and the United States have already effected organizations for the purpose of raising funds for the relief of Belgian doctors and druggists. A similar organization is being set on foot in this country, and we wish it every success. The indications are that the response will be a generous and prompt one.

We have instances of Belgian doctors who were enjoying the blessings of comfortable homes, who have been turned adrift and reduced to the direst distress. When one has brought home such cases, the words of Mark Antony assume a real meaning:

"Cry 'Havoc,' and let slip the dogs of war.

ORIGINAL CONTRIBUTIONS

PSCYHOSES AND NEUROSES OF UROGENITAL ORIGIN.*

BY NOAH E. ARONSTAM, M.D.

Detroit, Michigan.

MALADIES of a neurasthenic and psychic nature bordering on the brink of insanity and mental aberrations of minor import, are apt to follow in the wake of diseases of the genito-urinary tract, especially those of the urethra and its adnexa. It is incredible with what persistency the mind of a patient will dwell on pre-existing affections even if all traces of them have been satisfactorily eradicated. That class of patients is apt to become a burden, not alone to themselves, but a positive annoyance to the physician as well, who after repeated and painstaking examinations becomes convinced that there is nothing of any pathological significance in the entire urogenital apparatus, and thus accordingly acquaints the patient of the fact and endeavours to remove his morbid conception. To his dismay, he will, however, discover that there is something very grave in the urogenital sphere. No manner of persuasion and reasoning will avail under these circumstances to dispel his illusion; the patient will run the gamut of a number of physicians, until either some charlatan by divers surreptitious means will actually alleviate him of his fancy or suggestive affliction, or else time alone will effect a cure.

It would be very interesting to learn the underlying etiological factors that give rise to this type of nervous manifestations coincident to the diseases of the male genitalia. Various theories have been advanced. One of these goes so far as to ascribe the neurastheniacal symptoms to the absorption of a toxin from the urethra, which, acting upon the nerve centres, is capable of creating a host of manifestations of a nervous or psychic character. Another of the theories propounded contends that unless a predisposing tendency to unbalanced mentality or a highly nervous temperament exists, such sequelæ are not prone to develop; the presence of a urethritis or some other venereal malady at some time, merely acting as the exciting or determining factor. The latter seems to be the more plausible of the two theories, a feeble, nervous mechanism and perverted volition are wholly responsible for these morbidities in the mental sphere.

* Read before the Maimanidas Medical Society, Detroit, Mich.

Among the diseases of the genito-urinary system that have been known to be instrumental in the production of the above disorders with their attendant train of symptoms, may be mentioned gonococic urethritis. In the author's opinion it is the most frequent causative factor in the province of venereal diseases. Of less importance in an etiologic sense, are the diseases of the urethral adnexa, namely, the prostate, seminal vesicles and epididymis. This article does not attempt to encroach on the territory of the purely psychological, revolving around the sexual domain. It only intends to discuss the neuroses and psychoses coincident to or following the various inflammatory conditions of the urethral canal, and prominently so that due to the invasion of the gonococcus. Every physician is liable to meet with cases of urethritis accompanied by some form of mental disturbance during the acute, subacute and the chronic stages of the affection. But there are well-authenticated cases on record, and their number is not inconsiderable, where, even after the total destruction of the micro-organisms as ascertained on microscopical examination and complement fixation test, and after the complete cessation of the discharge and the disappearance of shreds and flocculi from the urine, in short, after the patient is apparently cured, he will stoutly insist that he does not feel well and express the opinion that he is not absolutely free from his gonorrhœa. The train of subjective symptoms that he enumerates is very uncertain and ill-defined. He will admit that he can detect nothing abnormal in the urinary stream; he experiences no pain or burning sensation on micturition; there is no "morning drop"; but there is a peculiar, piercing or darting pain in the glans penis of a very evanescent character, coupled by indefinite painful sensations in the vesical and hypogastric regions, and occasionally in the back. But it is the shooting pains in the glans that make him apprehensive. Urinary and microscopic examinations will reveal nothing of importance; the urethroscope likewise will only elicit negative results, and still the patient keeps on clamoring for relief. If the latter is not accorded to him, he will invariably drift into other hands with similar success and will eventually become an inveterate melancholic or hypochondriac. The above is the only symptomatology that can be obtained on a close and careful examination of the patient. There is nothing pathologically palpable in his make-up. We have solely to rely upon his own subjective interpretation of his condition. To illustrate the above, the author desires to append three cases taken at random from his records, as follows:

ILLUSTRATIVE CASES.

Case I. S. F., aet. 29; single; family history negative. Past history: Had a gonococic urethritis three years ago and fully recovered

from it in about six weeks. St. pr. Specific urethritis contracted five months ago. No discharge on the last examination, three weeks after the cessation of all urethral symptoms; no gonococci demonstrable; normal and painless micturition. Flocculi and shreds absent from the urine on three glass tests examinations with and without primary flushing of the urethra (confirmatory three glass tests.) Urethroscopic examination—anterior and posterior—negative. Complains of vague and migratory painful sensations in the hypogastric and in both inguinal regions.

He believes he is not entirely well from his urethral trouble. Attempts to convince him of the contrary proved unsuccessful. Nervines and tonics seemed but little to influence his condition; neither was suasion of any particular value in ridding him of his imaginary trouble. He commenced to lose weight rapidly and refused to be treated any longer, all the time vehemently begging for relief from his urethral disease. He left for the East to visit his parents. Their family physician informed the author later that his patient contracted the fulminant type of phthisis pulmonalis and is rapidly dwindling away. This case illustrates the far-reaching effects of gonococic urethritis indirectly, and the possible consequence of this to some people trivial affection of the urethra.

Case 2. M. B., aet. 20; fruit vendor, unmarried. Family history negative. Past history: Has had repeated outbreaks of herpes preputialis and two years ago multiple chaneroids. St. pr. Prepuce considerably elongated. Gonococic urethritis for the first time. All urethral symptoms have completely disappeared, save for a few thin, curly and twisted shreds in the urine in the canal. Microscopic examinations of the deposit (procured on centrifugal 4 c.c. of urine) by Gram's stain was devoid of any positive results. He complained bitterly of pain in the back and hypogastric region. Urine normal; no pathological constituents, save indican. Sp. gr. 1024. Temperature and pulse normal. He attributes these painful sensations to the uncured urethral disorder, and he persistently maintains he is not perfectly well as yet, although the most scrutinizing urethroscopic examination in addition to the above evinces the contrary. The pain in the lumbar and vesical regions is getting worse from day to day; his mind unceasingly ponders over his imaginary condition, which he regards as serious. Internal medication intending to improve his general and nervous tone, supplemented by proper hygiene and diet, utterly failed. At present the patient is still under surveillance, but it is difficult to foretell at the present juncture how this case will terminate. In this case a circumcision was performed with a view to diverting the patient's morbid attention.

Case 3. L. G., aet. 23; single; clerk. Past and family history

negative. St. pr. gonococcic urethritis for the first time. Was treated by an advertising charlatan. Duration of disease and treatment, fourteen weeks. No flocculi or filaments in the urine. Micturites regularly and normally. No gonococci found on repeated examination with double stain. Complains of pain in the meatus urinarius, independent of urination. The urethroscope reveals the urethra intact. (Combined inspection.) Urethra patulous and no strictures present (28 French). He claims that the pain is worse at night, of a darting or shooting character and of but brief duration. His appetite is poor and he is losing flesh. The high cerebral stimulants availed but little. Suasion and reasoning proved futile. He acquired a haggard, pinched, hangdog expression, walks stoopingly and haltingly, though formerly he was robust and his gait was straight and manly. He has consulted a number of physicians and nearly all of them pronounced it neurasthenia or "nervousness." He ultimately returned to the author, intimating that he is on the verge of committing suicide, if his condition did not assume a more favorable aspect.

These are only a few of a number of instances from the author's records coming under his observation, that proved exceedingly rebellious and unyielding to any form of treatment, on account of the psychic or suggestive features of the malady. It is very likely that the suicidal inclinations of the patient thus affected may at times be realized by him, or else he may drift into an asylum as the unhappy recipient of various mental disorders, the origin of which can doubtlessly be traced to the previous existence of some pathological condition of the urethral canal and its adnexa, pre-eminently so gonococcic or specific urethritis. Under a systematic vigilance in a retreat or asylum, with the aid of proper hygiene and dietetic treatment, compulsory but wholesome outdoor work and exercise, whereby the mind will receive an impetus in a different direction, together with both mechano-therapy and general massage, a cure might be reasonably expected in time. The fact remains, however, that these cases furnish the most unsatisfactory class that falls to the lot of the genito-urinary surgeon.

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FAULTY VISION AS A FACTOR IN ILL-HEALTH.*

BY W. W. KABAR, M.D.

IN our lifelong struggle to preserve health and to overcome disease any suggestion we may receive as to probable and as yet generally unrecognized causes of ill-health must be of the greatest interest not only to the suffering patients, but also to the medical profession. If

* Read before the East Side Physicians' Association, Detroit, Mich.

the perpetual grind of the practitioner's life would not be enriched and ennobled by the desire to help, to learn, and to give more than he receives, the best in him would perish and the basest element prevail. Knowing that the best in us is craving for more knowledge and new weapons to be used in our glorious war against death, I hope that what I have to say about as yet not officially recognized causes of ill-health will be read with interest and without antagonism.

There is living in Atlantic City, N.J., a man, who thirty years ago came before the medical profession with a new and far-reaching theory that functional diseases were the forerunners and causes of organic diseases and that the functional diseases were caused by entirely unsuspected irritants, amongst whom the eye was the most frequent cause. He proved his theory not only to his own satisfaction, but also to the satisfaction of numerous physicians and patients. But instead of taking up his claim and proving or disproving it by facts and experimentations, the official world neglected him, derided him or belittled him. The history of Semmelweiss and other discoverers of great truths repeated itself in this case. But fortunately this discoverer, Dr. Geo. M. Gould, was not only a genius, but also a philosopher, a superb writer, a born fighter and a successful practitioner. So he kept on hammering away at ignorance until at last he lives to see the tide turning his way; he lives to see that the leaven of his teachings begin to change the practice of medicine to the better. We begin to find it perfectly in accord with good physiologic and pathologic teachings, that long-continued irritation will cause pathologic changes in our organs. If we stimulate the gastric nerve the result would be a hypersecretion of the gastric juices; if we continued the stimulation for a long time a gastritis would follow; if the gastritis be not cured or relieved an organic change would result in the gastric wall with a whole train of pathologic sequelæ.

The same would hold good of any other organ. Sexual imaginings will bring about reflex hyperæmia of the prostatic glands or the ovaries, as the case may be. Long-continued and oft-repeated functional hyperæmias will finally cause an organic enlargement or inflammation of these glands, who on their part again would produce a variety of local or reflex symptoms.

It is on account of such experiences that Dr. H. A. Wilson wrote: "With the exception of the infectious diseases (not always then), the traumatic, and a few unimportant others, all organic disease is of functional origin. The rule of physiology is that no muscle or set of muscles can be innervated continuously for long. Whenever this too long innervation exists, physiology passes into pathology, until, finally, functional passes into organic pathology."

All this is especially true of the eye, because it is anatomically more

endowed with nerves than any other organ, and because it is the most abused part of our body.

Physiologically the eye is the most important organ connecting us with the world outside. Vision dominates speech, writing, thinking and locomotion. Without vision there could be no life as we live it, no civilization. To see correctly is to avoid dangers and live; to see faultily is to perish. To continue life nature sacrifices every other function before it endangers sight.

To protect the eye and its sublime office it gave it the 2nd, 3rd, 4th, part of the 5th, the ophthalmic ganglion connecting it with the sympathetic, and the 6th pair of nerves. Through their roots these nerves are connected, indirectly, with the rest of the twelve pairs of nerves.

The purpose of the eye is to give us clear and distinct vision with no effort or the minimal amount of effort compatible with health. But does it do so? Not always. To do this it must not only act physiologically correct, which it usually does, but it must be optically perfect, which it never is.

The difference between a perfect eye and a faulty one may be only a difference in the diameter of the eye of 1-300th of an inch in one of its meridians. The most perfect eyes declared are on careful examination found to be imperfect. This imperfection, slight though it be, is sufficient to throw a blurred image on the retina, provided the ciliary muscle does not counteract this defect by compressing the lens (accommodation). The compression of the lens has to be kept up, continuously without intermission, as long as the eye is kept open and light strikes the retina.

As the overuse or abuse of as delicate an organ as the eye, endowed with so many sensitive nerves, is bound to produce baneful effects, why does not everybody suffer from eye-strain? For the simple reason that not everybody's defects are of equal seriousness, that everybody's reserve-energies and health are not alike and that the use or abuse of the eyes of different people are different.

Comparisons are always faulty, but if I am permitted I will compare our body to a household.

In eye-strain we would squander our income unnecessarily. A rich man, living on a vast income, may never notice that there is a great deal of superfluous expense in running his house; he will either consider his household economically managed, or, in case his attention be called to the waste, refuse to be bothered by such insignificant item.

The man of the middle class will do exactly as the rich man does, as long as times are good. But should his business take a reverse, we will notice him become very critical about the expense account. He may

even go as far as to eliminate certain extravagances, only to relapse into his old ways as soon as the times get better.

But in the case of a working-girl or a day-laborer, the shortage of one dollar a week very often means a calamity, and the continuous waste of such a small sum spells utter ruin to them.

That is the reason why we see so many people use their evidently faulty and uncorrected eyes without evil results. But the loss of health is there just the same. No amount of cleaning the sewers, or overhauling the furnace, or looking after electric wiring, not even a surgical operation on the back porch will remedy the extravagance, except the prevention of the leak. The only way to stop the leakage of health through the eyes is proper and most careful correction of the error by means of scientific glasses.

Nature does not talk to us in words, but in sign-language. To study medicine is essentially learning to understand a few of nature's signs. The more signs we understand the better diagnosticians we are. Until lately the sign-language of the eye was practically meaningless to us and therefor neglected, when Dr. Gould happened to get a clue by a few clinical cases reported by Dr. S. Weir Mitchell and one or two other physicians and starting from this clue he deciphered so many important signs, that a new chapter was begun in the history and practice of medicine.

Firstly Gould brought out forcefully the idea about functional diseases originating organic diseases.

Secondly, he dwelt upon the significance of eye-strain in the local diseases of the eye. Conjunctivitis, blepharitis, muscular imbalances, paresis, ulcerations of the cornea, iritis, senile cataracts and glaucoma are partly or wholly proven to be the ill-results of perpetual innervation.

Thirdly, Gould discovered the greatest and generally overlooked influence of ametropia (faulty vision) and incorrect posture of school children in writing in producing spinal curvatures. This is brought about through the effort of astigmatic eyes to see vertical lines clear and correct. Most everything on earth has its principal lines vertical. Where the axis of the astigmatism is not vertically located, but slightly to either side, the person so afflicted will tilt his head slightly in order to bring his "off-axis" in a vertical position, but in order to counteract this tilt and to bring his head back to the vertical position he bends his spine in the opposite direction and so produces functionally a curvature of the spine (scoliosis), which gets to be organic between the ages of 15 and 20.

This scoliosis cannot be greatly relieved by braces, instruments, massage or gymnastics, but it can be *prevented* by wearing *correct* glasses.

Dr. H. A. Wilson writes in the *N. Y. Med. Jour.*, 1906: "It is an

accepted axiom that any prolonged alteration of the normal relations that exist between the axis of the pelvis and the shoulders will invariably produce scoliosis. This might very properly include any persistent alteration of the position of the head."

And Dr. Albert Abrams shows in his book on spodylotherapy the evil tendency curvature of the spine has in causing innumerable functional lesions and neuroses, which all end in organic deterioration, all causing an enormous amount of suffering, unrelievable by our usual methods of treatment.

Fourthly, Gould discovered another cause of ill-health arising out of our tendency to make over left-handed children into right-handed people.

The reason why a child prefers its left to the right hand is that his left eye has better vision than the right one. As both halves of the brain are alike in form and capacity and both are born without impressions, it depends on the number of impressions it receives to develop in the dominant half. If the right eye is the better one the left brain gets the clearest impressions; if the left eye is better than the right one, the right brain gets them.

Now, it is a fact that the left half of the brain innervates the right side of the body, and vice versa, so by having a better right eye, and at least 90% of all people have a better right eye, the impressions go to the left brain and thence the stimulus to the right arm. After having received our first and most lasting impressions in one half of the brain it is entirely impossible to use with equal facility the other half, and only with difficulty under great disadvantages.

As the centres of speech and writing are located only on one side of the brain (right side for left-handed and left side for right-handed people), and the visual centres dominate the speech and writing centres, the result of our effort to change left-handed children into right-handed ones produces awkwardness, neurotics, stammerers, hesitators and abnormals of all kinds.

Fifth, Dr. Gould had the courage to claim and the ability to prove that eye-strain can and does stimulate to faulty action, and one or more than one of our organs of digestion, elimination and secretion into functional abnormalities.

In his presidential address in the annual meeting of the American Medical Association, 1906, Dr. Musser said: "Who has not seen correction of errors of refraction relieve so-called bilious attacks, periodical vomiting, anorexia, indigestion, and other symptoms?"

If any one has not seen it, the observing oculists have certainly seen innumerable patients cured of their stomach troubles, as if by miracle, by a pair of glasses.

Sixth, comes finally Gould's great service in calling our attention to the great class of eye-strain sufferers, who suffer from chronic headaches, migrain, nervousness, neurosis, insomnia, epileptoid or epileptic seizures, and finally the suicides and the insane.

Only a few days ago an article written by Dr. C. E. Pronger, of the Harrogate Infirmary, Harrogate, Eng., was published in the *Amer. Med. Jour.*, in which he says: "I firmly believe as a result of long experience, error of refraction to be the most constant and most powerful predisposing cause of insomnia."

He goes on to relate a number of cases, in which he proved the beneficial action of good glasses on all kinds of neuroses, and finishes: "We must hope for a diminution of this appalling number of suicides, and relief and happiness may be brought to that vast number, who, victims of insomnia and neurasthenia, or 'nervous break-down,' are dragging along a miserable existence."

Without taking recourse to my records, and writing from memory, I wish to illuminate the above by mentioning the case of a school principal wearing very strong cylindrical glasses, who suffered from violent pain in her right shoulder and arm whenever her glasses were worn bent and so the axis of the cylinders changed.

One of my physician-patients suffered from agorophobia (fear of crossing open places and streets) which symptom was greatly relieved by correct glasses.

One patient, a storekeeper, 56 years old, was cured of his vertigo, sinking spells and faintings by a pair of glasses.

A woman of 36 years, who had suffered for years of neurasthenia and denutrition, was immensely improved by careful refraction.

A woman of 48 I cured of migrain of twenty years' standing by refraction.

A mechanical engineer, whose trouble was diagnosed by an oculist as glaucoma and who treated him for this malady for six or eight weeks, the eyes of the patient certainly showing an abnormal tension, I refracted and cured by glasses. Of course, the patient had no glaucoma.

An insurance agent who was treated for rheumatism and syphilis and who was told by more than one physician that he would have to take anti-rheumatic and anti-syphilitic remedies for the rest of his life, was cured by glasses.

I mention these cases at random, not because they were exceptional cases, but because they came only lately under my care, because I have seen all of them long enough to know that the results were real and permanent, and because all of these patients had worn glasses for years without benefit, so there could be no question about suggestion.

I do not by any means want to insinuate that all functional dis-

eases or all reflex symptoms are caused by eye-strain; this would evidently be foolish and proposterous, but I do wish to state that of the many factors causing reflex symptoms the eye is not only the most overlooked, but also the most fruitful factor.

In conclusion: What are we, as general practitioners, to do about relieving functional troubles?

Firstly: Let us always keep in mind the etiologic factor of the eye. Except when we have positive reasons to suspect other causes producing the symptoms, let us have our patients refracted by a careful and competent man. *Never* take it for granted that the fact that your patient wears glasses means that the glasses are correct. As a matter of fact, not more than 25% of all glasses worn are in hailing distance of correctness.

In case you can not send your patient to an oculist, or in case the glasses do not relieve the symptoms, and still you have reasons to suspect the eye, use the atropin test by instilling a 1% atropin solution once a day for ten days in both of your patient's eyes. This will in almost all cases paralyze the accommodation, stop the eye-strain, and, in the latter case, give immediate relief.

As we are all ready and willing to test the patient for syphilis by giving him K. I., we ought, with as much justification, be willing to test our patients with atropin for eye-strain.

Educate your patients, that it often takes a good deal of time, a good many examinations, and repeated trials to eliminate, in difficult cases, all errors of refraction.

Also remind your patients of the fact that the eye is an ever-changing, living organism, and not a stationary glass ball, and that consequently the examination of the eyes has to be repeated whenever the refraction of the eye has changed.

Finally: Inform your patients that as a rule one who needs glasses for reading also needs them for distant use and vice versa.

Only by thus upholding the hands of the refractionist and by cooperating with him the immense benefits he could and would bestow on humanity would be given in the fullest measure.

510 Fine Arts Building.

THE CANADIAN RED CROSS SOCIETY AND ITS WORK.

By COLONEL G. STERLING RYERSON, M.D., President of the Society

INASMUCH as the Canadian Red Cross Society is closely allied with the medical service and does its work in connection with it, some account of its organization and work may be of interest to the profession at the present time.

ORGANIZATION.

It was originally organized by the writer as the Canadian branch of the British National Society for Aid to the Sick and Wounded in War, in 1896. Its organization was enlarged and completed in 1909, when it was incorporated under its present name. This organization comprised provincial branches in all the provinces, under whom are the local branches, now numbering one hundred and sixty-five, and distributed from Halifax to Vancouver.

HOW GOVERNED.

The society is governed by a central council of eighteen members, to whom are added one member elected by each provincial body. From the central council, which has its head office in Toronto, are selected seven members, who, with the officers, form an executive committee and who exercise the functions of the council when it is not in session.

OBJECTS.

The Canadian Society is affiliated with, but is not a branch of, the British Red Cross Society, and has for its aims and objects to collect funds and material and to provide assistance in time of war. To examine, systematize and co-ordinate all offers of help, in order to prevent overlapping. It also has power to train men and women in first aid and home nursing and to form First Aid Detachments.

FORMER ACTIVITIES.

During the Spanish-American War it accorded some help to the belligerents, and during the South African War its work was extensive, sending large quantities of medical supplies and comforts to the front, besides expending some \$30,000 in various aids to the sick and wounded.

ITS ACTIVITIES IN THE PRESENT WAR.

Within three days after war was declared a meeting of the executive committee was held and a programme of work was determined upon. An office and depot was opened, branches were formed and the collection of money and supplies was begun. Thanks to the generosity and sympathy of the public much has been done, but more remains to be accomplished, especially if the war is to be of considerable duration.

The first duty of the society was to aid the hospitals at Valcartier and Quebec. Large quantities of hospital foodstuffs, comforts of clothing, oil stoves, toilet soap, towels, operating gowns, rubber gloves, etc., were sent. When the contingent moved off it carried with the hospitals large quantities of stores furnished by the society. Since the arrival of the contingent in England large quantities of supplies have

been forwarded to the Canadian Red Cross Commissioner, Lieut.-Col. C. A. Hodgetts, in London. These supplies are drawn on by the Canadian hospitals or are distributed to the British Red Cross Society on requisition. The following are some of the articles sent and the quantities of each: Roller and triangular bandages, 50,000; bed jackets, 5,900; bed socks, 8,733; blankets, 24,305; sleeping caps, 4,422; cholera belts, 4,398; housewives, 6,490; invalid kit bags, 3,844; pneumonia jackets, 1,729; surgical pads, 1,429; ice bag covers, 1,668; hot water bottle covers, 6,490; pyjamas, 5,275; pillows, 20,247; sheets, 7,373; shirts (flannel), 32,220; night-shirts, 10,224; pairs of socks, 56,290; sweater coats, 6,489; towels, 15,228; drawers and undershirts, 6,709.

FOODS AND MEDICAL SUPPLIES.

Arrowroot, 400 lbs.; biscuits, 4,000; cream, in tins, 800; corn flour, 1,000; condensed milk, 1,000; jams, 5,000; Oxo cubes, 3,040; crutches, 200 pairs; rubber sheeting, 1,000 yards; hot water bottles, 386; other articles, including hair brushes, tooth brushes, combs, razors, stationery, thermos flasks, plain gauze, 7,000 yards; bichloride and iodoform gauze, rubber gloves, chloroform, talcum powder, toilet soap, 15,000 cakes; pipes, games, tobacco, cigarettes, rice, bed pan covers, dressing gowns, knee caps, arm slings, sponges, wristlets and many other articles which need not be enumerated, as sufficient has been said to give an idea of the material required.

FINANCIAL AID.

In addition to the long list of material shipped it should be mentioned that the central executive committee have rendered financial aid as follows:

\$75,000 in cash has been sent to the British Red Cross Society for immediate aid. It has also supplied twelve motor ambulances, at an average cost of \$2,000, to the British Society, and has supplied seven motor ambulances and a complete motor kitchen to the Canadian contingent. These latter ambulances are somewhat larger and more powerfully engined than those given the British Society, costing \$2,500 each, whereas the motor kitchen cost \$3,500. The executive have paid the cost of one coach in the Red Cross train, viz., \$9,500. In addition they have provided all the equipment of the Duchess of Connaught Canadian Red Cross Hospital, at Clevedon, Berkshire, at a cost of \$10,000. Large quantities of supplies have been ordered to be sent to the Queen Mary Canadian Military Hospital at Shorncliffe, and to the Franco-Canadian Hospital at Dinard, Normandy. From all this it will be seen that the Canadian people through the medium of the Canadian Red Cross Society have been able to do something to relieve the discomforts and suffering caused by the war.

REMARKS.

I am often asked why should voluntary aid take the place of supplying what should be the duty of the Government to supply the wants of the sick and wounded? The answer is that no Government can keep up in time of peace a medical establishment capable of coping with the requirements of war, and especially of modern war, with its hordes of wounded, and because the Red Cross is the medium of the expression of the sympathy of the people. The Red Cross is the sole means of communication between the public and the sick and wounded, and aids all wounded, irrespective of creed, color, race or country. It is therefore the broadest philanthropic society in the world and deserves the support of all feeling and thinking men. Its work is confined under British law to the sick and wounded only. The comforts of the fighting man in health is cared for in this country by the Canadian Women's Patriotic Service League, and the distributions are made by the Canadian War Contingent Association in England.

Toronto, December 15th, 1914.

PULMONARY ABSCESS AND BRONCHIECTASIS.

1. The differential diagnosis of true lung abscess and suppurative bronchiectasis is important.
2. Radiographical study of each case is essential.
3. Bronchoscopical examination is a valuable procedure and should not be omitted.
4. Drainage of a lung abscess by thoracotomy is likely to result in cure.
5. Drainage of large infected bronchiectasis may be followed by improvement, but complete recovery is unlikely.
6. Extensive thoracoplasty should be reserved for those cases in which other operations have failed.
7. Exploration of the pleural cavity and of the lungs by intercostal thoracotomy is feasible and reasonably safe.
8. Extirpation of a bronchiectasis by removal of the affected portion of the lung may lead to complete recovery, but the danger of the operation is great.
9. Artificial pneumothorax and Tuffler's extrapleural tamponade should be reserved for cases of pure tuberculosis.
10. Intratracheal insufflation is a simple, accurate, and safe method of securing differential pressure.
11. Operations involving one lung can be performed with inhalation anaesthesia.—*Tr. Am. Surg. Ass.*, N. Y., April, 1914.—*Med. Times.*

CURRENT MEDICAL LITERATURE

MEDICINE

ARTIFICIAL PNEUMOTHORAX.

H. Morrision Davies (*Brit. Med. Jour.*) discusses the therapeutic value of nitrogen displacement of the lung in pulmonary tuberculosis and believes this to be considerable if the case is properly chosen and the treatment properly conducted. The early acute lesion responds better than the chronic fibrous one, and there is greater likelihood of finding a free pleural space in the former than in the latter. But all well defined or suspected cases of pulmonary tuberculosis, with very few exceptions, may be suitable for this form of treatment. To determine its suitability, it is necessary to prove that sanitarium or general measures have not checked the disease in a period of three months; this is best done by taking a radiograph of the lungs at the first visit, and comparing these findings by those shown by a subsequent plate. This course should not be followed in cases of pulmonary hemorrhage; here immediate resort to pneumothorax is the most efficient means of controlling the bleeding. Presence of a tuberculosis lesion in the other lung is no necessary contraindication of the pneumothorax treatment. The proper method of making a pneumothorax is to administer a dose of morphine some time before the puncture, and to anesthetize the track of the needle thoroughly, preventing all danger of pleural reflex. The first injection should consist of 100 c. c. of oxygen gas followed by an equal amount of nitrogen, thus reducing the initial reaction to a minimum, so that the temperature usually falls after two or three days. Two days after, 350 c. c. of nitrogen are injected, and so long as there is no reaction, injections can be made at intervals of two days, giving 500 c. c. and 750 c. c. and repeating this amount until the pressure during inspiration stays below plus one mm. of mercury. The author believes that displacement of the lung should be maintained for eighteen months. This method has been tried in the treatment of bronchiectasis and putrid bronchitis with no good results, excepting the forcible emptying of the accumulated fluid from the lungs.—*New York Medical Journal.*

DIAGNOSIS AND PROGNOSIS OF CONGENITAL CARDIAC LESIONS.

M. Abelman, St. Petersburg (*Ergeb. Inner. Med. und Kinderhke*, 1913, vol. xii., p. 143), in a very interesting paper the author remarks on the great difficulty of making a diagnosis of the exact lesion in any

individual case, and on the uncertainty of the symptoms of any particular anomaly. As the heart in the child is more horizontally placed than in the adult he holds that the area of cardiac dullness is not of so much value in deciding whether the right or left ventricle is enlarged, and that a truer idea of the conditions is obtained by means of X-ray examination. It is by auscultation, however, that our most helpful information is obtained, although here also, since congenital anomalies of the heart are usually multiple and not single, it is not infrequently impossible to make a correct anatomical diagnosis.

The author attempts to give guides from an analysis of 34 cases which he has personally observed. He first of all deals with the differential diagnosis between congenital and acquired cardiac disease, a point of no small difficulty when the case first comes under observation at the age of two or three or more years. Functional murmurs due to anaemia he admits are decidedly rare under four years of age, but when present are invariably systolic in rhythm, loudest at the base, never conducted to the back, and usually disappear in the recumbent posture. The history of the case is of value in differentiating between congenital and acquired lesions, as, *e.g.*, if the child were known to have been born healthy and to have remained so until being attacked by some acute infection, when dyspnoea and palpitation developed, then there is great probability of an acquired lesion. On the other hand a history of cyanosis, dyspnoea, and palpitation during the early months of life is in favor of a congenital lesion, and this possibility is enhanced if there are other deformities present. Instead of cyanosis, an important sign of congenital heart disease, there may be extreme pallor, as was noted in nine of the author's 34 cases. The cyanosis, too, may only appear later—the “*forme tardive*” of the French. Cyanosis, when evidence of acquired heart disease, is a late phenomenon, and is usually accompanied by œdema and serous effusion, both of which are conspicuous by their absence in congenital heart affections. Clubbing of the fingers and toes, increase in the number of red blood cells and in the percentage of hæmoglobin, are other features of congenital mischief, but are only present when the condition is well advanced. The murmur in congenital disease is, as a rule, loud, audible over a wide area, and at no one place can it be said to be of maximum intensity, whereas in acquired mischief the opposite is the rule. It is usually systolic in rhythm, and may be diastolic as well, but never diastolic alone. A loud murmur with enlarged heart and weak cardiac impulse points to some cardiac defect. It may be, and often is, possible to say that some congenital cardiac lesion is present, but to diagnose the exact anatomical conditions is one of the most difficult of problems—in fact, Heubner has remarked that it is vain to attempt any such thing.

The following, nevertheless, are the chief diagnostic features of the various individual, and combinations of, congenital anomalies. A V.S. murmur as loud in the interscapular region, and especially on left side, as over the pericardium points to a *patent ductus arteriosus*; in *pulmonic stenosis* the murmur may be well conducted behind, but it is never louder there than in front; in *pure pulmonic stenosis* the second pulmonic sound is almost or wholly inaudible, due in great part to the fall of blood-pressure in the lesser circulation, but where this lesion is complicated by a *patent ductus arteriosus* the second sound may be accentuated.

In nine of the author's 34 cases a *defect in the interventricular septum* was diagnosed, and verified *post-mortem* in three of them. In all a loud, rough and practically continuous murmur was audible, with its seat of maximum intensity about the middle of the sternum and not conducted into the vessels of the neck. The cardiac sounds could be recognized distinctly, and the second pulmonic sound was of normal volume. In the cases (two in number), in which this lesion was present alone, cyanosis was absent, whereas in one case, where pulmonic stenosis existed in addition, cyanosis was evident.

A *patent foramen ovale* does not, according to the author, allow of a definite diagnosis.

Pulmonic stenosis—the commonest of all lesions—and met with fifteen times in the author's series—seems to be incompatible with long life. The usually considered characteristic symptom—early cyanosis, V.S. murmur, with seat of maximum intensity in the second left interspace, and weak or absent second pulmonic sound—are seldom found in practice, because this lesion is hardly ever present alone. When accompanied by a patent foramen ovale, persistence of the ductus Botalli, or by a defect in the interventricular septum, the second pulmonic sound is still present or even accentuated. With a persistent ductus arteriosus the V.S. murmur is rougher, conducted into the vessels of the neck, and, as previously mentioned, the second pulmonic sound is accentuated; percussion may reveal in the second left interspace an area of dullness, which X-ray examination has demonstrated to be due to the dilated duct. Example: Child, *æt.* 12-12 years; marked cyanosis; strong apex impulse in fifth and sixth interspaces; cardiac dullness increased to left as far as anterior axillary line; V.S. murmur at base, with seat of maximum intensity at pulmonic area, and with a diastolic element over manubrium sterni; second pulmonic sound accentuated. At age of 2½ years child passed successfully through an attack of scarlet fever, but died at age of 4½ years from pneumonia. *Post-mortem.*—Pulmonic stenosis, with a much dilated and patent ductus arteriosus.

So far as *aortic stenosis* is concerned, those cases with narrowing of the isthmus are alone of clinical interest. Example: A girl first came under observation at the age of 2 years, with a history of breathlessness and palpitation in the early days of life; never cyanotic. The pulse was anaerotic, the apex beat situated in anterior axillary line, and the whole precordium bulged. At base a rough V.S. murmur was audible, as also both second pulmonic and aortic sounds. In general, it may be stated that the symptoms of stenosis of the isthmus are identical with those of acquired aortic stenosis.

For the diagnosis of *persistent ductus arteriosus* the following combination of symptoms is of value: A rough V.S. murmur (when an aneurysmal dilatation of the ductus develops a V.D. element appears), with its seat of maximum intensity at the sternal end of second left interspace, and at times louder in the left carotid than in the right. Gerhardt has drawn attention to a small patch of dulness situated in the second left interspace, and capping the cardiac dulness. By means of the X-rays, Zinn has shown that this area of dulness is probably due to a dilated ductus arteriosus and pulmonary artery, as with the fluorescent screen definite pulsation is visible. Sokolow, of Petersburg, holds that inequality of the radial pulses is met with in this condition, and the pulsus paradoxus is also mentioned as a sign of a persistent ductus Botalli. Hochsinger considers *transposition of the great vessels* probable when the cyanosis is extreme, the heart's sounds pure, and the second sounds at the base accentuated.

While discussing the question of prognosis, the author mentions a case which first came under observation, with marked cyanosis and a loud V.S. murmur, at the age of 6 months. At the age of 6 years both the murmur and cyanosis commenced to get less marked, and at the time of writing the patient is a healthy-looking girl of 23 years. It cannot, of course, be declared, he admits, that the condition has healed, since severe congenital cardiac anomalies may be unaccompanied by either murmur or cyanosis. So far as prognosis is concerned, it can only be said that when dyspnoea is marked the outlook is grave, and that when X-ray examination does not reveal any enlargement of the heart, it is unlikely that the defect is of any severity.—*Glasgow Medical Journal*.

DIAGNOSIS AND TREATMENT OF PLEURISY.

Königer gives a collective review of this subject with especial reference to progress. The affection he regards as almost invariably secondary. Under symptomatic diagnosis there is not much actually new to

record. Two triangles, the Garland and Grocco-Rauchfuss, have been isolated with especial respect to the routine physical examination and these seem to elevate percussion above auscultation, the latter giving many equivocal results. The X-ray is of especial value in incipient and localized pleurisy, notably the diaphragmatic and interlobular forms. Trial puncture needs no discussion. Under etiological diagnosis the author lays great weight on the history and general examination, with especial reference to the possibility of tuberculosis. A complex case suggests the latter. The pleuritic exudate, already mentioned as a symptom, must be carefully studied for its physical, chemical, bacteriological, serological, and histological qualities. Nevertheless, it is seldom that one finds an efficient cause, like a bacterium in pure culture. Animal inoculations, once so commonly practiced with scanty results, now give something like 80 per cent. of positives if we wait for weeks, which, of course, is prohibitive in practice. Even the antiformin method of studying sediments may require hours to find a few isolated tubercle bacilli. Hence for one or another reason study of exudates is not practical; with rapid methods results are usually negative. Of greater significance is the cell count of the centrifuged effusion. The technique, despite the comparatively rapid results, is complex. A great abundance of lymphocytes suggests tuberculosis in an acute febrile pleurisy, but should the condition be chronic this lymphocytosis does not possess much diagnostic value. An excess of polynuclear leucocytes in recent cases is far from excluding the presence of tuberculosis. In empyema there are several well marked differences between the ordinary purulent and tuberculous forms, one of which relates largely to the fate of the leucocytes. The cytology of pleural exudates is too extensive a subject to be summed up in a few words. This study is more or less a side issue at best because advances in our technical resources for diagnosis seem to render the non-tuberculous or rheumatic case the exception. We may, of course, temporarily assume that a given case which presents no immediate evidence pointing to tuberculosis is nonspecific and treat it symptomatically. If pus is evacuated for relief, it should, of course, be examined for tubercle bacilli. The author approves of the theory that the pleura is the natural protector of the lungs from the action of disease germs; for example recovery from tuberculous pleurisy causes a general recession of all the phenomena of tuberculous origin. In regard to treatment not much is to be said. In large effusions we have numerous surgical resources; but in certain cases of localized tuberculous pleurisy local treatment can be dispensed with, general measures being sufficient.

—*Medical Record.*

PHARMACOLOGY OF DIGITALIS.

Gottlieb (*Archives des maladies du coeur, des vaisseaux, et du sang*, January, 1914) recently communicated to the XVII Congrès International des Science Médicales a paper on recent advances in treatment by digitalis and its derivatives. He insists on the inapplicability of results obtained by experiments on normal animals to morbid states. He instances camphor as an example. In health this drug has little or no effect upon the circulation or upon the heart. In vasomotor paralyses, on the contrary, the irritability of the vasomotor centre is markedly augmented, and the heart, which has almost ceased to beat from any cause, starts off again after a dose of camphor. The present task of pharmacology in relation to digitalis is to experiment in diseased conditions with minimal doses, which scarcely affect the normal circulation. The slowing of the heart-beat, so much insisted upon by Cushny and his collaborators, occurs only in that form of arrhythmia connected with auricular fibrillation. It is not in this way that the classical effect of digitalis in conditions of venous stasis, where there is neither arrhythmia or abnormal rapidity of the pulse, can be explained. The author divides the digitalis group of substances into two classes—those which are easily absorbed by the heart muscles and as easily disengaged, and those which are more slowly absorbed and act over a longer period. In the former class is strophanthin; in the latter digitoxin; others are intermediate. It has been shown that there are differences in the effect of the gastric and intestinal contents under different circumstances. Strophanthin is easily altered in the stomach and intestines. Digitoxin is much more stable, but is absorbed with difficulty. Ogawa has shown that digipuratum is fairly well absorbed, except where there is portal stasis, when absorption may be almost *nil*. The drawbacks incidental to the administration of digitalis by the mouth are avoided by giving strophanthin or digipuratum intravenously. In therapeutic doses intravenously neither nausea nor vomiting occur. For this and other reasons it would seem that gastric disturbance apt to be caused by digitalis is due to a local irritating action on the mucous membrane and not to an excitation of the centre of vomiting. Digipuratum is recommended as the best form in which to give digitalis by the mouth. It is soluble in slightly alkaline media, is thus easily absorbed in the intestine, but passes through the stomach; it is fairly stable. The pure glucosides isolated from digitalis do not seem to have all the therapeutic properties of the leaves. Digipuratum is a mixture of the totality of the active principles, but in view of the inconstancy and variability of these, and our want of definite knowledge regarding them, it is best that the dose for each case should

be ascertained by careful trial. The physiological method of standardizing digitalis preparations is to be preferred, but presents practical difficulties. By injecting different quantities of a preparation, the quality of which is known, into the lymphatic sac of the frog (after the method of Houghton) its strength can be estimated, but the quality of different specimens of digitalis leaves or preparations varies so much that experiments on warm blooded animals are also required, in order to obtain a complete estimation of the value of any particular specimen.—*British Medical Journal*.

THE TRAUMATIC NEUROSIS.

Dr. Tom A. Williams, M.B., C.M., (Edin.), Washington, D.C., President Washington Society Nervous and Mental Diseases, Corres. Mem. Soc. De Neurol, Paris, etc., in the *American Journal of the Medical Sciences*, makes the following statements:

Of this misnomer the cause is shown to be purely psychic, derived from a false notion of the patient which induces depressing emotions which disturb both the bodily health and life relation. A clear illustration of the mechanism is that of the "conditioning" of the gastric reflex of dogs by psychological stimuli whether these are pleasurable or painful. The removal of the extraneous suggestion would remedy the neurosis but for the fact that memory maintains its action. So that the mental content must be modified at its foundation, and this requires considerable analysis of the patient's trends. Hence the complete failure of such naïve procedures as reassurance and suggestion.

Law suits and malingering, so often interwoven with these cases, have created misunderstandings. But indemnity is not necessarily curative even of the malingerer. A case which lasted seven years is quoted, after receiving heavy damages.

In the complicated case, proper psychological reconstruction, made possible by clear analysis, inevitably cures, as the mechanism of neurotic disturbances after accidents differs in no way from that we find when there has been no accident at all. Furthermore, its nature is not of a complexity beyond the understanding of a layman; so that its principles can readily be grasped when presented in court by an expert witness who really understands them.

ABDERHALDEN TEST IN MENTAL DISEASE.

Charles E. Simon, Baltimore (*Journal A. M. A.*, May 30, 1914), takes up the claims of Fauser as to the findings of the Abderhalden test in certain types of insanity with special reference dementia præcox. He reviews the literature which followed Fauser's publication and says that in surveying it one cannot help but being impressed, on the one hand by the wonderful uniformity of the results reported by Fauser and the wide divergence from those of certain other authors, like Hauptmann and Bumke. He thinks that there is good ground to suspect that Fauser was too enthusiastic in his views and also that his opponents may have lacked complete control of the technic. Fauser himself states that he obtained a reaction with sex gland repeatedly in cases in which it was unexpected and that the diagnosis between maniac depressive insanity and dementia præcox could not always be made with certainty. Simon relates his own experience with the use of the test in 106 cases and says "to summarize the results" that a sex gland reaction may be obtained in nearly if not all cases of dementia præcox at some stage or another but that this action is not specific as Fauser asserts. He finds that the reaction may also be obtained in other forms of insanity and he does not attempt to explain them. He must therefore conclude that Fauser's rule has exceptions or that the positive findings in manic-depressive insanity or paresis are due to errors of diagnosis or technic. The fact, however, remains that in dementia præcox the positive reaction is the rule while in the purely functional psychoses it is the exception. Simon, therefore, discusses at length the technic employed and which he thinks meets fairly any criticism from the technical point of view as far as our knowledge goes at present. He believes, however, that advances can still be made and while we cannot, as yet, draw positive conclusions regarding the significance of the reaction in dementia præcox, certain possibilities suggest themselves. One of these is that of a perverted function of the cells concerned in the production of the internal secretion of the sex glands in dementia. "Considering the problem from the clinical side, the all-important question of course suggests itself whether or not the reaction has any relation to the pathogenesis of dementia præcox. Theoretically, this is of course perfectly possible. Granted that anti-sexgland ferments do occur in the circulation in dementia præcox, and that their presence were the outcome of the appearance in the circulation of an abnormal secretion or of abnormal cells, then we may also assume that digestion of these cells or cell-products will take place, and that all conditions would thus be given for a chronic protein intoxication which might very well expend itself on the central

nervous system. Should this be true, then we might also expect that the administration of sex gland to such patients would cause an aggravation of the patient's condition, while partial or entire castration, possibly combined with the transplantation of normal organs, might similarly be expected to have a beneficial influence. Evidently, the problem is now open to investigation from many sides, and it does not seem unreasonable to expect that definite advances will be achieved in the near future."

ADRENALIN CHLORIDE IN EXOPHTHALMIC GOITRE.

I. L. van Zandt records a case of exophthalmic goitre which he treated by adrenalin chloride solution (*Ameri. Med.*, April, 1914). Bearing in mind the alleged antagonism between the thyroid and the adrenals, he thought that the excessive action of the thyroid in the disease might be controlled and possibly cured by adrenalin. The patient, a woman of about 30, had one child aged 10. There was no history of miscarriages. She had generally good health until four and a half years ago, when she developed exophthalmic goitre. She has had but little treatment, and has steadily refused surgical measures. The author was summoned hastily to see her, and found her almost dead from "heart failure"; her pulse was very feeble and intermittent—60 to the minute. After strychnine hypodermically, followed by strychnine and a preparation of *cactus grandiflora*, she rallied by the next day; the depression seems to have followed a severe attack of vomiting. At this time she had extreme exophthalmos, tachycardia, and a large goitre visively pulsating, extreme nervousness, and a sense of something terrible impending; she had a constant headache with occasional very severe paroxysms. About eight days later six drops of adrenalin chloride solution was given four times a day; this was dropped into a spoon and a few drops of water added, but not enough to cause swallowing, and this was kept in the mouth to be absorbed therefrom. The author says this method is next to a hypodermic injection in rapidity and certainty of action. Within half an hour the visible pulsation had ceased and the flushing of the face was lessened. A month later all her signs and symptoms had greatly diminished, her nervousness was all gone, and she said she had never felt better. Her continuous headache had left her after the first dose, and had not returned. Van Zandt admits that she is not yet cured, but he claims that if this action of adrenalin is at all uniform in exophthalmic goitre it will furnish an excellent preparatory treatment for surgical intervention.—*British Medical Journal*.

SURGERY

UNDER THE CHARGE OF A. H. PERFECT, M.B., SURGEON TO THE
TORONTO WESTERN HOSPITAL

CELLULOID SPLINTS.

The use of celluloid splints in the treatment of paralytic diseases, especially in the after-treatment of acute poliomyelitis is strongly advocated by G. W. Robinson, Kansas City, Mo. (*Journal A. M. A.*, August 29, 1914). In his opinion the paralyzed limbs should be fixed in the normal position of rest and held in such a position by a splint which gives sufficient support to enable the patient to walk during the stage of repair, thus applying a physiologic stimulus to aid in the recovery of the muscle. All cases of paralysis of the legs are suitable for splinting, he says, except those with complete loss of power in the psoas and iliacus group and in the glutei; also those in which the back, lumbar and abdominal muscles are much affected. But if these alone are weak with little involvement of the legs, a spinal jacket is frequently helpful. The extent of the splint should vary with the extent of the paralysis. If the limb is extensively paralyzed the splint should encompass the entire leg as far as the tuber ischii behind, the trochanter on the outer side, and the ramus of the pubes on the other. If limited to the muscles below the knee a splint reaching the knee will suffice. Splints are also convenient in some other conditions like tabes, hypertonia, Charcot's disease, etc. Robinson gives full directions for making the celluloid splints, especially the first taking of the negative cast. The celluloid splints should be worn next to the skin, as a stocking will force it out of place. It should be applied while the patient is still in bed, laced on and worn day and night, but removed twice a day for massage and passive movements. The patient should be encouraged to get up and walk as soon as possible and this can be done in the average case at the end of the first month.

OPERATION FOR THE TREATMENT OF MOVABLE KIDNEY.

After nephrorrhaphy many patients have complained of considerable discomfort, or even of actual pain, in the loin. The usual incision for this operation is an oblique one, close to, and parallel with, the last rib. After partial decapsulation, the organ is stitched by some method or other to the margins of the wound. Thus, the greater part, if not the whole, of the kidney becomes fixed in the space between the last rib and the crest of the ilium instead of lying, as normally, well under

cover of the ribs. As a result of this abnormal position the ureter tends to become kinked, and thus obstruction to the flow of urine may occur; and further, the kidney is exposed to the pressure of the patient's clothes, or in certain movements it may be caught between the lower ribs and the crest of the ilium.

The author has practised for some years a modification of this operation which removes these objections, and which at the same time gives thorough fixation. The renal capsule is split from end to end along the convex border, and then stripped for about half its extent from the anterior and posterior surfaces of the kidney. The upper three-fourths of these two flaps of capsule are now folded back over the part of the capsule which has been left adherent, and are retained in that position by a few stitches passing from the free edge of the flaps to the adherent capsule near the hilus, care being taken not to injure the pelvis. These stitches prevent the flaps from slipping back over the denuded renal surface. Three fixation stitches of strong catgut are next passed through the ends of the flaps, which are still free, at the lower end of the kidney. By this means, the part of the capsule in the grip of the stitch is twisted and puckered, and the tendency for the stitch to cut out is diminished. These stitches are not tied in the meantime. The kidney is now pushed back into its normal position, care being taken to place the upper pole behind the liver. One end of each of the three fixation stitches is now passed through the muscles and fascia through the upper margin of the wound, near its posterior angle, and tied as they are passed. The kidney thus lies well under cover of the ribs, with its lower pole on a level with the upper margin of the wound. The cavity under the kidney is packed with gauze and a dressing applied. This packing is left undisturbed for six or seven days, but subsequently it is renewed every two or three days till the wound has closed. The gauze gives temporary support to the kidney and relieves the strain on the fixation stitches. By this method the kidney is fixed in its position by a broad band of fibrous tissue which has formed between its denuded surface and the posterior abdominal wall.—Peter Paterson (*Lancet*, January 3, 1914).—*Monthly Cyclopaedia*.

THE DANGERS OF TWILIGHT ANESTHESIA.

It has long been known that pain could cause death under chloroform a short time after the beginning of its administration, even though trifling operations, such as the extraction of teeth, were being performed. This has been attributed to shock, or reflex cardiac arrest from irritation of the nasal branches of the fifth pair. Suggestive in connection here-

with is the fact that Depree recently observed a sudden death from stoppage of the heart caused by the injection of five minims of a one to 1,000 solution of epinephrine in the nose of a patient who had been lightly anesthetized with chloroform. So slight was the anesthesia, in fact, that the corneal reflex was quite brisk. Lévy had previously observed, in experiments on cats, that when a small dose of epinephrine hydrochloride solution was injected into a vein, there occurred a well-marked rise of blood pressure, followed later by marked irregularity of the heart, but only when deep chloroform anesthesia existed. When, however, the same injection was made while the animal was under light chloroform anesthesia, the effect became so intense that death due to ventricular fibrillation ensued in almost every instance. Lévy had observed a similar effect in man, the action of epinephrine in a lightly chloroformed subject being acceleration of the pulse with raised tension, then still greater frequency with pulse less readily felt and sometimes perceptibly irregular at the wrist. A few temporary pauses may be noted, and then the heart suddenly ceases beating; the pupils dilate widely, intense pallor supervenes, and cessation of respiration follows. Such a termination has been observed in other cases.

Death, thus brought on by the external or intravenous use of epinephrine, seems but to illustrate the morbid process irrespective of any use whatsoever of the adrenal principle and through abnormal activity of the adrenals themselves. While Starling and von Anrep have held that the rise of blood pressure which occurs in asphyxia was due to the fact that the increased carbon dioxide content of the blood stimulated the adrenals and therefore the secretion of epinephrine, Cannon and Hoskins found that sensory excitation and fear also enhanced markedly the production of this adrenal principle. Linked, these observations explain the many deaths observed during the first stage of chloroform under the influence of fright, excitement, pain, etc. Precisely as if it had been applied locally or injected intravenously, the excess of epinephrine gave rise to cardiac fibrillation followed by death.

Can all this be said to apply also to ether? Clark and Cathcart (*Glasgow Medical Journal*, April, 1914) have recently urged that it does. They found that in the case of the rabbit anesthetized with ether, the action of carbon dioxide on the heart and circulation was practically nil when the anesthesia was deep, but that it was marked when the anesthesia was light. They argue that during deep anesthesia the extra production of epinephrine as the result of carbon dioxide did not take place, while under light anesthesia the adrenals produced an excess of their secretion sufficient to affect the heart. They were thus led to conclude that safety lies in deep, and danger in light anesthesia; that continuous and not intermittent administration is essential; and, finally, that the

use of epinephrine in any form during anesthesia is fraught with danger.

Still, the rôle of the adrenals in ether anesthesia is purely speculative, and considerable clinical evidence tends to militate against these conclusions in respect of this agent. This cannot be said of chloroform, however; all evidence, clinical as well as experimental, tends to show that twilight sleep produced by this anesthetic, and the use of epinephrine during that state, are dangerous measures. And this, as pointed out editorially in this journal as long ago as December 2, 1905, will probably be found to apply to other agents, used for the same purpose; although these have not as yet been submitted to close scrutiny so far as their relations to organic carbon dioxide and epinephrine are concerned.—*N. Y. Medical Journal*.

THE ABUSE AND DANGERS OF PITUITRIN.

Drs. Rongz and Arluck, in the *N. Y. Med. Jour.*, make the following statements:

ing statements:

1. Pituitrin does not induce labor pains.
2. It should not be used in the early part of the first stage of labor, for its action is too transient.
3. It should not be used in complete inertia because of danger of rupture of the uterus.
4. It is contraindicated in cases of dystocia due to malposition or contracted pelvis.
5. It should never be used in cases in which a sudden rise of blood pressure may prove dangerous.
6. A single dose of pituitrin may be used as an adjuvant in cases where pregnancy is interrupted, either by catheter or bag, and only when contractions of the uterus have already set in.
7. It should be used only in cases in which the cervix is dilated or dilatable and the presenting part engaged in the pelvic outlet.
8. It should be used cautiously in cases in which the fetal heart sounds are feeble or irregular.
9. It should never be used unless a general anesthetic is within easy reach, for the contractions may become so violent that rupture of the uterus becomes imminent.

Finally, the conclusions reached in this paper are based purely on personal observations of the action of this drug in a very large series of cases. We feel that it may not be in accord with the experience of many other observers, still we maintain that in order to obviate many com-

plications, which at times may become very dangerous, this drug should be used conservatively.

We appreciate its value when properly used; we realize its dangers when given injudiciously, and we cannot but advise the general practitioner to be conservative in its use.—*Am. Jour. of Surgery.*

THE USE OF HORSE SERUM FOR THE PREVENTION OF HEMORRHAGE IN NOSE AND THROAT OPERATIONS.

Dr. Clement F. Theisen, Albany, claimed that in a previous series of cases of hemorrhages after tonsillectomy and other operations after the failure of other methods, the bleeding was controlled by injections of blood serum. In a new series of cases the serum was used before operating, when it was expected that there would be an unusual loss of blood. The injections were given when from a history of cases of severe spontaneous hemorrhages in the patient himself such a result was to be anticipated, and they were given irrespective of the coagulation time before operating. It had been recognized that the coagulation of the blood was dependent on the action of thrombin, the so-called fibrin ferment, but Voetglin and Macht had recently isolated from the blood and the adrenal cortex a new vasoconstrictor substance, and it was quite possible that the action of the serum was due to this. In his own observations the coagulation time had been estimated by the coagulometer of Russel and Brodie, as modified by Boggs. In the eight cases of his series reported in the paper the average coagulation time before injection of the serum was 5.18 minutes and after injection 4.12 minutes, making an average decrease in coagulation time of 1.06 minutes. When the serum had been used before tonsillectomy in a subject of the hemorrhagic or hemophilic diathesis the operator left his patient with a feeling of much greater security. Judging by a search of the literature the much-talked-of danger of anaphylaxis was practically nil, when as in his cases only one injection of serum had to be used. Dr. Theisen said that no claim was made in his paper that blood serum was infallible. It had, indeed, been successful in his hands, but in some cases it might fail.—*Medical Record.*

TWO CASES OF PELVIC INFLAMMATION OPENED THROUGH THE BLADDER.

By M. Barragan y Bonet. The first was a case of pericystitis from vesical calculus and perforation of the bladder wall, in which, after the treatment, there was seen a conical eminence in the bladder. This

was on the left side of the organ around the vertex, when incised it gave vent to a quantity of bloody pus. The after-treatment consisted in addition to drainage, of irrigations with two per cent. formol. A little later, when the purulent discharge had lessened, the lavage was done with one in 2,000 solution of oxycyanide of mercury, followed by the injection of eight to ten c. c. of iodoform oil. The patient made an uninterrupted recovery. The second case was one of pelvic abscess which had ruptured into the bladder. The condition had originated in the ovary and tube of the left side, and did not yield to vesical drainage; an anterior colpotomy was successful.

INTERNAL DERANGEMENTS OF THE KNEE.

By Robert Jones.—One condition which gives considerable disability is rupture of the crucial ligaments. The diagnosis of ruptured crucials is simple if their functions are remembered. The anterior crucial ligament is tense when the knee is fully extended and prevents the tibia from being displaced forward on the femur. The posterior crucial ligament is tense in complete flexion and prevents the tibia from being displaced backward on the femur. Both ligaments check inward rotation of the tibia. Hence, if after an injury of the knee, the tibia can be displaced backward or forward or rotated inward in the extended position, an injury of one or both crucial ligaments may be assumed. If in the extended positions the tibia cannot be displaced forward it may be assumed that the anterior crucial ligament is not torn. If in full flexion the tibia cannot be displaced backward, the posterior crucial ligament is not ruptured.—*Surgery, Gynecology and Obstetrics.*

GALLSTONES EJECTED THROUGH THE MOUTH.

By A. R. Carmon.—The unique case is reported of a woman who, about a month after an attack of gallstone colic with jaundice, was taken apparently with acute indigestion, vomiting frequently for about four days and bringing up a number of gallstones, varying in size from that of a pea to a small walnut. The author collected more than thirty stones made up chiefly of biliary pigments. The patient subsequently remained in excellent health.

ABSCESS ORIGINATING IN PILONIDAL SINUS.

By Louis J. Krouse.—A pilonidal sinus is a fistulous tract of varying extent in the lower part of the spine, terminating in a blind ex-

tremity. The French have called it posterior umbilicus. The situation of the sinus is over the coccyx and always in the median line. It causes irritation and itching and, occasionally, a discharge of pus. A lock of hair is occasionally found in the cavity. The following elements are necessary for its formation: The presence of a congenital dimple, abundant pilous development—hence it is seen only in the adult and almost always in the male sex—insufficient attention to cleanliness. It may connect with the rectum. The following methods of treatment have been employed: Curettage of the sinus; dissecting out the fistulous tract; cutting the sinus along its entire length and stitching the lining membrane to the skin. The walls of the sinus are composed of granulating tissue, not true skin. It is regarded as an imperfection in the development of the embryo.

IMBEDDED RADIUM TUBES IN CANCER; SARCOMA REMAINING CURED NINE YEARS AFTER RADIATION.

By W. J. Morton.—That the alpha, beta, and gamma rays of the radioactive elements are the sole known demonstrable means of effecting a deterrent influence upon the vitality and proliferative power of cancer cells is now established beyond doubt. The action of radiation upon cells is selective, in the sense that normal tissues react in well recognized gradations. As to dose, the radiotherapist has the choice of a small quantity of radioactive substance used over a long period or of a large quantity over a short period. These and various other considerations must be taken into account in imbedding tubes of radioactive elements in cancer tissue. By this method all that is valuable in radiotherapy is retained, while there is an advantage in not being obliged to protect intervening normal tissue, and thus limit a desired dose. Imbedding the tube is an intensive radiotherapy, and must come more and more into practice.

SOME THINGS THAT INFLUENCE THE MORTALITY AFTER PROSTATECTOMY.

By Arthur L. Chute.—The high mortality that follows prostatectomy is considered to be unnecessary, and to depend very largely upon the functioning of the kidneys. The first thing urged is that kidneys that are not working well be brought into a condition in which they will act efficiently prior to the operation, and then to avoid injury to embarrassed or susceptible kidneys at the time of operation. He believes that the prognosis as regards recovery from a prostatectomy depends mainly on the renal function.

THE TREATMENT OF WOUNDS IN WAR.

By Sir W. Watson Cheyne.—The frequency of sepsis in the wounds is remarkable. Aseptic methods fail utterly in times of war because wounded men cannot be attended to at once, often not for many hours. During the interval, their wounds almost invariably become infected, and in the case of land troops frequently either with the tetanus or the aerogenes bacillus or both. All wounds except those inflicted by rifle bullets are in general extensive and the parts are severely torn and bruised. The infectious material is often actually driven into the wound under these conditions. Two different courses of treatment must be followed, depending upon the freshness of the wound. When seen within twenty-four hours—exceptionally even within forty-eight hours—after the injury, an attempt must be made chemically to destroy the infectious agents present. For this purpose only one antiseptic has been proved of great value, namely, phenol. The most effective method of procedure consists in the thorough primary cleansing of the skin about the wound by ether soap and one to twenty solution of phenol. The wound is then covered with gauze saturated with the phenol solution; the badly soiled fragments of tissue are removed, the wound is enlarged if necessary to give access to all its recesses, and hemostasis secured. In an extremity bleeding may be stopped by a tourniquet, in the trunk, by application of hemostatic forceps and firm plugging with gauze. When this is accomplished, the entire cavity is to be swabbed out thoroughly with liquefied phenol, being sure that the drug reaches every small recess. Recesses may be washed out with the one to twenty solution and the application repeated. The tourniquet is then released, in the case of an extremity, and the ends of the bleeding vessels are clamped and tied off. In trunk wounds the clamps are removed, one at a time, the bleeding vessel touched with liquefied phenol, a fresh clamp applied, and the vessel ligated. The wound should then be dressed with antiseptic gauze, the best being salicylic acid gauze, with a layer of cyanide gauze next the skin to protect it. By this method the wound is completely sterilized; growth of pathogenic organisms in the dressings, which are soon saturated with discharges, is prevented by the antiseptic. In wounds more than twenty-four to forty-eight hours old sterilization cannot be made complete by any method of local applications. In these cases the use of strong antiseptics and the mechanical removal of any considerable amount of tissue are contraindicated, as they tend to break down the natural barriers which have formed. Instead, continuous irrigation with sterile normal saline solution is the best of all methods, and drainage should be established by means of open rubber tubes, counter openings being

made if necessary. Here, as before, the dressings should be antiseptic. In no case, whether already too late to be completely disinfected or not, the dressings should be very light and thin, as thick masses of gauze absorb the pus and discharges, which undergo decomposition, and the dressing forms an irritant poultice for the promotion of bacterial growth. By these methods it should be possible to convert every case which is seen within twenty-four hours into an aseptic one and secure healing in blood clot. Phenol in the concentration used—liquefied—kills not only the organisms but also their spores and is active in the presence of albuminous and fatty fluids. The method harks back to the time of Lister and is but a slight modification of his original technic.—*British Medical Journal*.

FUNCTIONAL KIDNEY TESTS AND PREOPERATIVE AND POSTOPERATIVE TREATMENT IN THE REDUCTION OF POSTATECTOMY MORTALITY.

By B. A. Thomas.—The most appropriate method of prostatectomy in a given case depends on the pathological condition present, rather than on the normal anatomical relationship of the prostate. This pathological condition is of greater consideration than the statistical low mortality rate of either the perineal or suprapubic method, and more discrimination in this respect offers a means of shaving even the present low percentage. The cystoscope is a most important aid in the determination of the avenue of approach in the particular case. Although the renal function is the paramount consideration in determining the operability of a case, a study of the other organic conditions must never be slighted. Indigocarmin is superseded by no other kidney test in the estimation of the renal function. Apparently of more dependence than merely the onset and quantity of excretion of indigocarmin is the index of elimination described by the author. A prostatectomy mortality of 3.3 per cent, is attributed largely to cystoscopic aid in determining the method of operation, and also to the index of elimination of indigocarmin in discrimination as to the operability of cases.

GYNÆCOLOGY AND OBSTETRICS

UNDER THE CHARGE OF S. M. HAY, M.D., C.M., GYNÆCOLOGIST TO THE TORONTO WESTERN HOSPITAL.

UTERINE HAEMORRHAGES IN YOUNG GIRLS.

Dr. Henry C. Coe, of New York, stated (Med. Soc. State of N.Y.) that in the absence of any discovered cause for the hæmorrhage, local or

general, the practitioner was thrown back upon experimental medicine, and must interrogate rigidly the ductless glands, with more or less doubtful results. Organotherapy must be regarded as the best curative agent. The prognosis must depend upon the actual or supposed cause of the condition. Care should be exercised in making caustic applications to the endometrium, which were not absolutely controllable and might cause irreparable injury to the delicate organs in subject of tender years. One of his colleagues had met with success in the treatment of obstinate hæmorrhage in young women, by ligation of the uterine arteries per vaginam, which was practically out of the question in young children. The writer could conceive of cases in which explorative abdominal section might be elected, even when pelvic examination was negative, but it would be a desperate case indeed in which both ovaries should be removed, not to speak of supravaginal amputation of the uterus.

Dr. Harvey P. Jack, of Hornell, had had many cases of hæmorrhage in young girls. In several repeated curettements, hygienic measures, parotid gland, and thyroids had been administered without relief. These cases seemed hardly to recover from the exhausting hæmorrhage of one menstruation before another began. Thyroids in small doses, long continued, had proved of great benefit in a few, but the agent that had cured every one of these severe cases so far, and two were now under treatment, was calcium chloride. One girl in particular had been brought from a bleached out nervous wreck to brilliant health by the use of this drug alone.—*New York Med. Jour.*

“PAINLESS CHILDBIRTH” AND PAINFUL MAGAZINE EXPLOITATION.

An article that is likely to arouse the interest of certain of the laity appears in one of the popular magazines for June under the caption “Painless Childbirth.” It is written by two women who made a special study of the method at Freiburg in Baden, where Krönig and Gauss have made trial of scopolamine-morphine narcosis in midwifery. This method has been closely watched by the medical profession for a number of years; it has been tried throughout Europe and considerable difference of opinion has arisen as to the value of this attempt to rob the lying-in room of some of its terrors. A comprehensive review of narcosis in childbirth is presented by H. Fuchs of Danzig in the *Universal Medical Record* for December, 1913. He compares the relative merits of chloro-

form and of ether, preferring the latter in hospital cases; of nitrous oxide and oxygen; of cocainization of the genital area on the nose, as devised by Fliess; of hypnosis; of suggestion-narcosis; of the use of drugs such as chloral hydrate, and finally of scopolamine-morphine narcosis.

The essential of this method consists in the production of a clouding of consciousness, a "twilight sleep" (Dämmer Schlaf) as it is called. "When the pains come, the women usually cry out just as loud as any other lying-in woman, answer the question whether they have pains in the affirmative, but during the intervals between the pains fall into a deep sleep. If awakened from this sleep and questioned about the pains they have suffered there is a complete loss of memory, this is, if the semi-sleep is complete. Psychologically the facts of the case are that the pains are perceived at the moment, but then make no impression; they leave behind in the higher cerebral centres no memory picture. It results that, if the semi-sleep is properly produced the whole of the processes of labor are banished from remembrance." During twilight sleep there is a loss of psychic control and the assistance of the patient cannot be obtained by the accoucheur. To the question whether scopolamine-morphine anesthesia is harmless to the organism as a whole, Fuchs answers in the affirmative, but he believes that this combination of drugs adversely influences the course of labor, increasing the pain intervals, and shortening and weakening the pains themselves. Prolongation of labor is a regular consequence of the twilight-sleep. Furthermore scopolamine-morphine anesthesia is not innocuous to the child. According to Fuchs, the excitability of the respiratory centre is lowered with the result that one-fourth of the children are born in a state of oligopnea or apnea.

If one now turns to the account of the method of Krönig and Gauss as given in the magazine article one notices the exaggerations and circumlocutions that are almost inseparable from this type of literature. The statement is made that twilight sleep "is not in any way injurious to the mother," and "in no way injurious to the child." It is stated that in the Freiburg clinic forceps "are almost never used," and on page 44 this is contradicted by the statement that "the frequency of forceps cases has settled down to an average of from 6 to 7 per cent." If it were not misleading to the unthinking reader most amusing indeed would be the testimony that is cited of some of the patients who journeyed to Freiburg to experience the benefits of twilight sleep. Thus we are told of the Scotch noblewomen who in spite of the precedent that the heir of the family should be born "in his own heather and beneath his own castle walls," nevertheless journeyed to the clinic, in possession of two German sentences: The first was "Where is Professor Krönig?" and the second was, "I will have a painless child." "The 'painless child'

from recent photographs, is the most beautiful child that the heart of a Raeburn might ache to paint. Her baby having been so very satisfactory, she is one of the mothers who returned for a second." Another glowing testimonial of the Freiburg method appears in the recital of a case in which a woman gave birth to a boy at 5 o'clock in the morning, at 8 was sitting up enjoying her coffee and rolls, at noon ate a typical German midday meal of soup, meat, vegetables, and compote, and in a week was returning calls of congratulation.

One of the serious drawbacks of the popularization of medical topics in magazines is the fact that usually the whole truth is not presented. A glowing account of one phase of the subject is usually given and the reader receives a distorted idea of a subject which wise men are still weighing in the balance. This is particularly true of the question of "painless childbirth." Even if one disregard the valid sentimental objection to the open discussion of such a topic, there can be nothing but condemnation of the unreal and one-sided portrayal in a popular magazine of a strictly medical subject such as that of analgesia in obstetrics.—*Medical Record*.

TREATMENT OF RETAINED FETAL MEMBRANES AT TERM.

P. Guildal (*Ugeskrift for Læger*, March 12th, 1914) has investigated the material in the maternity wing at the Rigshospital in Copenhagen for the ten-year period 1903 to 1912, with a view to ascertaining the significance of retention of the membranes at term. He points out that, while retention of part or the whole of the placenta is unanimously regarded as an indication for interference, there are conflicting views as to the treatment of retained membranes. Even the frequency with which this accident occurs is estimated at widely divergent values, ranging from 1 to 2 per cent. of all confinements. This divergence is mainly due to the different conceptions of what constitutes retention of membranes, and the author, therefore, finds it necessary to define this point. At the Rigshospital uniformity of record is ensured by the notes being almost exclusively made by the same person—the senior physician. Every abnormality, such as laceration of the membranes, is noted; and the author has included in his statistics only those cases in which partial or complete retention of the membranes was definitely recorded. Of 14,078 cases, 346, or 2.5 per cent., showed partial or complete retention of the membranes. The routine adopted at the hospital after the birth of a child consists of close observation of the uterus, its distension with blood and hemorrhage per vaginam being guarded against. If neither occurs,

the contraction of the uterus and its expulsion of the placenta into the lower uterine segment are awaited, and are assisted by the abdominal contractions of the patient, and by light pressure on the fundus. If, however, hæmorrhage occurs, or the placenta is not detached within half an hour to an hour of birth, Credé's method is practised. If this fails, and there is hæmorrhage or risk of sepsis from delay, Credé's method is aided by general anæsthesia, and if this also fails, manual removal of the placenta is resorted to. When the placenta is detached, but the membranes are adherent, the placenta is rotated so as to twist the membranes into a cord. If light traction on this failed to bring away less than half of the membranes, it was the practice till 1911 to introduce a couple of fingers into the uterus and pull on the rest of the membranes. This manœuvre was abandoned, as it seldom effected the removal of more than a few shreds of membrane. The puerperal morbidity among the patients with retention of membranes treated in this manner was 35.8 per cent. During 1911 and 1912, when the treatment was expectant, the puerperal morbidity was 34 per cent. There is, therefore, in this respect no evidence to support the removal of retained membranes; and as the manual removal in the first series of cases was undertaken in a hospital where antiseptic precautions were scrupulously carried out, it is evident that the results in general practice must be even less satisfactory. Credé's method has often been held responsible for retention of membranes, and it was practised in 5 cases out of the author's 346 cases. This is equivalent to an incidence of 1.4 per cent., as compared with an incidence of 0.7 per cent. for the total of births. The influence of abnormalities of the placenta on the retention of membranes is considerable; it occurred in 42 per cent. of the cases of retained membranes, whereas it occurred only in 20 per cent. of all births. The author is not convinced that retention of membranes disposes to hæmorrhage, which he observed in 23 cases, or 7 per cent. Only in one of these cases was the hæmorrhage violent. The incidence of hæmorrhage is, therefore, scarcely greater than when the membranes are completely removed. Retention of membranes, whether actively treated or not, certainly increases the puerperal morbidity, and in 119 cases, or 34.4 per cent., the rectal temperature was 100.4° F. or more in the puerperium. Judged by the same standard, the puerperal morbidity among all the births during the same period was 20.2 per cent. In 69 cases, or 20 per cent. of all the cases of retention of membranes, the spontaneous discharge of fragments of membrane was observed, the period at which this occurred being most often between the fourth and eighth days of the puerperium. The question whether retention of the membranes disposes to metritis or endometritis has often been raised, but the author has observed only one case of such

a coincidence. He does not, therefore, attempt to answer this question.—
Brit. Med Jour.

A CIRCULAR ABOUT CANCER.

The American Society for the Control of Cancer has recently prepared for general distribution a circular entitled, "What You Should Know About Cancer." The society was organized in 1913 as a national association "to disseminate knowledge concerning the symptoms, diagnosis, treatment and prevention of cancer, to investigate the conditions under which cancer is found, and to compile statistics in regard thereto." The purpose of the society, as thus stated in its constitution, is to direct a campaign of education for the prevention of this disease. The society does not undertake to support pathological research or charitable or hospital care of individual cases, but endeavors to coöperate with all existing institutions as a clearing house of information.

The circular deals, in popular language, with the nature, prevalence, control, and cure of cancer, and with the efficacy of radium in cancer. Some selections from it are as follows:—

"Cancer is almost invariably at first a local disease. It is easily cured if promptly recognized and at once removed by competent treatment. It is practically always incurable in its later stages.

"The disease usually begins in some unhealthy spot or some point of local irritation: In external cancer there is something to be seen or felt, such as a wart, a mole, a lump or scab, or an unhealed wound or sore. Pain is rarely present. Cancer inside the body is often recognized by symptoms before a lump can be seen or felt. Persistent indigestion, with loss of weight and change of color, is always especially conspicuous.

"Persistent abnormal discharge from any part of the body should arouse the suspicion of cancer, particularly if the discharge is bloody. The early and hopeful stages of cancer are usually painless.

"The only cure for cancer is to remove every vestige of the disease. The only sure way to do this is by a surgical operation. If taken at the beginning, the majority of cases of cancer are curable. All cases will end in death if let alone. Records of our best hospitals prove that the chances of cure are very high with early operation, and that these chances decrease with every day of delay. Early diagnosis is, therefore, all-important.

"The American Society for the Control of Cancer is studying these hospital records and will spread nation-wide the message of courage and hope in early recognition and prompt operation. By publishing circulars and articles in newspapers and magazines, and by organizing lec-

tures and public meetings, this society is conducting a general campaign of education based on the latest knowledge of the disease. Thoughtful and influential people can help this work by joining the society. Write to the office, 289 Fourth Avenue, New York City, for further information.

“According to the most authoritative opinion, the curative effects of radium are practically limited to-day to superficial cancers of the skin, and to superficial growths of mucous membranes and certain deeper-lying tumors of bone, etc., which are not very malignant. Radium has probably been shown to exert a definitely curative effect on certain of these cases, while the disease is still local and in the early stages. Radium definitely relieves suffering when used in the advanced stages of deeper-seated cancers; but in those cases it improves only the visible or tangible manifestations and exerts no effect upon the disseminated disease as a whole. It is believed that there is as yet no proof that radium has finally cured any case of advanced and disseminated cancer.

“The public should take warning against dishonest and fake, money-getting radium-cure establishments, conducted by individuals who possess little or no radium, and have no knowledge of its use. These people promise cures, but are, in reality, unable to obtain even those palliative effects which are possible from radium.

“The best results of radium therapy can be secured only when comparatively large amounts are available for use, and the present limited world's supply of this metal places it out of reach of the great majority of patients.”

TREATMENT OF GONOCOCCUS VULVOVAGINITIS.

In contrast to the pessimistic reports of some observers, G. G. Smith (*Amer. Jour. Dis. Child.*, 1914, vii., 230) records his results in sixteen cases reported a year ago and seen recently. It seems that 50 per cent. of these cases the evidence of cure would satisfy the most skeptical. Of the remaining 50 per cent. no one seems to be still definitely gonorrhoeal, though three of them may be such though the organism cannot be found. Two cases are ruled out because of a moderately positive blood test, although in every other way one of them appears to be a cure. In an acute case, confinement to bed, regulation of the bowels, much water, a light diet and the frequent bathing of the external genitals with warm boric solution are the measures employed. After the acute condition subsides, the child is placed on her back on the table, her hips elevated by a douche-pan. The labia are separated and a female soft rubber catheter, size 12 or 14 French, well lubricated, is passed through the

opening in the hymen as far as it will go. A fountain syringe is hung about 2 feet above the patient. The tube should be tipped with the glass part of a medicine dropper, which fits securely into the funnel end of the catheter. The solution selected for this douche, is allowed to run. From 1 to 2 quarts, heated to about 110 in the reservoir, should be used. After this solution has run into the vagina and out again around the catheter, the catheter and glass tip are separated, and through the catheter, which has been held in place all this time, 1 or 2 drams of one of the silver salts is injected with a hand syringe. The catheter is then withdrawn, the child holds her thighs close together to prevent the escape of the silver preparation and lies in this position, hips elevated, for at least fifteen minutes. This treatment should be given twice a day, but even if used only once daily, is very effective in checking the discharge. The solutions used for the douche are sterile water, boric acid solution 2 per cent., sodium bicarbonate a teaspoonful to a quart, or potassium permanganate 1-8000 or 1-6000. The purpose of the douche is the removal of mucous preliminary to the application of silver, and the increase of circulation locally through heat. In the more acute stages the blandest solutions are the best, sodium bicarbonate being especially soothing. Later potassium permanganate with its slight astringent action is good, and in the chronic stages, silver nitrate as strong as 1-1000 may be used. In choosing a silver salt, one should start with the least irritating preparation. Argyrol 10 per cent. is well borne in the more acute cases; later it can be increased to 20 per cent.; or the somewhat more irritant protargol can be used (not stronger than 5 per cent.) Urethritis is treated by the instillation of 1 or 2 c.c. of 5 per cent. argyrol into the urethra by means of a medicine dropper. The treatment should be carried on for at least a month after all symptoms have disappeared. One must remember, however, that occasionally a discharge may be kept up by too persistent treatment.—*Amer. Jour of Obstetrics and Diseases of Women.*

RESULTS OF RADICAL OPERATIVE TREATMENT OF CANCER OF THE UTERUS.

Dr. Thomas Wilson, of Birmingham, England, after reviewing the history of the operative treatment of uterine cancer, observed that the difficulties of estimating justly the results of any curative method of treatment of cancer were very great by reason of the uncertain course and duration of the disease. Cancer did not grow with equal steps, but now halted, again receded, and anon made rapid and tumultuous pro-

gress. In different patients the earliest symptoms made their appearance at various stages of the disease. When cancer began in the uterus, one patient had recognizable symptoms at the very beginning, while another was conscious of nothing unusual until the disease was already far advanced. The duration of the disease was in the highest degree uncertain; of two women with the affection apparently in the same stage, one might die in a few weeks and the other live for several years. In the practice of the operating surgeon, groups of cases, successful as regards ultimate cure, alternated with other groups apparently similar, but all ending in rapid recurrence. All which things tended to show that the actual living virus of cancer, when at length it was discovered, would be found to pass through varying phases of growth and activity, now active and virulent, now stationary or sluggish. On the other hand, marked differences existed in individual hosts as well as in the various organs and tissues of the body. In some organs and persons cancer appeared to take root easily; it grew rapidly and soon became generalized. In some very early cases of uterine cancer, the regional glands were already invaded; while in patients dead of the disease the glands were reported to be free in as many as fifty-four per cent. Relative immunity varying in degree, resided in some organs and tissues, and in certain individuals. Not every person, exposed to the causes of cancer, whatever these might be, manifested the disease. Many were called, but few were chosen. Here then were the two factors which went far to explain the impossibility of forming an opinion on the course of the disease and on the probable result of operation in any individual case. As for standards of comparison with regard to operability, in the large German clinics they found that the cases of cancer of the uterine cervix afforded a ratio of operability of forty-five to sixty per cent. and even higher, and an absolute curability of twenty per cent. Wertheim's five year completed statistics of 450 cases showed an operable ratio of forty-six per cent., with a primary mortality of 19.5 per cent., and an absolute curability of nineteen per cent. In Great Britain, with rare exceptions, the operability was not greater than from thirty to forty per cent., and the total curability more than ten per cent. The low operable ratio was not due to any difference in the disease, but rather to the fact that the general public and the main body of the medical profession had not yet grasped the truth that uterine cancer was curable in a large proportion of those cases that applied early for treatment. The consequence of this ignorance was that women did not seek medical aid promptly, and that when they did, the necessary investigation was only too often delayed.

In Great Britain as, generally speaking, in America, gynecological work was spread over a large number of clinics of small or moderate size, and the opportunities afforded to the individual operator were com-

paratively limited. In testing and establishing a new operation, such as extended abdominal hysterectomy for uterine cancer, this arrangement had many disadvantages when compared with the large clinics and extensive opportunities that were found on the European continent. To this more than to any one cause was probably due the fact that these operations had been practised extensively and successfully in Vienna and Germany far in advance of the work that had been done in Great Britain.

Doctor Wilson then examined his own work that had been done in the gynecological department of the Birmingham General Hospital. This department had fourteen beds and was a fairly typical one in Great Britain. His total five year results up to June 30, 1909, had been investigated and showed that, with an increased operable ratio and the adoption of the abdominal method of operation, the absolute curability of his cases had risen from 5.5 to 10.2 per cent. It followed, from his experience, that although the final results hitherto obtained in Great Britain were inferior to those of the best continental clinics, they were steadily improving and might be confidently expected still further to do so. Hardly a year passed free from the joyous announcement of new and certain cures for cancer. Every new treatment was hailed with acclamation, tried with enthusiasm, held to be almost consciously selective in its action on the cancer cells, and then was dropped quietly into the oblivion of disappointing and forgotten things. Hitherto, surgical measures alone had stood the test of time and had justified their use, not only by progressively improving results, but also by affording opportunities for increasing our knowledge of the fell disease in the human race. The exact nature and the mode of origin of cancer were still veiled from our view, and the seer who should expound these was eagerly awaited. In the meantime it behooved us to continue to give to our patients the benefit of those methods which gave the greatest promise, being neither unduly lifted up by success nor cast down by many and grievous disappointments.—*N. F. Med. Jour.*

PERSONAL AND NEWS ITEMS

Ontario.

Quite recently there were several cases of smallpox in the Toronto Isolation Hospital. They were all from the city.

The local Board of Health of Minto township has appointed Dr. S. M. Henry, of Harriston, as Medical Officer of Health, in succession to the late Dr. H. R. McCullough.

At Osgoode Hall recently the Appellate Court allowed the appeal of Dr. Andrew Haig, of Campbellford, against the decision of Chief Justice Falconbridge for \$1,200. The action was brought by Charles H. Cassan, a friend of the doctor. The two men were out on a fishing expedition and Cassan's eye was injured. Dr. Haig attended Cassan and the latter claims that the doctor poisoned his eye by not using the right solution. The Appellate Court disagreed with the judgment of the Chief Justice.

Dr. Alex. McKay, who for some years has been a member of the Toronto Public School Board, has been appointed by the board to the position of chief medical officer of the board, in place of Dr. Struthers, who resigned. The salary is \$3,500. Dr. McKay has entered upon the duties of his new office.

Dr. W. E. Struthers, who held the position of chief medical inspector of schools in Toronto, has been appointed to the head of the medical service of the Workmen's Compensation Act. He has entered upon his duties, as the Act comes into operation at the first of the year. The salary is \$4,500.

Dr. P. E. Doolittle was chief in command of the motor squadron of 800 cars during the recent mobilization of troops in Toronto.

Dr. Hastings, Medical Health Officer for Toronto, attended the annual convention of the American Public Health Association, which met in Jacksonville, Florida. He was elected vice-president.

Hereafter, citizens of Toronto who cannot afford to call in a doctor when they feel that they are in danger of contagious disease getting a grip in the home, may get medical attention free of charge.

Hon. Dr. Roche, Minister of the Interior, returned to the capital on 30th November, after an absence of about seven months. Dr. Roche is reported to have fully recovered from his operation of last summer in Rochester, and will resume the work of his department.

Dr. Hastings reported a short time ago that it had been decided not to adopt the liquid system of chlorinating the water supply. No trace of colon was found in the water during November.

There were 114 patients removed to the Toronto Isolation Hospital during the month of November.

During November of this year 44 cases of tuberculosis were reported in Toronto to Dr. Hastings, being 11 more than during November of last year.

Dr. H. A. Stevenson was a candidate for the London Mayoralty. He was endorsed by the Trades and Labor Council.

Dr. Smirlie Lawson, of Toronto, sustained a severe injury to his

ankle during a game of football. He was elected president of the Inter-provincial Amateur Football Union.

Dr. George, Provincial Health Officer, and Mr. Geo. Young, Provincial Sanitary Inspector, left 3rd December for Fort Frances and Rainy River districts, where there was reported a serious outbreak of smallpox. The inhabitants claimed that the infection was due to the influx of settlers from the other side of the line.

The Consumptive Preventorium sent in its account for treating patients—a total of 11,165 days, at the regular rate of 70 cents per day. This was ordered to be paid. Dr. Hastings testified to the good work being done by this North Toronto institution.

The Provincial Health Inspector states that in the 11 months of the year 417 cases of smallpox have been reported, and in December 33 cases. This disease is on the increase owing to the failure of doctors to diagnose the cases properly.

As the result of the diphtheria epidemic throughout the city, the St. Thomas Board of Health at a special meeting on 15th December ordered all public schools in the city to be closed until further notice. Children under fifteen years of age will not be admitted to the picture shows. Physicians are to report all cases of tonsillitis to the health officers, until the diphtheria outbreak is stamped out.

Forty-nine members of the graduating class in medicine at the University of Toronto have signified their intention to qualify for certificates as officers of the Army Medical Corps. An arrangement has been made by the Faculty of Medicine with the warm approval of the senate of the University, whereby these men will be released from all academic duties for two weeks after the New Year in order to attend a provisional school of instruction to be opened by the Army Medical Corps. They will take the course in groups of 20. When they are graduated in the spring and receive their licenses as physicians they will be eligible without further examinations for subaltern's certificates in the Medical Corps.

The Ontario Medical Council has started a campaign against unlicensed practitioners. This is proper, and one of the duties laid upon the Council by law.

Tuberculosis Sunday was well observed, and many ministers referred to the need for strenuous efforts to prevent the spread of the disease, and the Minister of Education, Dr. Pyne, has given his approval to the giving of instructions on the subject in the schools.

The Health Department of Toronto has denied the accuracy of Dr. J. B. Fraser's statement that infant mortality has been increased by the use of sterilized milk.

One of the splendidly practical works undertaken by women is that done by the Liberal Women's Association, of Toronto, who have interested themselves deeply in the furnishing and arranging of the hospital for the soldiers at the Exhibitions Grounds, which is well situated at the east end.

The slaughter houses of the Province are to be brought under the supervision of the Board of Health, as to drainage, ventilation, etc.

Quebec.

A deputation from the Montreal General Hospital, the Western Hospital, and the Notre Dame Hospital waited on the Montreal Board of Control a short time ago, and asked for \$85,000 in aid of these hospitals in order that they might be able to continue their work. The superintendent of the Montreal General Hospital stated that unless it received financial aid it would be forced to close its doors.

An epidemic of typhoid fever has occurred at Aylmer. It is thought to have been caused by the pollution of the Ottawa River.

Dr. James McGregor, formerly of Megantic, has gone to Europe with the American Red Cross contingent.

Dr. James C. Lee, one of the house surgeons of the Montreal General Hospital, has joined the Army Medical Corps, England.

St. Justine's Hospital for Sick Children, Montreal, has been opened. It has 180 beds.

Western Provinces.

Dr. C. S. Mahood, Medical Officer of Health for Calgary, has been made a Fellow of the Royal Institute of Public Health, London.

Dr. Andrew Croll, of Saskatchewan, has been elected a Fellow of the American College of Surgeons.

The following have passed the examinations prescribed by the University of Alberta, and are entitled to practise in that Province: W. W. Cross, C. T. Galbraith, F. R. Gray, T. W. Moore, H. C. Swartzlander, J. Thomson, J. H. E. Hastings.

From Abroad.

A number of patriotic efforts have been made in Cobourg to assist the Queen's Canadian Hospital in England, of which Dr. Donald Armour, an old Cobourg boy, is chief surgeon. The ladies of Cobourg have been most energetic.

Dr. Rupert Blue, surgeon-general of the United States Health Service, declares that lake pollution is becoming a very serious problem. He points out that at least 1,600 vessels sail on the Great Lakes, carrying 16,000,000 passengers. He contends that the waters of these lakes play an important rôle in the high typhoid fever rate. These vessels and passengers secure all the water they require from these lakes. It is stated that the lake water should be purified before it is used.

In 1891 the suicide rate in the United States was 13.5 per 100,000. In 1901 the rate had risen to 16.6; and in 1911 it was 19.6. There appears to be some relationship between the ratio of business failures and the suicide rate. When the former is high so is the latter.

A movement has been started in New York for the organization of the physicians, surgeons and pharmacists of the United States into a relief society for the 5,000 Belgians of these professions who have been so seriously affected by the war. A similar organization has been formed in Britain.

Dr. George W. Crile, whose reputation as a surgeon is international, left Cleveland December 30th for the American Ambulance Hospital near Paris, where he will do relief work among wounded soldiers of the European war. He will be accompanied by another physician and several nurses.

Major-General Hughes reports that exceedingly good work was being done at Salisbury by Col. Nasmith, of Toronto, who has had charge of the water supply and sanitation. He was loaned to the first expeditionary force by Toronto, for which place he was water expert. Recently Col. Horrocks, who has supervision of health precautions for the British army, looked into the work which Col. Nasmith has been doing at Salisbury and expressed his approval.

A Russian surgeon named Zeidler reports thirty-one patients who recovered from stab wounds of the heart in the hospital at Abuchow. Prompt and rapid operation is the probable reason for this good showing.

In publishing the address to the Duchess of Connaught from the Canadian Women's Hospital Ship Fund, when they presented \$282,857 to the Admiralty for the sick and wounded, the Admiralty and Army Council say they desire to express their grateful acknowledgements of this generous patriotic gift of the women of Canada and their recognition of the spirit of loyalty and devotion to the cause of the Empire which has prompted it. They are confident that in this they represent the sentiments of all officers and men of his Majesty's naval and military forces.

British and French hospitals at Constantinople are now being managed by the American Red Cross Chapter in the Turkish capital. A cablegram announcing this reached Red Cross headquarters recently, just after it had been decided to accept a formal invitation from the British Government to take over the operation of the English hospital at Smyrna, Asiatic Turkey. The British authorities believe their hospitals in Turkey will be secure from molestation under the American Red Cross flag.

The work of the Women's Christian Medical College, Ludhiana, India, was described in an address by Dr. Margaret Wallace at the annual meeting of the Canadian Auxiliary Committee of the college, which took place on Thursday afternoon, December 3rd, in the Guild Hall, Toronto. Dr. Wallace has been a professor in the college for six years and fully understands the work and its needs.

Dr. Alexis Carrol, of New York, is now making an extended tour of investigation of the French military medical establishments, says the Dunkirk correspondent of the *Petit Parisien*. The correspondent met Dr. Carrol at Zuydschoote, Belgium, attired in a French surgeon's uniform and having on one arm a gold stripe such as usually is given to a junior house surgeon on mobilization. The doctor was talking with a sub-lieutenant of a transport corps, and the correspondent recognized in the officer the playwright, Francois DeCroisset.

Paul Balbaud, of the University of Toronto, writing to the *Mail and Empire*, describes an exciting time when near Lille, where a battle was raging near an asylum with 1,400 inmates. Some of these were quite helpless and most of them were greatly excited. The soldiers removed these inmates to a place of safety.

The serious shortage of doctors for home work in Britain is beginning to be felt. Many institutions now find it almost impossible to secure medical officers, even with considerably increased salaries. The army medical service has lost many members. Medical students have abandoned their studies for the field. Many home doctors now find it impossible to take any holidays, since no locum tenens can be found, and there is a movement here to increase the number of women doctors and give them public appointments on a much larger scale than before.

The Methodist Mission Rooms have received word that the new Medical College in connection with the Union University, Chentu, China, has opened with a freshman class of nine Chinese students.

Dr. Joseph A. Blake, of New York, and Mrs. Katherine Alexander Duer, formerly Mrs. Clarence H. Mackay, of New York, were married in Paris.

The French Government has conferred upon Dr. Ambrose Stanton, son of Mr. Thomas Stanton, for many years a well-known merchant of Kendal, Clarke township, Ontario, the honor of L'Ordre Royal du Merite Cambodge. This order carries with it a handsome gold medal, and is in recognition of his services to science in connection with his research work in Burmah. Dr. Stanton has also been elected vice-president of the East India Medical Association.

The permanent court-martial of France sentenced Surgeon-Majors Collins and Wohlfart, who were in charge of the principal field hospital of the 2nd German Army Corps, to a year's imprisonment for alleged pillage. Nine deaconesses attached to the hospital were given sentences ranging from one month to three months, and twenty subordinates sentences ranging from one month to three years on the same charge.

The advance guard of the Canadian medical contingent left Britain at the beginning of November. It consists of 100 doctors, who have gone over to establish a Canadian hospital in France, which promises to be one of the most magnificently equipped of the many which have come from England, Australia, America and India. The hospital is located at the side of the Forest of Hardelot. Many of the medical men are French-Canadians. The Canadian Government gave \$100,000 towards its establishment.

Dr. Maximilian Wall, physician of the Royal Mail steamship Trent, from New York via West Indies for Southampton, was arrested on the arrival of the vessel on a charge of espionage. Dr. Wall was born in England of German parentage.

King George visited the Indian hospital in France, where he spent some time talking with the wounded. His Majesty inquired from the Indian wounded of the nature and occasion of their wounds. They were astonished to find from the questions he put that he knew the details of the actions they had fought in and the names of the regiments engaged. In a convalescent camp a Sepoy arose from his bed and called out, "God Save the King!" It was the only English he knew.

Charles Barrett Lockwood, F.R.C.S., surgeon to St. Bartholomew's Hospital, died very unexpectedly of sepsis. He was operating on a seriously infected patient and was compelled to work quickly. He pricked his finger as he was inserting almost the last stitch. He was in his 56th year, and at the height of a splendid surgical reputation.

Dr. John Shrady, of New York, died there at the age of 85. He was a noted physician of the American war.

Dr. Eustace Smith, senior physician to the East London Hospital

for Children, died on 14th November. He was born in 1835, and had attained marked eminence as an authority on children's diseases.

The British War Relief Association has been incorporated in New York. Its special object is stated to be to raise funds to provide a motor ambulance corps for service in the European war. On November 11, the war relief contributions in New York, exclusive of those of the Rockefeller Foundation, had exceeded \$1,500,000.

In a prosecution for violating Michigan Public Acts of 1907, No. 164, by the publication of an illegal medical advertisement the defendant claimed that the advertisement had been prepared and published by her husband without her authority and consent. It was held proper to charge the jury that it was not necessary, in order to convict the defendant, to find that she personally caused the advertisement to be inserted, it being sufficient if she caused the insertion by her duly authorized agent.

Surgeon-Major-General Sir John By Cole Reade, K.C.B., Army Medical Staff (retired), died at 25 Coleherne Road, Earl's Court, on November 5th, aged 82. He was the son of George Hume Reade, staff surgeon, and colonel of the 3rd Regiment, Canadian militia, and was born at Perth, Ontario, on July 7th, 1832. He was educated at Edinburgh University, took the L.R.C.S.Ed. in 1854, and entered the army as assistant surgeon on March 24th, 1854. He became surgeon in 1866, surgeon-major in 1873, surgeon-major-general in 1888, and retired on April 1st, 1893.

The Rockefeller Institute for Medical Research will receive \$200,000 under the will of Henry Rutherford, for cancer research work. This bequest was threatened by a contest of the will filed by a cousin of the testator, but the contest was dismissed and the will admitted to probate.

British and French hospitals in Constantinople are now being managed by the American Red Cross chapter in the Turkish capital. A cablegram announcing this reached Red Cross headquarters in Washington just after it had been decided to accept a formal invitation from the British Government to take over the operation of the English hospital at Smyrna, Asiatic Turkey.

A fully equipped hospital with twenty beds for the exclusive use of Russian wounded has been established in Petrograd by members of the American colony in that city. No contributions have been solicited or accepted from other than Americans.

A National Council for Combating Venereal Diseases was inaugu-

ated recently in London. The movement originated with Major Leonard Darwin, president of the Eugenics Education Society, who applied to the president of the Royal College of Surgeons for co-operation. He agreed, and enlisted the presidents of the Sister College and the Royal Society of Medicine. A strong committee was formed who communicated with the Royal Commission on the subject. They extended the proposals so as to embrace the question of popular instruction, especially for the poor, on the dangers of ignorance and recklessness regarding these diseases.

OBITUARY

M. D. SUDWORTH.

The body of Dr. Sudworth, of Ingersoll, was found dead on the Waterloo road on the night of 4th December. Dr. Orton, the coroner, was notified, and held an inquest. It was found that the doctor had suffered from Bright's disease, which had caused his sudden death. He was 25 years of age, and graduated only one year ago. He was a son of Dr. Sudworth, a dentist, of Ingersoll.

SUSAN GRACE DOUGALL.

Dr. Susan Grace Dougall, daughter of the late Mr. John Dougall, founder of *The Montreal Witness*, and a sister of Mr. John Redpath Dougall, of *The Montreal Weekly Witness*, died Saturday, 5th December, at the residence of Mr. J. R. Dougall, 693 Mountain St., Montreal, aged 63 years.

LLEWELLYN BROCK.

The death of Dr. Brock, of Guelph, occurred 11th December. He had been in indifferent health for some weeks. About a week before he made a trip to Toronto and on returning home suffered a severe chill, pneumonia developing shortly after, from which he never recovered. Born at the old home on the York road, he received his early education in Toronto, afterwards being graduated in medicine from the University of Toronto. He took up practice in Guelph, and for many years was recognized as one of the leading medical men of the district.

Dr. Brock was twice married, first to Miss Hamilton, two sons being born to them. His second wife was Miss Carthew; one child was born

to them, but it died when only a few years old. He leaves besides his wife, two brothers, Mr. W. R. Brock, of Toronto, and Mr. Geoffrey Brock, of Winnipeg.

In the work of the Children's Aid Society he took a keen interest, being at the time of his death honorary president of the Guelph society. He was a member of St. George's Anglican Church.

A. M. ROSEBRUGH.

Dr. Abner Mulholland Rosebrugh, the well-known eye specialist, died at his residence, 249 Huron St., Toronto, 25th November, after a long illness.

The late Dr. Rosebrugh, who was of U. E. Loyalist descent, was born at Branchton, Ont., in 1835, and later graduated from Victoria University in 1859, having studied medicine. After taking post-graduate courses in New York and London, he returned to Toronto and organized the Free Dispensary in 1863, and organized the Toronto Eye and Ear Infirmary in 1867. He subsequently devoted his attention to medical electricity and ophthalmology, lectured at Victoria and made several inventions.

In association with a friend he helped to perfect the method of simultaneous transmission of telephonic and telegraph messages over the same line. Dr. Rosebrugh also made other inventions which were adopted by the Bell Telephone Company.

Besides his many medical interests, the late Dr. Rosebrugh took an active interest in prison reform, to the commission on which he was appointed by the Government in 1890, and founded the Ontario Society for the Reformation of Inebriates. He also wrote several medical books. The interment took place at Mount Pleasant Cemetery.

ALTON H. GARRATT.

Dr. Alton H. Garrett died at noon on 21st November at his home, 53 College Street, Toronto. He had been in ill-health for several months, but had suffered from heart disease for many years. He was able to attend to his practice until about one month before his death. He was born on a farm in Prince Edward county forty-nine years ago. He pursued his medical education at Trinity University, from which he graduated in 1886. He commenced practice at Greensborough, Hastings county, where he remained one year, when he removed to Toronto, as he found the long drives and exposure injurious to his

health. In Toronto he soon acquired a large practice and was highly esteemed, both by the profession and his patients. In 1889 he married Miss Fletcher, who with one son, survive him. He held a number of important positions, such as being a member of the staffs of the General Hospital, St. Michael's Hospital, the Simcoe Dispensary. He was a prominent Mason and Anglican. His remains were taken to Wellington for interment.

WILLIAM HIGGINBOTHAM.

Dr. William Higginbotham, of Brantford, died recently. He graduated from Queen's University in 1871, and became a member of the College of Physicians and Surgeons in the same year.

F. L. De VERTEUIL.

Dr. Verteuil lost his life in the naval action off the coast of Chile when the Good Hope was sunk, being surgeon on that war vessel. He was son of Dr. J. Verteuil, a surgeon in the British army. He leaves a widow and two children.

JAMES G. ROBERTSON.

Dr. Robertson died on 3rd November in the Winnipeg General Hospital. He was in his 29th year. He graduated from the Manitoba Medical College in 1911.

R. J. LOCKHART.

Dr. Lockhart, of Hespeler, Ont., died in British Columbia, where he had lived for a few years with the view of regaining his health.

BRADFORD PATTERSON.

Dr. Patterson, of Barrie, died November 6th at the age of 95. He had practised in Markham, Collingwood and Newmarket. He was a surgeon in the American army during the Civil War.

JAMES LESLIE.

Dr. Leslie, of Hamilton, died there on 8th October. He was a

native of Scotland, where he was born in 1832. He was a graduate of Aberdeen University and a licentiate of the Royal College of Physicians, Edinburgh. At one time he was surgeon on a ship in the Arctic regions. He spent the latter 30 years in Hamilton, where he was much esteemed. His son is a surgeon with the Canadian contingent.

MARSHALL MACKLIN.

Dr. Macklin, of Bresler, Sask., died last October. He was well known throughout the West as a surgeon to the Canadian Pacific Ry.

DR. SCHULTZ.

Dr. Schultz, of Elmira, Ont., died suddenly of heart disease on 23rd November. He had retired from practice.

BOOK REVIEWS

HUMAN ANATOMY

Morris's Human Anatomy, a Complete Systematic Treatise by English and American Authors. Edited by C. M. Jackson, M.S., M.D., Professor and Director of the Department of Anatomy, University of Minnesota. Eleven hundred and eighty-two illustrations, three hundred and fifty-eight printed in colors. Fifth edition, revised and largely rewritten. Philadelphia: P. Blakiston's Son and Company, 1012 Walnut Street. Price, in cloth, \$6.00 net.

This splendid work on anatomy has just appeared as the fifth edition after a very careful revision. The following anatomists of high standing have taken part in the production of various sections of the book, namely, Charles R. Bardeen, University of Wisconsin; Eliot R. Clark, Johns Hopkins University; Irving Hardesty, Tulane University, Louisiana; C. M. Jackson, University of Minnesota; F. W. Jones, London School of Medicine for Women; Abram T. Kerr, Cornell University; J. Playfair McMurrich, University of Toronto; John Morley, Manchester University; H. D. Senior, University of Bellevue Hospital Medical College. N.Y.; R. J. Terry, Washington University, St. Louis; Peter Thompson, University of Birmingham; David Waterson, King's College, London. This volume contains fifteen hundred and forty pages. The paper is thin but of excellent quality, and takes the type and cuts well, and has a good surface for reading, which is a very important feature in a

work of this sort. It is seldom that one has the good fortune to review a work where the illustrations are so well executed as in the present one. They are really so accurate and so beautifully colored and shaded that nothing is left for the most exacting to desire. The lights and shades of the illustrations bring out the perspective correctly, a feature of much value in a work on anatomy.

Sir Henry Morris is a master in clear expression, and the work when it first appeared at once attracted attention on this account. In sections which he did not contribute his editorial judgment was felt. In the editions that have followed since any expressions that admitted of improvement have been carefully revised. It might be said now that there is not an obscure sentence in the volume. The entire work has been prepared so as to be as useful as possible for the student on the one hand and the active practitioner of medicine on the other. All scientific books should be prepared with the object of being helpful to the man engaged in the busy work of that calling for which the volume is the technical basis.

The B.N.A. nomenclature is followed as closely as possible throughout. The Anglicized form of the terms are used, unless where the Latin terms have become fully adopted as the one to be employed. This has the effect of reducing about 30,000 terms to 5,000.

The authors have followed the original plan of teaching the subject by sections and not by regions. Thus the vascular system constitutes a section, as does the nervous system, and so on. At the end of the volume there is a full and ably prepared section on regional anatomy, entitled "Clinical and Topographical Anatomy." In this section the various regions are carefully described. This section is a most valuable one.

The volume is furnished with a thumb index, which aids materially to the rapid use of the pages by the reader.

Any person who has this volume need go no further so far as anatomy is concerned, and we bespeak for this work a hearty welcome by the medical profession, for it is worthy of such.

LOCAL AND REGIONAL ANÆSTHESIA.

Local and Regional Anesthesia, including Analgesia. By Carroll W. Allen, M.D., of Tulane University, New Orleans, with an introduction by Rudolph Matas, M.D., of Tulane University, New Orleans. Octavo of 625 pages, with 255 illustrations. Philadelphia and London: W. B. Saunders Company, 1914. Cloth, \$6.00 net; half Morocco, \$7.50 net. Sole Canadian agents, the J. F. Hartz Company, Toronto.

We have here a book of much merit. The subject of local anæ-

thetia has made much progress during recent years. The risks and many inconveniences of inducing anæsthesia by a general anæsthetic have been strong stimuli to impell on those who were working on the various local anæsthetics. The perusal of such a volume as the one before us goes to prove with what splendid result these labors have been crowned. The various local anæsthetics are considered, such as cocain, eucaïn, akoin, holocain, tropacocain, stovain, alypin, novocain hydrochlorid, chlore-tone, orthoform, nirvanin, anesthesin, subcutin, propäsïn, quinine salts and magnesium salts. The author gives the preference to beta-eucaïn. The technic for the employment of these drugs is laid down with the utmost care and fulness. The classes of operations suitable for local anæsthesia are detailed, and the author claims a very wide range of application for this method. Operations for the cure of hernia, the removal of the breast, the excision of the thyroid gland, and many others can be successfully performed under local anæsthesia. Careful attention is given to the toxic effects of these agents, and further, to their relative toxicity. Directions are given for the making of the solutions for use and the method of using them. With such a work as this at one's command he need not make any mistakes in the use of local anæsthetics. The book is got up in excellent form, printed on the best quality of paper, in clear type, and well illustrated. We can very highly recommend this volume as one that contains the results of long and painstaking labor in this field of medical research and practice.

ABDOMINAL OPERATIONS.

Abdominal Operations. By Sir Berkeley Moynihan, M.S. (London), F.R.C.S., Leeds, England. Third edition, entirely reset and enlarged. Two octavo volumes, totaling 980 pages, with 371 illustrations, five in color. Philadelphia and London: W. B. Saunders Company, 1914. Cloth, \$10.00 net; half Morocco, \$13.00 net. Sole Canadian agents, The J. F. Hartz Company, Toronto.

When one states that these two volumes give the last word that can be said on the subject of abdominal surgery, he cannot be accused of indulging in hyperbole. In volume one we have General Considerations, Operations upon the Stomach, Operations upon the Intestines. In volume two there are sections devoted to Operations upon the Liver, and Operations upon the Pancreas and Spleen. The author makes the statement that he "describes in detail only those operations and methods which are practised by himself." This is just what the profession would wish. There are two sorts of books: One where the author com-

piles from others, and gives the various opinions and methods. The other sort of book is that in which the author gives his own methods and experience. In the case of an author of the eminent standing of Sir Berkeley Moynihan this latter is the proper course. The reader would not wish the distinguished author to spend his time recording the experiences and methods of others, when his own are so valuable and outstanding. Sir Berkeley Moynihan is not a follower, but a leader, and it is as the latter that his book is of first-class importance to the surgical profession of the world, for a work such as this will be read by surgeons of all languages.

The publishers have done their part well. The paper, binding, typography and illustrations are of such a quality as to leave nothing to be complained of or to be desired. But, important as these things are, they are not the essential things. The one thing necessary to make a great book is the matter it contains, and here this work takes a first place. The author is a surgeon of such wide experience that he has now attained the maximum of excellence as to the operations to be performed for the various conditions, and his method of setting them forth in writing is as clear as his own conception of them.

There is a definiteness about the work that is restful and refreshing. When the reader turns to some condition demanding an operation he is not confused by the account of a series of methods and left to make his own choice, like a confused child in a toy shop. Instead of this most unsatisfactory method, the author clearly states how he does the operation, or the operation which he prefers if he follows the plan of another surgeon; and, in this way, leaves no doubt whatever on the reader's mind. What the eminent author recommends the reader feels to be good enough for him. This would be very dangerous in many instances, but it is the safest thing to do in this case. "I follow Moynihan" might be a good motto for many a surgeon.

We have made no attempt to go into the various operations in detail, as this could not be done in the space at our command. The only way to obtain an adequate idea of this work is to study it; and this every surgeon who operates in the abdominal cavity should do. There is no surgeon so eminent that he can afford to pass this work by unnoticed. As was said of Shakespeare "that he was not of his own time, but for all time," so it can be said of Moynihan that "he is not of his own country, but for all countries and surgeons."

TROPICAL DISEASES.

The Diagnosis and Treatment of Tropical Diseases. By E. R. Stitt, A.B., Ph.G., M.D., Medical Director, U. S. Navy; Graduate, London School of Tropical

Medicine; Head of Department of Tropical Medicine, U.S. Naval Medical School; Professor of Tropical Medicine, Georgetown University; Professor of Tropical Medicine, George Washington University; Lecturer in Tropical Medicine, Jefferson Medical College; formerly Associate Professor of Medical Zoology, University of the Philippines, and Instructor in Bacteriology and Pathology, U. S. Naval Medical School. With 86 illustrations. Philadelphia: P. Blakiston's Son and Company, 1012 Walnut Street. Price, \$2.00 net.

For those who wish sound information on tropical diseases this is the book to go to, as every phase of the subject is discussed. The author takes these diseases up under the headings. Protogoa, Bacteria, Filtrable Viruses, Food Diseases, Helminthic Infections, Granulomata, Skin Diseases, Diseases of Disputed Nature, and Diagnosis. The book deals in the fullest manner with etiology, pathology and treatment, which, of course, is largely preventive. This work is a genuine contribution to modern scientific medical literature. It is written by one who knows his subject and can tell what he knows. We have much pleasure in reviewing this excellent volume on tropical diseases, and bid for it a warm welcome by the medical profession.

MEDICAL NURSING.

By A. S. Woodwark, M.D., B.S., Lond.; M.R.C.P., Lond.; Lecturer on Medical Nursing, and Physician to the Royal Waterloo Hospital and Miller General Hospital for southeast London; Medical Tutor to King's College Hospital; Extra Mural Lecturer to the Dreadnought Hospital; Late Casualty Physician to St. Bartholomew's Hospital, and Senior Resident Medical Officer, Royal Free Hospital. London: Edward Arnold, 1914. Price, 4s 6d net.

Of the class of manuals to which this belongs this is certainly a good addition. The book deals wisely and well with the many questions of medical nursing. There are several chapters in general considerations. These are followed by directions for the nursing of the diseases of the different systems. There are instructions on massage, and, finally, much advice on invalid cookery. There are 68 illustrations in the book. We have examined the contents of this volume carefully and can heartily recommend it to nurses who wish a safe guide in the management of medical cases. The author gives many brief notes on diseases such as will prove of much help to a nurse in the proper care of her patient. We are sure if nurses only knew of this book it would have a large sale.

PROGRESSIVE MEDICINE.

A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by H. A. Hare, M.D., and L. F. Appleman, M.D. Vol. iv., December, 1914. Diseases of the Digestive Tract and Allied

Organs, the Liver, Pancreas and Peritoneum; Diseases of the Kidneys; Genito-Urinary Diseases; Surgery of the Extremities, Shock, Anaesthesia, Infections, Fractures and Dislocations, and Tumors; Practical Therapeutic Notes. Philadelphia and New York: Lea and Febiger, 1914. Price, in paper covers, per year, \$6.00.

The contributors to this volume are Edward H. Goodman, John Rose Bradford, Charles W. Bonney, Joseph C. Bloodgood, and H. R. M. Landis. The mere mention of these names would be all that is required to set forth its claims to the consideration of the medical profession. The publishers leave nothing undone to make this one of the very best of the serial medical publications. It is a quarterly review of the highest order of merit. Each section is assigned to a writer of the highest standing, who in turn tries to make his section the best in the volume. In this way we have the best from the best.

MISCELLANEOUS

THE AMERICAN RED CROSS SOCIETY.

The American National Red Cross Society opened its tenth annual meeting in Washington on 9th December, with President Wilson, its active head, designated as the presiding officer of the afternoon session. Reviews of the relief work accomplished by the society during the past year and proposed for the future, with special reference to the European war, stirred the delegates to a high pitch of enthusiasm.

Counselor Lansing, of the State Department, presented the report of the International Relief Board, of which he is chairman.

The report showed that more than 180 surgeons and nurses have so far been sent to Europe, and said more were urgently needed.

"So great are the number of wounded," it said, "that there are constantly being received reports of the need of vast quantities of surgical and hospital supplies."

CANADIAN M.D.'S FOR FRANCE.

These Canadian doctors, fifteen in number, arrived in France in the latter part of November:

Lieut.-Col. W. A. Scott, Lieut.-Col. R. D. Rudolf, Major P. Goldsmith, Captains C. E. Cole, P. R. Menzies, J. C. Calhoun, G. R. Philp and W. L. C. McBeth, all of Toronto; Captains W. Bethune and M. V.

Leslie, both of Hamilton; Captain W. H. Tytler, of Guelph; Captain McKay, of Montreal; Major R. L. Gardner, Captains W. P. Dillon and N. MacLeod, of Ottawa.

All the doctors named belong to No. 2 General Hospital of the Canadian expeditionary force. The hospital is commanded by Lieut.-Col. J. W. Bridges.

MEDICAL NEEDS.

Inoculation is the thing!

The scientists of every land
 Are laboring with guinea pigs
 A happy and devoted band.
 Phylacogens are their delight,
 This is a prophylactic era,
 And many of the ills of life
 Are fought with variegated sera.

And while rheumatics may be cured
 By needle punches in the arm,
 And gout no longer threatens us,
 And shingles cause us no alarm,
 The doctors have a deal to do
 Before disease is all destroyed
 And we can sit, a healthy lot,
 In bliss complete and unalloyed.

No serum yet has been devised
 To keep a man from writing verse
 With crippled feet (like David's friend),
 Though the disease is growing worse.
 And if we could inoculate
 For Stingy Fever it were well,
 For how the world has ailed with this
 No Paragraphic Pen can tell.

Oh, for a prophylactic aid,
 A serum of especial sort,
 To cure the men who think the world
 Was made for Fashion and for Sport.
 Another stern and fierce disease
 Lurks often in the City air.
 No remedy is found to ease
 The ill of Wanting to be Mayor.

VITAL STATISTICS OF TORONTO.

The following are the comparative figures:—

	Nov. 1914.	Nov. 1913.	Oct. 1914.
Births	1,148	1,189	1,202
Marriages	424	604	573
Deaths	459	467	553

The deaths from contagious diseases were as follows:

	Nov. 1914.	Nov. 1913.	Oct. 1914.
Scarlet fever	1	2	1
Diphtheria	20	6	7
Measles	0	1	0
Whooping cough	0	1	2
Typhoid fever	2	5	11
Tuberculosis	31	17	25
Cerebro spinal meningitis	0	0	1

LETTER FROM LIEUT.-COL. A. T. SHILLINGTON, M.D.

Lieutenant-Colonel A. T. Shillington, writing from Boulogne, France, under date of Nov. 10th, to an Ottawa friend, says in part:

“We landed in France Monday morning at 6 a.m. It is some honor to be the first Canadian commanding officer, and the first Canadian unit to arrive on the Continent. I have nine officers, thirty-five nursing sisters and ninety-three men with me.

“We are in this old French city of Boulogne, and are waiting for orders to open our hospital. We may go a little further inland, but expect to know definitely to-morrow, when we will get down to work. I saw 1,000 wounded arrive from the front yesterday, and it is going to be a great privilege to get to work and help take care of them. I do not know when any other Canadians will arrive, but I am glad to be here, where I can get ready to take care of them when they arrive.

“I have seen a great many of the Indian troops, and they are very keen and look good fighters, and glad to be here. I have also seen two or three hundred of the wounded Indians, and they are happy and do not mind the suffering.

“The British have thirteen hospitals here, all full and doing good work.”

VITAL STATISTICS OF ONTARIO.

An improvement in the health of the province is reflected in the November returns to the Provincial Board of Health. During the month there were reported only 982 cases of communicable disease, compared with 1,120 in December of last year. The principal reduction was in the number of scarlet fever and typhoid cases. Measles was more prevalent and diphtheria about the same as last year. The detailed returns show:

Diseases.	—1914—		—1913—	
	Cases.	Deaths	Cases.	Deaths.
Smallpox	55	2	54	0
Scarlet fever	164	2	298	8
Diphtheria	329	37	319	22
Measles	201	2	175	5
Whooping cough	42	1	60	8
Typhoid	92	10	120	28
Tuberculosis	94	60	90	48
Infantile paralysis	2	0	1	0
Cerebro spinal meningitis	3	3	3	0
	982	117	1,120	119

A PSALM FOR DOCTORS.

The teacher of false ethics is our master; we know only want.

He maketh us serve the dispensary gratis; he leadeth us likewise into other fields of free service.

He thinketh not of our interests; he leadeth us in paths of sacrifice for his vanity's sake.

Yea, though we ask for the economic products of our labor, we receive only titles; for thou art with us; thy retainers they impress and flatter us.

Thou preparest a dinner before us in the presence of said retainers; we are crowned as altruists; but the cost of living proceedeth apace.

Surely hardship and hypocrisy shall follow us all the days of our lives, if we continue to give something for nothing forever.—*Long Island Medical Journal*, July, 1914.

THE NEEDS OF THE CANADIAN HOSPITAL.

Mrs. Edmund Bristol has received a letter from her brother, Mr. Donald Armour, surgeon-in-chief of the Queen's Canadian Military Hospital at Shorncliffe, in which he says in part:

"We need bandages, white gauze or butter muslin, surgeons' lint, boracic lint, tow, unbleached wool, wood wool (these last three are cheaper than ordinary cotton wool). Any hospital—that is, medical or surgical supplies—you can collect will be a perfect Godsend. These things are getting scarce in England, and prices have gone up terribly. Antitetanic serum is almost unobtainable. I got the last twelve dozen left in London—War Office has commandeered it all. Of clothing, underclothes and colored handkerchiefs are wanted."

Mrs. Bristol will be pleased to receive donations for the Queen's Canadian Military Hospital. They may be sent to her address, 179 Beverley Street, Toronto.

BASEBALL ACCIDENTS.

Thirty-five deaths and 918 injuries were caused by baseball during 1914, according to figures made public by a sports writer who kept a tabulation of the season's records.

Of the players who died from injuries twenty were hit by pitched balls, five were struck by bats, four were in collisions, four over-exerted themselves, one was hurt sliding to a base, and one was killed in a fight. Injuries to amateur players are classed as follows:

Broken limbs, 314; concussion of brain, 18; fractured skulls, 13; paralysis, 4; sprains, 37; spiked, 26; fractures, 17; dislocations, 7; torn ligaments, 10.

Players hurt in the minor leagues number 116; American League, 69; National League, 61; Federal League, 56, and college teams, 8.

THE CANADIAN HOSPITAL IN BRITAIN.

The Queen's Canadian Military Hospital, which has been established in England through the Canadian War Contingent Association, is regarded by War Office officials as equal to any voluntary hospital

started since the beginning of the war, according to information received from Hon. George H. Perley, Acting High Commissioner. Mr. Perley is president of the association, which includes in its membership Canadians and Anglo-Canadians resident in Great Britain. It is estimated that the provision and maintenance of the hospital for a year will cost \$100,000, and Canadians are being asked to subscribe.

MEDICAL PREPARATIONS

THE TEST OF A TONIC.

The field and function of a systematic tonic is generally understood and appreciated by both physician and patient. To stimulate, whip or goad the vital processes is not to "tone," but, on the contrary, to ultimately depress. A real tonic is not a mere "pick-me-up," but some agent that adds genuine strength, force and vigor to the organism. The genuine tonic is a builder or reconstructor of both blood and tissue. Any agent which will increase the power of the blood to carry and distribute the life-giving oxygen is a tonic in the best and truest sense of the word. Iron in some form is an ideal tonic, as it builds up the vital red cells of the blood and the hemoglobin which is their essential oxygen-carrying element. Of all forms of iron, none is quite as generally acceptable and readily tolerable and assimilable as Pepto-Mangan (Gude). It creates appetite, tones up the absorbents, builds the blood, and thus is a real tonic and reconstructive of high order. It is especially desirable because of its freedom from irritant properties, and because it never causes a constipated habit.

GLYCO-THYMOLINE IN TYPHOID FEVER.

To keep the alimentary tract as free as possible from fermentable matter, to inhibit as far as possible the activity of the putrefactive bacteria which normally inhabit the intestinal canal, and to eliminate the toxin produced by the bacillus typhosus as rapidly as possible are desirable results to accomplish in treating typhoid cases.

The power of Glyco-Thymoline to produce these results is amply proven by clinical reports from eminent physicians in all parts of the country.

The distressing condition of fissured tongue and "cracked" lips is immediately relieved and the sordes of teeth and mouth quickly removed by the use of Glyco-Thymoline.