Western Canada Medical Journal

A MONTHLY JOURNAL OF MEDICINE
SURGERY AND ALLIED SCIENCES

WINNIPEG, CANADA

VOL. IV NOVEMBER 1910 NO. 11

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Western Canada Medical Journal

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Commonwealth Block, Winnipeg, Man.

Published on the Fifteenth of Each Month

Vol. IV — NOVEMBER, 1910 — No. 11

INDEX TO CONTENTS

EDITORIAL 481

PRESIDENTIAL ADDRESS TO THE WINNIPEG MEDICO-SURGICAL SOCIETY by Dr. J. O. Todd 485

PRESIDENTIAL ADDRESS TO THE WINNIPEG CLINICAL SOCIETY By Dr. R. F. Rorke 489

CONSIDERATIONS CONCERNING THE IDENTITY OF LANDRY'S PARALYSIS AND ANTERIOR POLIOMYELITIS. By S. Peirce, M.D. Pathologist to the Winnipeg General Hospital 494

CLINICAL MEMORANDA, 2 Cases 501

Continued on page III

INDEX TO CONTENTS

Continued from page I

MISTAKES IN DIAGNOSIS AND THEIR AVOIDANCE. By R. P. Rowlands, M.S. F.R.C.S. Assistant Surgeon to Guy's Hospital..... 504
CORRESPONDENCE..... 512
A PSEUDO-ARACHNOID MEMBRANE ASSOCIATED WITH EPILEPSY 517
EXTRACTS..... 519
MEDICAL NEWS..... 522
STATISTICS..... 527
MARRIAGES..... 527
OBITUARY..... 527
PERSONAL..... 528

NOTICES

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Remittances at the risk of the sender, unless made by Registered Letter, Cheque, Express Order or Postal Order.

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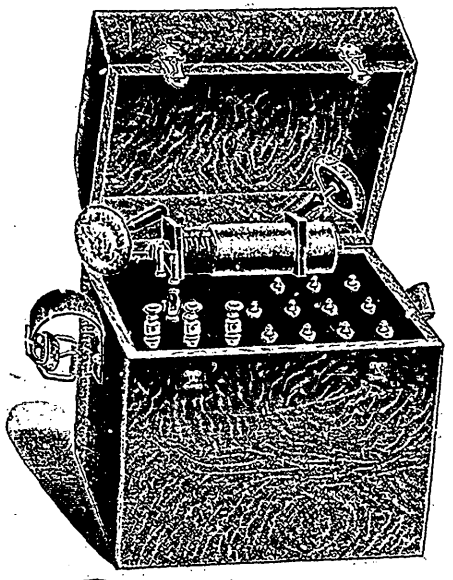

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An Unconventional Cough Syrup.

There are "cough syrups" without end. Some of them, it is needless to say, have little or no therapeutic value. Conversely, there are some that no physician need hesitate to prescribe. One of these—Syrup Cocillana Compound (P. D. & Co.)—is so exceptional in many particulars as to be worthy of special mention just now, when coughs are so plentifully in evidence. By its name no one would recognize it as a preparation for "coughs" and "colds," and this, in connection with its general efficiency, constitutes one of its chief claims to distinction. It is a product which the layman knows nothing about. It does not encourage counter-prescription or self-medication. It was designed especially with reference to the needs of the prescriptionist.

The formula of Syrup Cocillana Compound, which of course is plainly printed on the label, is quite unusual. Let us briefly consider its components: Euphorbia pilulifera—serviceable in the treatment of chronic bronchitis and ephysema; wild lettuce—a wild and harmless narcotic, useful in spasmodic and irritable coughs; cocillana—valuable expectorant, tonic and laxative, exerts an influence on the respiratory organs similar to that of ipecac; syrup squill compound—serviceable in subacute and chronic bronchitis, as an expectorant, and as an emetic in croup; cascarin—the bitter glucoside of cascara sagrada, useful for its laxative action; heroin hydrochloride—a derivative of morphine and extensively prescribed in the treatment of cough, carminative and antiseptic, serviceable in coughs of pharyngeal origin.

Syrup Cocillana Compound would seem to be worthy of extensive prescriptiona.

MEDICAL JOURNAL

VOL. IV NOVEMBER, 1910 No. 11

EDITORIAL

Time the Profession of Manitoba Realized its Rights

About twenty-five years ago the medical profession of Manitoba was called together by the College of Physicians and Surgeons in Winnipeg for the purpose of obtaining a definite opinion as to the advisability of establishing a medical school in the province of Manitoba, and finally at a meeting in an upper chamber of the Confederation Life Building, thirteen members of the profession were elected by ballot as Trustees and empowered to obtain a charter for the establishment of a medical school. At the same session of the Legislature at which application was made for the charter, four medical men, led by Dr. Aikens and Dr. Chown, tried to obtain a charter for a private institution. The late Premier Norquay, however, did not consider it right to place the medical education of the province in the care of any other than the whole profession. Consequently he supported the Trustees' application which was eventually passed. Thus the incorporation of the present medical school as an institution under the control of the medical profession of Manitoba. That it is this now in theory only, not in fact, is the fault of the apathy of the profession. This "letting things slide" and then complaining seems to be a characteristic of the profession. So far it has been a case of "Let him take who has the power"—and a few have taken the power. The profession has the power and right if it chooses to control the Medical School.

A few considered that the institution should be a private

corporation according to their construction of the charter, and though no money had been put out by the Trustees individually except as small subscriptions pooled voluntarily for equipment for their lectures, the medical profession was ignored. After the first appointment of professors, however, five members of the profession, Drs. Gray, Blanchard, Patterson, J. R. Jones and the late Dr. Neilson, later came to the rescue of the apathetic profession and fought the battle for their rights, proving that the Medical School was not a private corporation and that those members who had taken upon themselves the control were only Trustees.

For the last three years, we have pointed out the closed corporation tactics of the Medical School. However, we find now the fault is not with the Medical School authorities but with the medical profession of Manitoba who have allowed matters to so drift that, although legally they have the control, the School is to all intents and purposes a closed corporation. Is it not time the profession placed the Medical School on a basis satisfactory to all? What is needed for this and other reforms?

Need of Unity Voiced By Societies.

The answer to this can be found curiously in the addresses of both the president of the Clinical Society and the president of the Medical Society, which we publish in this number—Unity. That both Societies feel Unity the greatest need is evidence that there must be a lack. This is serious. In every calling in life great changes are taking place—great reforms—some by evolution, others by revolution. This call for Unity shows a desire to join together for some progressive purpose. We cannot jog along in the same old rut. We must change and advance with the times, or get passed in the race. If we can advance peacefully by evolution, so much the better for the cause and the individual—but choke evolution and you get revolution. What could choke evolution in this case—what could retard progress? The answer is here: "Foreign men who have visited Canada

have not been slow to criticise the manner in which finances have here been permitted to concentrate into the hands of a few principal men and institutions till it has become almost impossible to carry out any considerable undertaking without their help or permission. That the position needs broadening in the worst possible manner is very evident. It will not eventually mean less business to the institutions which have heretofore dominated the situation. It suggests the thought that possibly a new group of financiers may have arisen to do battle with the old and to create a broader situation." Substitute medicine for finance and you have the position of medical affairs in the West at the present time. Of course, there are those who will tell us the old, old story of perfect unity and peace except for what they are pleased to term "a few soreheads." These judge others by themselves and cannot conceive of men wanting anything but material advantage to themselves in every act of their life. However, the army calling for reform is increasing in number and strength daily. To those who think that there is no need for the request for Unity, we would point out that the presidents of Societies can very easily gauge whether there is unity among the members. Last year there was no mention of this need, proving that the desire for reform must be increasing and the leaders for the year must have felt that in many points there was a lack of united action of members—the old order not being in accord with the new. However, the realization of the need for reform is not limited to our profession, nor to Manitoba. All over the world this is going on. We are lagging. The profession as a whole, while following the march of scientific achievements, has forgotten to take steps to improve its material welfare and its business relations with the public. Unity is needed for this. For our own protection we need to be united—for protection from quacks and charlatans who have obtained freedom to practice from the various cults which have sprung up from time to time and threaten the public health by neglect of all laws pertaining to quarantine of contagious diseases. Further, we need unity to obtain

beneficial legislation at the hands of the political powers. At present the profession has no real voice on vital questions before the State. This is caused by division over petty matters. The true welfare of the race can only be attained through co-operation of the profession and the public, or if the profession as a whole continues apathetic on this matter then it will be the co-operation of the progressive band with the public. To return to the benefit to ourselves. Many evils could be removed, for instance, there is no law that can reach the commission-paying, fee-splitting, commercial surgeon who is in the profession for revenue only. He is too hard-shelled to be moved by moral suasion, but when he sees unanimity of feeling expressed against his methods he may change. Many a conscientious scientific physician, after a lifetime of toil, has gone to his reward leaving a good name as an only heritage to widow and children—a sad reflection upon our business integrity and co-operation. Co-operation would enable the doctor to take more interest in his duties as a citizen. Organization or Unity is the watchword in every other avenue of business. That the medical profession generally is awakening to its needs is shown by the present great activity in the cause of medical reform going on all over the world. WHAT ARE WE GOING TO DO?

ORIGINAL COMMUNICATIONS

PRESIDENTIAL ADDRESS TO THE WINNIPEG MEDICO-SURGICAL SOCIETY.

By Dr. J. O. Todd.

One more stroke in Time's infinite pulse record has to be marked off since we last met in annual gathering and it is my happy lot not to be called upon to note a missing face from our midst, but on the contrary, to welcome fresh ones. It seldom happens that a body of our numbers can listen to the unmuffled stroke of Time's Hammer as he tolls off the passing of a year. But while we have thus to be thankful for our own unbroken ranks we must bow the head to the passing of one who was a friend to the sick and the encourager of those whose work it is to help the sick—the passing of King Edward. In him were combined the qualities of brain and heart that make the great ruler and in the field of medicine his sound judgment chose and his warm heart infused sympathy into those methods of work best adapted to give direct help to the sick and encouragement to the physician.

Ladies and Gentlemen,—We are facing a new year in the work of this Association; surely we can do so with the formation of some good resolutions. There is virtue, I think, in the new year habit of making a good resolution and even if failures occur, there must, I feel, be, in the main, a great impulse for good given forth from the concentration of mind upon one purpose to do better. What one of us is there, as he faces the unwritten page of the future, that does not resolve to merit the inscription thereon of records of success. The reward, if the word reward is allowable, of success, comes to us in varying shape; sometimes we may think it passes us by, though that, I fancy, is but the effect of the passing mood for when we face our lives fairly and give play to untram-

melled judgment our conclusion will be that we have our reward proportioned to our work. Ladies and gentlemen of this association, we are members of a branch of the great organization of world-workers, the aim of which, however much befogged it may seem to our eyes, is the betterment of the human race, a healthy optimism is gaining. More and more it is being accepted that much, if not all, of the inequality and injustice of life is of man's own making and must be a man's own unmaking. Amidst the inconsistencies of government; in the jarring of doctrinal discussion; in the unhappy antagonisms of labor and capital; in the whirling rapids of many-consulted systems of health-giving, one can, I think, if clear-visioned, see the guiding forces that are determining for the righting of wrong. Foremost in the battlers for truth must be placed the physician. Slowly has he emerged from a position once menial and obscure to that of power till now he is recognized as the guiding factor in creating that greatest of a nation's assets—the people's health. Slowly has his knowledge of the workings of the human body in health and disease been accepted by a people ever ready to persecute and misunderstand. Time was when the physician was the ball of the thin-minded Voltaires and Montaignes; but the righteousness of true medicine was voiced by those clear-toned tribunes of the profession, Lydenham, Harvey, Hunter and from their days a steadily increasing respect has been paid. This can most truly be said of the profession in older countries than ours. In Canada we are far from being an effective body, chiefly, as it seems to me, from our faulty organization. In the union of the profession is its strength and always we have before us the example of the greatest of all medical organizations, the British Medical Association, and in the nation to the south of us, the American Medical Association, with its steadily increasing effectiveness. In Canada we are in the formative stage and it is unfair to compare too criticaliy our conditions with those of older states. The Canadian profession has developed from widely separated spots of settlement and it has been but natural that these

isolated points should grow with such its own laws and that from the variety of conditions there should arise diversity of law. Each of these settlements has been drawn into closer touch by improvement of transportation and by rapidly increasing population and with these must come a breaking of pioneer conditions and with the passing of pioneer conditions must pass also pioneer methods. Hospital management that did duty under such conditions will not do for the modern institution. Sanitary measures have to overcome constantly multiplying complications—Colleges for the teaching of medicine need the equipment and governing policy of the age and the work of medical associations becomes important. It is not enough that medical societies meet to discuss technical points, they ought to be devoting some energy to larger ques-questions. To my mind a great step in the right direction has been taken by some of the Eastern provincial associations in affiliating themselves to the national body. Some may not think that the time is ripe for this action on the part of the Western associations. In my opinion it ought to be done. The splendid position of the British Association is due to the effective linking of all its branches. The steady advance of the American Medical Association has come with the perfection of its affiliating policy and it seems to me that the failure of a movement that is almost universally opposed in Canada —the movement for Dominion Registration—can be charged to this lack of organization. Had affiliation of provincial societies preceded the formation of this bill, I am convinced that its course would have been happier. Once show a united profession by a national organization having affiliation with such province and subdivisions thereof and its voice will be listened to. We need, in Canada, a national Department of Public Health, with a minister, responsible to the people. at its head.

At the present time, we in Canada, are struggling for a solution of the best form of hospital administration. What body of men is there, in our community, so competent to speak on this question as the body medical and yet how little

attention have we, as a body, given to the vital principles now being discussed. Is there adequate hospital accommodation in Winnipeg or is there not? Where could these and many other matters of importance to the profession and public be more intelligently discussed and lines of action decided upon than in our societies? To my mind such advice as our medical men are in a position to give to the public is best done through the avenues of our associations and not left to the somewhat star-chamber method or self-advertising-inspired-way of private talks or newspaper letters of individual medical men. Our great national society, our provincial associations and the representative local bodies should make pronouncements on public health affairs. Legislators and hospital administrators think that we do not care, that we have no power and instead of obeying the commands of a united profession, they listen to the words of individual medical men with too often the result that imperfect legislation on the one hand or ill-judged measures on the other, is effected.

Ladies and Gentlemen,—I make my plea, then, for organization and close my address with a short quotation from the brilliant article from the pen of Lauriston Stow, of London, England. "I am appealing to you to support professional union. Assured that the aim of the profession is an absolutely unselfish one, I desire to see its members cast from them as a guide to conduct in their mutual relations, the miserable doctrines of the struggle for existence and the survival of the fittest, and, working shoulder to shoulder, build firm the foundation of a great professional brotherhood."

PRESIDENTIAL ADDRESS TO THE WINNIPEG CLINICAL SOCIETY

By Dr. R. F. Rorke

Members of the Clinical Society of Winnipeg:—

In accordance with the custom of this and other societies of a similar nature, I wish to make a few remarks upon some points of current interest to the medical profession in general.

However, first allow me to thank most heartily all those who have been kind enough to bring cases, both surgical and medical, here for examination and discussion. I use the terms medical and surgical in their widest sense. I trust the clinics have proved interesting and profitable to all who have taken part in them. If I may be allowed to suggest, to our newly elected officers, from my observations during the past year, I would say that it would be better to include some of the more common clinical conditions in our proceedings. It seems to me upon many of the everyday illnesses a thorough discussion of their clinical manifestations and treatment could be made of interest to everyone, besides a more complete interchange of ideas and methods would be possible. I do not wish it inferred that I deprecate the exhibition of the rarer pathological conditions, but rather that we are inclined to let them assume too large proportions in our transactions, thus displacing the careful consideration of the diseases which it is essential that we know minutely.

It is a pleasure to be able to chronicle that during the present year provision has been made for the care and treatment of persons suffering from incipient Phthisis, also that advanced cases of Tuberculosis are to be provided for, as far as the city is concerned, at least.

The last named institution should render less bitter and less uncomfortable the closing days of many unfortunate individuals, while the former should realize the educational influences in methods of general hygiene as well as rescue many who would otherwise become advanced cases and both should

prove of considerable value in limiting the disease to the primary sufferers.

Some steps have also been taken in the matter of providing better accommodation for those having diseases requiring isolation. It is to be sincerely hoped that the question be not allowed to rest until properly accomplished. I think we will all agree that for those whom the authorities insist upon isolating in a hospital when they are not able to fulfil the requirements of the regulations at home, proper and adequate provision for their care and treatment should be made.

Upon such questions as these it may be very pertinently asked if we, as a profession, are not very remiss in our attitude toward preventative measures that must be undertaken by the various public bodies. It is rather the usual way for us to go on temporizing and putting up with all sorts of inconveniences for our patients and ourselves to the detriment of our results and consequently to our professional reputations. There is no doubt but that we as a class suffer in prestige and fail to accomplish much of the good of which we are capable by our lack of organization, or, perhaps, by our diffidence in laying our views before the public. It would be more dignified and business-like, I think, to state clearly our position as far as the present status of our knowledge will allow, upon all questions, municipal or national, necessary to safeguard the health and development of the human race.

It ought to be possible and feasible to provide machinery adequately representing the profession, that might be consulted or act in an initiatory way where desirable. Such a body ought to be of great value in the settlement of those difficulties upon which medical men as a class possess special knowledge.

There is another point in the relations between the public and the medical man upon which I shall speak briefly, mainly because it is not a live question here as yet but is so in the industrial countries of Europe and is sure to eventually be so here when our industrial population becomes greater.

That the social and economic conditions in America, more especially in the United States, are quite rapidly becoming like those of Europe was the subject of two articles in the October number of the North American Review. One dealt with the political issues having a sociological bearing. It shows how corporate wealth is becoming the dominating power and that democracy will, in all probability, have to fight its battles all over again from a different standpoint.

The other article deals with changes taking place in the trade of United States, how they are fast losing their place as a large exporter of food stuffs of various kinds and that within a comparatively short time the country will not be producing enough for its own needs.

During the present epoch there in much restlessness among all those engaged in industrial occupations. The wage-earner has come to insist upon some better provisions being made for his present as well as his future welfare. He feels that he is not getting his due proportion of the profits of his labor, besides the increase of knowledge must add to the desire for independence.

To meet this condition of affairs governments are enacting measures of various kinds to provide for old age pensions, accident and invalidity insurance to which the government, employer and employee contribute in varying proportions. Besides these there are compensation acts governing an employer's liability for accidents; in fact, a recent discussion in the British courts makes it seem desirable for an employer to have every workman examined before engaging him as an employee. The case referred to was one where a man suddenly died while engaged in screwing bolts together to make a condenser bath. At the post-mortem it was found that rupture of an aneurysm of the Aorta was the cause of death. The man knew nothing of its existence. The House of Lords held that the employer was liable for damages, though it was shown that the man was not fit to work and might have died in his sleep. Just in passing I may say that it seems strange to see a socialism that a few decades ago was warning against

the fraternal sm of governments now equally strenuous in endeavoring to obtain a number of decidedly fraternal provisions. Another peculiar thing is that the medical man is classed with the capitalist and not with the wage-earners. I leave it to you to decide how closely that decision corresponds to the facts.

Under all these new arrangements the medical man becomes a necessary and important factor in carrying them into effect. Just here is where the trouble comes in. There is a very strong tendency from both sides to give us very meagre remuneration. We know how benefit societies value our services, that the corporations are just as niggardly in recognizing a sufficient compense for work done and that the State is quite as bad an offender.

In Germany, where there is compulsory insurance upon all persons earning less than a stated sum, about $500.00 a year, I believe, it is found that it does not apply to the pauper nor to the casual worker who is a probable candidate for pauperism, therefore, under like conditions, there is no probability of the necessity of medical and surgical charity dying out for lack of material. I have introduced this paragraph to show that the need of professional philanthropy will not be abolished by these new schemes.

In Great Britain and Ireland the reports of a Royal Commission upon the Poor Law has given rise to a great deal of discussion upon the question of State insurance for sickness and invalidity. It is proposed to make it compulsory for all those earning 160£ a year or less to take out a required amount of insurance. If this is done there will, it is estimated, remain rathere less than one million persons with a greater income than that mentioned above. Reckoning five persons as the average number composing a family there would not be more than five millions men, women and children available for those medical men in private practice.

This would place the wage-earners out of the other thirty-nine millions making up the total population of the United Knigdom under the provisions of the insurance regulations

which, it is said, would withdraw them from the private practitioner's clientele. Then medical attendants becoming government officials or at any rate reducing their practice to contract work for which it is though by the authorities 250£ a year would be the probable salary.

Medical men see the probability of most unfavorable conditions arising out of such plans. They are mostly agreed that in the treatment required by the very poor from whom no fees can be expected the patient need not have the choosing of his medical adviser. However, for those contributing to an insurance fund some considerable scope must be given them to select their medical men. Here again there seem to be difficulties in the way some fearing a system of bribery, if I may call it so, by which one physician out of a group in a locality might get most of the work. It is just at such points where the fallibility of human nature manifests itself and no doubt it will be most difficult to provide safeguards, indeed, it seems to me that our present conditions have the same disadvantages.

The point I wish to make is that the medical profession should not wait to deal with the contract conditions of practice but should set its house in order to meet the question before it arrives. It seems to me that we must endeavor to interest the leaders of our occupation in our sociological conditions. They who give so freely of their time and talents to the laity should surely be able to give considerable time and thought to subjects having such an important bearing upon the existence of their colleagues. I have no fear but that the matter will be satisfactorily settled if the profession take the time and trouble to go seriously into the subject, neither do I fear that a body of men who have given so freely of their best for the general welfare of mankind will be cheese-paring and exacting in their demands from the public.

CONSIDERATIONS CONCERNING THE IDENTITY OF LANDRY'S PARALYSIS AND ANTERIOR POLIOMYELITIS.*

By R. Peirce, M.D.,

Pathologist to the Winnipeg General Hospital.

Dating from 1907 to the present day the disease known as Anterior Poliomyelitis has been epidemic in North America. Largely developed in New York it has spread westward in Michigan, Wisconsin, Minnesota and Manitoba. It is safe, I think, to predict that when the literature of this epidemic comes to be revised several diseases hitherto described as separate entities will be seen to be merely manifestations of this dreaded and protean malady.

The object of the present paper is to call in question the right of Landry's Paralysis to be described as a separate disease and to fuse it with Poliomyelitis. That the one is but a manifestation of the other has been already recognized where large epidemics of the latter disease have been studied, e. g., by Wickman in Stockholm[1] and by Koplik in New York.[2]

The description given below of Landry's Paralysis is taken from the monograph on that disease by E. Farquhar Buzzard which appears with a slight difference in both the System of Medicine by Allbutt and Rolleston and the System edited by Sir Wm. Osler.

"In 1859 Landry described the following case of acute general paralysis which ran a rapid and fatal course in rather less than two weeks.

A laboring man, aged 43, who had been in very indifferent health for a year before his death complained for a few weeks preceding the onset of any definite paralysis, of tingling in his fingers and toes and of general weakness which, however, did not prevent his walking a considerable distance to the hospital where he came under observation on June 1, 1859. On June 13th his legs began to fail and the tingling sensations spread towards the proximal parts of his upper and lower extremities. In a few days all four limbs were

*Read before the Medico-Chirurgical Society of Winnipeg, October, 1910.

more or less completely paralysed and after a short interval the muscles of the trunk and especially the diaphragm shared in the general los. of power. There was no pain and his mind remained clear. The temperature was not raised and the actions of the bladder and bowels were unimpared but the reflexes were lost and there was some blunting of the sensibility in the peripheral parts of the limbs. The paralyzed muscles responded to the faradic current and did not show any tendency to contraction. With increasing respiratory difficulty some weakness of the masticatory muscles and of the tongue appeared although all the movements of the face and eye-balls were normally performed. A sense of constriction round the thorax and numbness in the limbs were described in addition to the tingling already referred to. The patient died quite suddenly on June 25th while he was being propped up in order to take food. With the exception of pleuritic adhesions no gross changes were detected at the necropsy. A careful microscopic examination of the spinal cord failed to reveal any morbid process. The peripheral nerves were not investigated." [3]

Buzzard gives the following diagnostic table differentiating Landry's Paralysis from Anterior Poliomyelitis:—

	Landry's Paralysis	Anterior Poliomyelitis
Temperature	99°-101°	102°-104°
Constitutional	No constitutional symptoms of importance	Vomiting, anorexia, rigors, convulsions in children.
Sensory	Early paraesthesias, very little or no sensory loss, little pain or tenderness.	Acute pains in back and limbs much increased by passive movements. No sensory loss
Motor	Progressive, symmetrical and even distribution of palsy over trunk and limbs. No atrophy or electrical changes until late date.	General palsy at first but escape of muscles here and there soon noticed. Early atrophy and electrical changes in some muscles.
Cranial Nerves	Partial affection of deglutition, articulation and phonation if life is prolonged.	Occassion affection of one joint or one occular or one glossal muscle.
Prognosis	Very grave but if recovery takes place it is often complete and permanent.	As regards life, depending on respiratory embarrassment; as regards complete recovery, very bad.

Although in the classical case Landry found no change in the spinal cord, nevertheless Buzzard notes the following changes in typical cases:

"The cord is firm and natural in consistence, although the vascularity of the grey matter may be obviously increased. Small haemorrhages may be noticed in the nerve tissues. The cerebro-spinal fluid is abundant and clear.

Microscopically—a smaller or larger number of cells especially of the anterior horns and Clark's column show—the changes characteristic of degeneration—these are most marked usually in the lumbo-sacral enlargement. The vessels are engorged—rarely a slight excess of round cells may be seen in the immediate neighborhood of one or two vessels." [5]

It will be seen that these changes differ in degree rather than in kind from those described in Anterior Poliomyelitis. Mr. Allan Starr, of New York, in Nervous Diseases, Organic and Functional, describes the symptoms of the disease as follows:—

"The disease begins suddenly and affects first the muscles of the lower extremities, producing a rapidly increasing flaccid paralysis. There is no tremor, contracture, spasm, or cramp in the muscles. There is loss of the tendon reflexes. There may be numbness of the legs but there is rarely pain. The paralysis advances rapidly from the legs to the thighs, then to the muscles of the trunk, back, thorax, arms, neck, then to the muscles of deglution and speech. The bladder and rectum usually remain in a normal condition, though in a few cases they have been paralysed. Sensory disturbances in some cases do not appear at all, in others numbness or formication may be felt, but there is usually no marked anaesthesia. Consciousness remains clear to the very end. The disease runs its course in from three days up to two weeks."[6]

In connection with the pathology of the disease Starr admits that different observers have made conflicting findings, some finding no changes in the spinal cord, others like Bailey and Ewing describe "a widely disseminated acute Myelitis,

with vasular and peri-vasular inflammatory conditions with acute degenerative processes, and with all the characteristic appearances seen in cases of very acute myelitis."[7]

In September 1908 and again in August 1910 (i. e., during the months when Poliomyelitis is known to be most prevalent) there occurred at the Winnipeg General Hospital two cases of an acute ascending paralysis which, in the light of the foregoing, must be diagnosed as Landry's Paralysis. Their histories are as follows:—

Case 1. A young man, a painter, English, age 28, took sick August 20th 1910 with pains in the stomach. The next day he had slight headache. He continued work, however, during the 22nd, 23rd and 24th. On the 25th he consulted a physician who suspecting typhoid advised his admission to the hospital. He was admitted August 26th. At this time he had slight paresis of the legs—staggering when he walked. He complained of numbness of the right leg. His temperature was 101½. On August 27th he had lost almost complete power over his legs. The left leg was completely paralysed. The right could be extended but not flexed. There was no apparent loss of sensation. Paralysis was flaccid and passive movement caused no pain. Tendon reflexes were absent. He had retention of urine. On August 28th the legs were completely paralysed and he began to show respiratory distress. The diaphragm and lower thoracic muscles became paralysed and as long as power in his arms persisted he maintained respiration by means of the muscles of the neck and shoulder girdle. Then the left and later the right arm showed signs of weakness, also the muscles of deglutition, the patient finding difficulty in clearing the throat of mucus. Still sensation in the legs remained normal and the mind clear. Artificial respiration maintained life for some hours, but the patient died at 7.30 p.m., August 28th, eight days after the onset of symptoms and three days after the commencement of paralysis.

Case 2. A young man, laborer, American, age 24, took sick September 14th 1908, with numbness all over the top and back of the head and slight headache.

On September 15th, 16th and 17th his headache became more severe and he developed anorexia but his condition was not such as to compel him to stay in bed. On September 18th he consulted a physician who diagnosed typhoid and advised his removal to the hospital. He was admitted on September 20th. At this time his temperature was 102½. He had severe frontal headache. Urinalysis was normal. Widal reaction, negative. He had some slight difficulty in walking. The pupils were unequally dilated. On September 22nd the right leg and left arm were paralysed. Sensation remained normal; tendon reflexes were absent. There was no pain on passive movement of the paralysed limbs. Pupils were equal and reacted to accommodation and light. He had retention of urine, but no incontinence of feces. On September 23rd left leg and right arme became paralysed. On September 24th he developed respiratory distress. This continued with increasing intensity until his death on October 2nd, eighteen days after the onset of symptoms and ten days after the commencement of paralysis. His temperature only once rose to 103 (at the time of the onset of respiratory failure) and for a week previous to his death did not rise above 100 degrees. His mind remained clear until the end.

Considering these two cases in conjunction with the diagnostic table published by Buzzard it will be seen that in the comparatively low range of temperature, in the absence of marked constitutional symptoms, in the presence of paraesthesias and the absence of pain on passive movements of the paralysed limbs, on the progressive nature of the palsy advancing rapidly to a fatal issue—the conclusion is inevitable that on clinical grounds alone these must be classed as true cases of Landry's Paralysis and NOT Anterior Poliomyelitis.

Both of these cases came to autopsy. Of the second permission was given to remove the cord only. On the first a complete autopsy was made and the brain, cord, and portions of other organs were preserved. The organs of case 1 showed nothing of importance beyond excessive congestion of the kidneys and spleen and the changes in the heart and

lungs incidental to death from suffocation. There were no signs of typhoid ulceration in the bowel. In neither case were there any marked naked eye changes in the meninges or substance of the cord beyond engorgement of the vessels and pin-point haemorrhages in the substance of the cord. Microscopic changes in the cord, however, were striking and similar in both cases. These consisted of moderate round-celled infiltration of the meninges with marked perivascular round-celled infiltration of the vessels of the cord, most marked around the branches of the anterior spinal artery, but not confined entirely to it. The large motor cells of the cord appeared in various stages of degeneration. In the lumbar enlargement these had practically all undergone dissolution with the exception of a few scattered cells. In the dorsal region the cells of the anterior horn appeared as only a few shrunken remnants, but the cells of the posterior vesicular column of Clark appeared unaffected. In sections made immediately below the medulla similar changes were noted. Perivascular infiltration was present but less in intensity. The motor cells showing most marked degenerative change were those in the neighborhood of the antero-median fissure. The posterior portion of the cord showed the persistence of a goodly number of multi-polar cells.

It will be seen that these are the changes characteristic of Anterior Poliomyelitis in early fatal cases. The following description of changes in the cord seen in fatal cases of Anterior Poliomyelitis occurring in the recent epidemic of this disease in Minnesota is by Dr. H. E. Robertson, of the Department of Pathology, University of Minnesota.

1. Congestion of vessels, especially those leading to the anterior horns.

2. Perivascular infiltration of polymorphonuclear and mononuclear cells, the latter being both lymphoid and endothelioid in type.

3. Infiltration of pia and nerves running from anterior horns.

4. Necrosis of grey matter of anterior horns, especially

the ganglion cells with diffuse infiltration of polymorphonuclear and mononuclear cells.

5. Haemorrhage into grey matter of anterior horns.

6. Thrombosis of vessels in region of haemorrhage (seen only in one case).[8]

These also, in the main, are the changes described by Flexner in the cords of cases of Anterior Poliomyelitis in monkeys produced experimentally.[9]

It will be seen that we here have two cases of undoubted Anterior Poliomyelitis clinically indistinguishable from Landry's Paralysis. On what grounds, then, are we justified in making a diagnosis of Landry's Paralysis? Only in the presence of an ascending paralysis, rapidly advancing to a fatal issue and without changes gross or microscopic in the cord. Such a condition is inconceivable. We can only conclude that were such changes are not recorded they are either those of Anterior Poliomyelitis, as in the case cited by Starr; or differ from them in intensity, not in kind, as in the descriptions given by Buzzard.

In view of the above facts the conclusion is scarcely to be avoided that Landry's Paralysis is but a manifestation of acute Anterior Poliomyelitis.

Winnipeg General Hospital, October, 1910.

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2. Am. Jour. Obstetrics, Sept. 1900, page 562.

3. A System of Medicine, Allbutt & Rolleston, 1910. Vol. 7, page 670.

4. Ibid, page 679.

5. Ibid, page 673.

6. Organic and Functional Nervous Diseases. Starr, 1900, page 455.

7. Loc. Cit., page 455.

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9. Jour. A.M..A, Vol. 55, No. 13, page 1105.

CLINICAL MEMORANDA

Winnipeg Clinical Society

Dr. Richardson presented the following case of Diaphragmatic Hernia.

Miss V., unmarried, aged 21. Seen first six months ago, from examination found pregnant seven months. Gave a history of two or three attacks of appendicitis but had refused operation. She had two subsequent attacks of appendicitis before labor. She suffered great inconvenience from constipation. Had a mastitis which resolved under local treatment previous to labor. Labor was normal. The mastitis developed again after labor and incisions had to be made into the breast under an anaesthetic. This drained well and healed quickly. A month later we removed the appendix which we found diseased. Four days after the operation she complained greatly of pain in the abdomen; on examination found her temperature 100-102 degrees, pulse 110, respiration 18, but there was no abdominal distention and the wound was healthy. The chest showed apex beat in the third inter space midway between the mid-line and nipple. On percussion an area of dullness was found under the heart. Percussing the right side of the chest found an area of dullness over the base of the right lung, though the border of the lung moved on respiration. Two days later the area beneath the heart became hyperesonat and remained so. The base of the left lung showed some dullness on percussion.

There was no vomiting. The temperature dropped, and the anorexia disappeared. The wound healed by first intention. Though the constipation remained very obstinate, there was no disturbance of respiration at any time.

In the discussion that followed it was suggested that it was a case of highly-placed Diaphragm but they could not account for the accompanying symptoms.

Dr. Rorke presented the following case:

I. D., male, aged 49, laborer. Complains of fainting spells.

History of illness: In the latter part of 1906, while handling cordwood, he received a severe blow in the testicles causing them to swell enormously and obliging him to remain in bed for twelve weeks, during which period he suffered severely from constipation that continued for the next two years, when he had a severe attack of loss of consciousness which was the beginning of his present illness.

Preceding this attack, which occurred at Kenora, he had been drinking moderately of beer, he fell from his chair, becoming completely unconscious, and was admitted to the Kenora hospital. He regained consciousness on the third day but was unable to recognize where he was. About a week later he returned to work. The patient remained well for a year when he began to suffer from milder attacks, and during the winter 1909-10, while working at lumbering, he had numerous attacks varying in frequency and periods of intermission. Quite frequently during a series the attacks would come on many times a day. I first saw him in May 1910, one of the days when he was suffering from many attacks. In describing the onset of an attack he says that there is a rather peculiar sensation described as palpitation in the precordial area which serves as a warning, and gives him time to grasp his chair or some convenient object to keep from falling; this is quickly followed by a period of unconsciousness. After the attack he feels rather weak and prostrated.

There is no history of any convulsive movements, biting of the tongue or involuntary passage of urine or froth on the lips, except possibly on one occasion when his wife thinks there was some to be seen.

Personal History. Patient was born in Scotland, coming to Canada in 1885. Does not remember being ill previous to coming to Canada, except with measles. Has never had acute rheumatism though he has had some pains in the shoulder joints. Had gonorrhoea in 1899, recovering in about a month and never stopped working for it. Has always worked at

heavy work and drank a good deal, especially whiskey.

Family History. Father died at age of 79, cause unknown. Mother died of cancer of the breast at the age of 45. One brother and one sister died in infancy. The other members of the family are alive and well. No brother or sister suffers from a similar ailment.

Present Condition. The patient is a man of medium height and muscular development, very little subcutaneous fat. The vessels in the temporal region are markedly tortuous and prominent. The skin shows evidences of psoriasis. The chest is slightly barrel-shaped. Noticeable pulsation in the epigastrium. Chest walls rather thin. Lungs, borders somewhat lower than normal. Cardiac area giving a percussion sound of lung except near the left border of the sternum.

Apex beat in the sixth intercostal space rather broad and firm just inside the nipple line. During two examinations the heart rate was 43 and 48 per minute respectively. The same rate was recorded in the radial artery at the wrist—at other times the rate was 60 per minute.

A systolic murmur was to be heard at the apex of the heart and on one occasion a diastolic murmur could be heard in the aortic area.

Abdomen—Negative.

Urine—Sp. Gr. 1022. No albumen or sugar.

Discussion. Dr. Speechly, Pilot Mound, expressed the opinion that a slow heart was usually a vigorous heart and thought that owing to the constipation epileptiform seizures should be the more probable diagnosis.

Dr. Rorke pointed out that there was no evidence of passing urine during the attack or biting the tongue, besides, the slowing of the pulse rate pointed to a heart lesion.

Dr. Hunter, who was taking polygraph tracings during the demonstration, was able to show that there were distinct evidences of more frequent beats in the auricle than in the ventricle.

MISTAKES IN DIAGNOSIS AND THEIR AVOIDANCE.

By R. P. Rowlands, M.S., F.R.C.S.

Assistant Surgeon to Guy's Hospital.

I wish to thank you for the honor you have done me by asking me to read a paper before you. I do not come professing to tell you something new, but to start a friendly discussion upon a subject that must appeal to all—"the making of mistakes and how to avoid some of them."

To err is human, and medical men are human, despite the people's high and flattering expectations. We all make mistakes, but do we always learn from them, or do we soothe ourselves by saying, "I should make the same mistake again to-morrow in a similar case*" He who believes this nonsense builds for himself a fool's paradise, and he deserves to grow no wiser. Surely we can learn how we fall and profit by our falls. We have either failed to collect or to consider judiciously all the available evidence, or we have not thought of all the possibilities, but we have allowed ourselves to be prejudiced in favor of what appears to be the obvious.

Accurate Diagnosis is a jewel of price to be sought by every available means, for it is the secret of reasonable and successful treatment and of intelligent prognosis. It is only obtained as a reward of labor. Nowhere are Carlyle's words on labor more applicable than to the medical man's arduous search for accuracy in diagnosis:

"Hast thou valued patience, courage, openness to light, or readiness to own thy mistakes. In wrestling with the dim brute powers of fact thou wilt continually learn."

"Is there not in thin inmost heart a spirit of active method giving thee no rest till thou unfold it-"

How should a diagnosis be made? It must be based upon facts, and, for the proper collection of these, orderly methods and accuracy of observatioin are essential. But even facts are of little value without the knowledge and understanding

that are necessary to interpret them aright. I propose to deal with these steps in order, and to illustrate my remarks by mentioning a few of my own mistakes, and some others.

The collection of facts is often a laborious business, demanding great patience and preserverance. It is particularly difficult to get a good history from some patients, who frequently forget to mention the most important things, because they naturally do not understand their significance. It is not always easy to obtain an accurate account of existing symptoms; for instance, a patient may be incapable of localizing an abdominal pain. The patient's account, if complete and carefully checked by cross-examination, is of the greatest value, and is usually very suggestive, indicating the lines along which the examinations are likely to be especially profitable. Yet, for some reason or another, material historical facts sometimes remain unknown until it is too late. A forearm was amputated for supposed sarcoma with spontaneous fractures of the radius and ulna. It was presented to a museum, where upon dissection the disease proved to be ununited fracture with considerable callus due to want of rest. It was found afterwards that the patient had sustained the fracture in a domestic quarrel. An X-ray examination or even an exploration would have settled the diagnosis and saved the limb.

Orderly Methods.

Systematic methods of examination are of great importance, and it is only by adopting them that most dreadful catastrophes such as diabetic and uraemic coma, following operations of convenience, can be avoided. Think of a young man going into diabetic coma after the removal of a varicocelle when the examination of the urine which should precede all operations would have prevented the operation. The well-known association of diabetes and boils and carbuncles should always be borne in mind. A doctor opened a carbuncle upon the forehead of a diabetic child. An anaesthetic was given and coma supervened. The parents thought that the brain must have been wounded at the operation. A systematic

examination should surely prevent gastro-jejunostomy for the vomiting of early pthisis, and the gastric crisis of locomotor ataxy, Yet this operation has been performed for these conditions. The same operation was nearly performed for uraemic vomiting, but the uraemic blindness brought in the ophthalmic surgeon, who saved the situation. When I was house-surgeon I sent in for operation for strangulated femoral hernia a woman who had been constipated and vomiting for three days, and had a tender, hard, irreducible swelling at the saphenous opening. The surgeon agreed, but the sister pointed out that there was early erysipelas at the ankle; the temperature was raised also.

A man, who was thought to have had influenza ten days earlier, was sent to me for cystoscopy. He walked into my consulting room. Upon systematic examination I discovered an appendicular abscess in the pelvis; the appendix was gangrenous.

So-called specialists are very apt to confine their examinations to their own especial regions, and to attribute all symptoms to disease of these regions. A specialist upon nervous disease overlooked hip disease in a child for months, thinking the wasting of the thigh to be due to infantile paralysis. Similarly, gynaecologists often overlook subacute appendicitis, and call it ovaritis. There are others who cannot get their minds off gout, duodenal ulcer, or chronic constipation.

We sometimes fail to have a correct diagnosis because we omit to use certain methods of examination, especially some of the fewer ones, which we may not appreciate at their true value or find too troublesome. Often there are difficulties of place and circumstances; it is one thing to make a diagnosis in a well equipped hospital and quite another to attempt one in a remote country cottage without modern conveniences. It is important to be open to receive information from every available source.

What a number of mistakes and incomplete diagnoses arise from not using the Roentgen rays! Think of the fractures and dislocations that have been overlooked, and the

compensations that have been claimed and awarded. A young man was out shooting buck in Siam, and was accidentally shot by his companion. There were two holes, one on each side of the crest of the tibia, and it was therefore thought that the bullet had passed through the leg, and noX-ray examination was made, although the patient travelled far to an apparatus. After a great deal of misery the bullet was shown to be in the central canal of the tibia, and was removed a year later.

A number of movable kidneys have been fixed, when stones are the real cause of the pain. It should be a rule in all urinary cases to examine with the X-rays before any operation is performed. All the urinary organs should be examined. Some time ago I had to remove a disorganized calculous kidney a year after an exploration for movable kidney had been found, and the movable tumor was said to have been the liver.

Stones were removed from the kidney of a man who soon afterwards died of uraemia. Many stones were then discovered in the opposite kidney. The X-ray examination had been limited to one side. Moreover, the average total urea excretion had not been estimated in this case, so that an entirely wrong estimate had been made of the danger of the operation. Numberless mistakes have been made because the cystoscope, sigmoidoscope, laryngoscope, and ophthalmoscope have not been used at the right time.

Accuracy of Observation.

The power of observation is to some extent inborn, and sometimes amounts to genius, but it is partly the result of habit and education. It is one of the most valuable acquisitions for a medical man, and one that his daily work fosters. There is little doubt that a country life in childhood, and the study of the exact sciences tend to cultivate it. Without it even systematic methods of examination are useless. It should be our constant endeavor to become more and more accurate. A number of mistakes are made over fluctuation. An old man had a large swelling in the left pectoral region,

thought to be a sarcoma of the ribs, but deep fluctuation proved it to be a chronic abscess. Another had a swelling over the hip, which was needlessly incised, because fluctuation had been tested across instead of along the course of the muscle fibres.

It is sometimes difficult to say whether a swelling is translucent or not, and mistakes are common from using a too powerful light. An old lady with a swelling over the front of the shoulder was said to have a Morrant Baker's cyst due to osteo-arthritis of the joint. But on examination with a more reasonable light, the swelling was not translucent. Moreover, the opposite shoulder also creaked. Her husband, who was an inventor with time on his hands, had ransacked the British Museum for information about Morrant Baker's cyst and its treatment, only to be referred back to his studies with special reference to lipoma. At the operation the fatty tumor was found to arise from the subsynovial tissue about the bicipital groove. This is the fourth case of the kind that I have seen, and the same mistake had been made by different observers over all of them. In using various difficult measures of examination, such as cystoscopy, beginners are apt to make a good many mistakes. A little blood clot has been mistaken for a vesical growth, and strictures of the rectum, urethra, oesophagus have been wrongly diagnosed, because of the folding of mucous membrane and pressure of the advancing instruments in wrong directions.

These valuable methods need a certain amount of judgment in their application, and it is well to remember the late Dr. Moxom's wise hint that a microscopic examination is not the best way of telling the difference between a turnip and a swede.

Similarly, sigmoidoscopy is not the most suitable way of discovering internal piles, bleeding from which has led to the needless suspicion of growth in the lower part of the large intestine, out of the reach of the finger.

It is rarely wise to accept the results of the observations of others; it is safer to confirm them whenever possible. I

was asked to operate upon a boy of about 7 years of age for intestinal obstruction. The distension of the abdomen and the bulging of the flanks were so enormous as to make it almost certain that the obstruction was low in the large intestine. Volvulus of the sigmoid colon was the only thing that could explain the extreme distension, but the boy was not nearly bad enough for this, nor did the history support it. The subcutaneous abdominal veins were greatly dilated. It was said that the rectum was normal, but on careful bimanual examination I discovered a softish enterolith which acted as a ball-valve at the upper part of the rectum. Upon pushing this back a great amount of liquid faeces and gas escaped. It was then possible to break up the faecal mass, and to remove it in pieces. The boy was able to go home after three days, and was saved from needless laparotomy.

Many mistakes are made in the examination of the urinary organs of women. It is too often forgotten that it is necessary to exclude a vaginal source of pathological products. Pus was repeatedly discovered in the urine of a young lady, and was associated with frequency of micturition and pain along the right ureter. The X-ray report was negative; therefore an exploration was suggested for tuberculosis of the right kidney. Later a catheter specimen was found to be normal, and a cystoscopic examination and segregation showed that both kidneys were normal; therefore, I explored the abdomen, and discovered the cause of the symptoms to be cystic disease of the right ovary, whose capsule was very thick as a result of suppurative appendicitis. For want of careful examination of the back spinal caries is often overlooked for months and treated as stomach ache. Without a wide knowledge it is impossible to be correct, and to keep himself up-to-date in this respect is one of the constant difficulties of a medical man. The busier he gets in his practice, the less time he has to devote to improving his mind. Strange as it may appear, there are many members of the profession who have not yet even heard of Dr. Hertz's ingenious method of examining the stomach and intestines with bismuth and the

X-rays. During the last year I have come across two patients with disease of the stomach, with extreme wasting, in which the diagnosis of malignant disease had been made and hopeless prognosis given. The bismuth method proved them to be suffering from hour-glass contraction of the stomach.. One of these Dr. Hertz kindly examined for me, and I successfully performed gastro-gastrostomy. The other one I examined by the bismuth method myself, and I have only operated on her this week. In this case there was pyloric obstruction as well, therefore Finney's operation had to be performed at the same time. The pyloric pouch was seen to be dilated on the screen, and pyloric stenosis was diagnosed. No amount of knowledge will avail without a proper understanding of the significance of the facts discovered, and without an imagination capable of suggesting all the possible solutions, and a judgment capable of deciding upon the most probable. It sometimes requires a very comprehensive mind to keep conscious of all the facts and possibilities of a difficult case, and in such cases it is always a wise plan to write down the most important points and things to be considered. One of the most helpful principles in diagnosis is that of exclusion of the improbable from the list of possible, and thus to select the most probable. Beyond this we often cannot go. It is very important to consider all the available evidence, and to decide which facts are material. In spite of our efforts there are many cases in which we are unable to arrive at a definite diagnosis. This is especially true in certain urgent abdominal conditions. In many of these an absolute diagnosis is often not essential. What is really important is to be able to decide without delay whether an exploration is, or is not, advisable. If we wait until we have made an absolute diagnosis we will lose a great many lives. The same is true of many subacute and chronic abdominal diseases. It is especially true of early malignant disease of the stomach and intestine.

Lightning diagnosis, although it may be very fascinating and brilliantly successful in some cases, is bound to lead to error in many others. It is always wise to put it to the test

of a cooler judgment soundly based upon all the available facts. The following is a glaring example of a mistake arising out of excessive hurry. A child was seen sucking a curling pin, and a little afterwards was found crying, and the pin was missing. The mother thought that the child had swallowed it, and hurried him off to the cottage hospital. There the abdomen was opened and the stomach examined, but the pin was not found. Three days later the pin was discovered in the patient's cot at home. Fortunately the child recovered. As a contrast, a triumph of more careful methods may be mentioned. An elderly woman was considered by two physicians and a surgeon to be suffering from malignant disease, probably affecting the gall-bladder. She was very ill, sallow and wasted. The shape of the swelling suggested to me that of the lower pole of the kidney and its distended pelvis, but the urine was said to be normal. Upon microscopic examination, however, pus cells were found in a centrifugal deposit. Cystoscope examination showed slight chronic cystitis, and no urine could be seen issuing from the right ureter. Segregation confirmed this. Pyonephrosis was therefore diagnosed. Radiography did not discover any stone, and the tuberculin tests were negative. Therefore some form of valvular obstruction was considered to be the most probable cause. At the operation the upper part of the ureter and the pelvis were folded like a concertina by old periureteral adhesions, and the junction of the ureter and the pelvis were valvular. The kidney was hopelessly disorganized, and was successfully removed. At one spot in front the kidney had perforated and had become adhered to the parietal muscles just below the liver. The resulting induration had previously been regarded as evidence of spreading malignant disease.—B.M.J., December, 1909.

CORRESPONDENCE

To the Editor.

Dear Sir,—I note that in the Old World some of our profession are airing their grievances in the newspapers. They find that whatever may be written to their own press goes little beyond the profession and this may be one of the reasons medical men seem so incapable of uniting to remedy their own ills, especially those of a pecuniary nature. One evil they are fighting is the "Prescribing Chemist." How often do patients take so and so on the advice of the chemist. This is obviously a great wrong, especially to the poorer class of patients who naturally, through their ignorance, are the chief victims,—for they pay for what they do not get—experienced advice. While mentioning this evil one hardly needs to state that there are many chemists who would scorn such a dishonorable way of earning money. There may be chemists unaware that if a patient dies under his treatment he will be charged with a grave crime—also for prescribing as an apothecary he is liable to a fine of $100.

Considering the amount of money, time and brains required to become a qualified practitioner and that as compared with other callings, the pecuniary results are very moderate. Surely, this is a matter the Council of Physicians and Surgeons everywhere should take up. With regard to the advisability of airing our grievances in the public press, many will refer to medical etiquette and the dignity of the profession. To be consistent, then, it would be well if certain members of our profession made less use of the daily papers for airing their views on every possible occasion.

Yours for progress,

MANITOBAN.

"SURGERY'S BALANCE SHEET."

Editor, Western Canada Medical Journal.

Sir,—In the October issue of your Journal there appears

an article under the above heading containing statements which are apt to be misleading.

The reference to "Surgeons who lose every case they touch" may be passed over with sorrow and regret that such men should continue to undertake operations. These men are not surgeons, they do not practice surgery and their results should not be debited to surgery properly so called. The statement that the mortality of operations for Cerebral Tumors is 100% is incorrect as a very superficial search in medical literature will demonstrate.

In Binghaid's System of Operative Surgery, Vol. III, pp. 269 and 270, will be found the following:—

Mortality—"Duret collected reports of 400 cases, of these 40=36%, died within one month. Oppenheim reports 371 cases of which 140 died=37.7%. Von Bergmann estimates the mortality at 36%, Knapp at 32%, Horsley reports 79 cases in which a correct diagnosis was made and the tumor removed, with 7 deaths from "shock"=8%, and 16 cases inaccurately diagnosed with 6 deaths=37%."

In the face of these statistics to state that operations for intra-cranial tumors are unjustifiable is absurd.

Referring to abdominal operations involving opening of the peritoneal cavity, it is stated, "Even in the hands of most accomplished surgeons death is a common result." This I deny, it is absolutely untrue. It would be easy to refute this wild assertion by overwhelming evidence, but it will suffice to give a brief statement of the personal experience of one who does not claim to be "a most accomplished surgeon" but merely competent and careful with sound judgment, a good working knowledge of anatomy and a sufficient degree of manual dexterity to do his work cleanly and with no unnecessary waste of time. I began to do important surgical work 25 (twenty-five) years ago. With regard to abdominal operations including a considerable number of cases of Appendicitis, operations on the stomach and intestines, the ball bladder and bile ducts, removal of tumors, ovarian and others, Hysterectomies for Fibroids, Pus tubes, Ectopic "Gestation"

and so forth. From the beginning until now my mortality is just over (six) 6% for all cases. If I exclude "expected deaths," that is cases which were apparently hopeless, in which operation was undertaken as a desperate effort to save life, the results show a mortality of only (two) 2%.

I have lost no case of "internal operation" for appendicitis nor have I lost a single case of "acute fulminating appendicitis," operated upon within the first 24 hours.* The only deaths after operation for appendicitis which have occurred in my practice were those in which the favorable time for interference had been allowed to pass by physicians who were either unobservant or who belonged to the "wait and watch" class. It is hardly fair to debit surgery with the inevitable or almost inevitable result of this antiquated practice. No doubt a large proportion of cases of appendicitis will get well without operation, probably 50% or more. The rest will surely die.

Whereas, if every case were operated on by a competent surgeon at the beginning of the illness, the mortality would be practically nil. It is the waiting to make sure that the case is sufficiently serious which loses the golden opportunity. In other words, good surgery is capable of saving say 98% of cases which would surely die and those which might have got well without operation are saved the risk of immediate death and the further risk of subsequent attacks—a very important point.

It is stated that "If the surgeon or the surgeon in combination with the physician is not able to say that death is inevitable without operation and that operation is likely to prevent death, then he knows too little to be entrust with the life of a human being."

On this point I have no hesitation in declaring most emphatically that in many cases if a surgeon waits until he is

*Some cases operated on within periods of time varying from 4 to 12 hours from onset of symptoms would possibly have been lost had the operation taken place even 24 hours from the commencement of the illness.

able to state that death is inevitable unless he operates, the death will occur in spite of the operation. And then there will be another, improper debit item to the account of the art of surgery. I am able to recall several cases in which I have advised immediate operation without being able to go so far as to say that death would inevitably follow if the operation did not take place, the result showing that death would infallibly have resulted had there been any delay.

To give one instance—Within the last few weeks I was asked by a colleague to see a healthy young married woman of fine physique with the following history: At eleven the previous night she retired to rest perfectly well. At 2 a.m. she was seized with violent abdominal pain. She vomited three times. The bowels acted. She became a little faint and chilly. I saw her at 9.30 a.m There was general abdominal tenderness, slight muscular rigidity, slight pallor, a normal temperature, pulse 120 and rather thin. She had not missed any menstrual periods and had had no symptoms of pregnancy. The diagnosis was ruptured ectopic gestation. In reality more of a guess than a scientific diagnosis. Now, we were certainly not at the time in a position to affirm that death would speedily follew unless an operation took place. Supposing the diagnosing to be correct it is perfectly well known that many cases recover without operation. Nevertheless immediate operation was advised and assented to. The pelvis and lower abdomen were full of blood and the bleeding when the rupture was found can best be described by the word furious. W ould it have been good practice to wait for symptoms of haemorrhage to become alarming and so in all probability have deprived the patient of her chance of life? Most decidedly not, and yet then and not till then could one have predicted a certain fatality without operation. The patient made a rapid and uneventful recovery and without doubt owes her life to prompt action under circumstances which your author regards as proving my unfitness to have charge of a human life.

No doubt there is much in the article that is deplorably

true. No doubt operations are lightly undertaken by men who are not capable of doing good surgical work. Probably your author is not far out when he describes the mortality after operations for appendicitis as appalling taking all cases and all operations into consideration. But I do not think that the remedy lies in the direction of legislation and inquests. Take deaths from anaesthesia, for instance. Death will occur no matter how careful the anaesthetist works. At one time inquests in London were not uncommon. The finding was invariably "death from misadventure," no blame attaching to any one. But anaesthesia is necessary and, to prevent alarming the public, for some years past it has been the custom of the great hospitals with the connivance of the authorities to ascribe deaths from anaesthesia as due to "shock."

Public enquiries would cause unnecessary alarm and it is in my judgment doubtful if there would follow any beneficial result. I believe the remedy lies with the teaching schools. It is not every man who takes up medicine who has what may be called a surgical head or surgical hands. It is not every man who has the temperament required to be a good operator. Let the teacher endeavor to find the right sort of men to train as surgeons and impress upon the others the advisability of leaving operations alone. Let them inculcate rather more ideal morality and discredit the mercantile idea, teach their students that it is not a fine thing to jeopardize a life for the sake of a fee. Give them a better clinical training so that they can learn to judge promptly where it is necessary to call in the surgeon and give them to understand the immense importance of every hour's time in doing so.

I have, I find, taken up more space than I intended, but it is impossible for one who is really devoted to his art to read your author's article without feeling deeply that with the best possible motive he has made a very unfair attack on modern surgery.

I have the honor to be Sir,

Your obedient servant,

M. S., M.D.

A PSEUDO-ARACHNOID MEMEBRANE ASSOCIATED WITH EPILEPSY.

Any fact relative to the cause or treatment of a condition which as yet is clouded by so much indefiniteness and obscurity as is epilepsy, should be eagerly considered by the profession. The discovery of a well-organized false membrane lying between the arachnoid and the piamater in a child of thirteen who suffered from epilepsy, is of sufficient interest to justify reporting.

This girl is one of a family of six, she being the only ailing member. No alcoholism, syphilis nor epilepsy could be elicited in any family connections. At the age of two years she had a severe attack of meningitis, recovering with apparently no sequalae. She enjoyed excellent health, not even complaining of headaches, until reaching her ninth year, when epilepsy developed. The attacks increased in number and severity until, at the age of thirteen, she had from six to eight per day, the spasms always beginning in the flexors of the left hand.

Medical treatment proving unavailing I decided to operate making a large osteaplastic flap over the right motor centre, exposing six square inches of brain surface. There was little adhesion between the dura and arachnoid, the latter was somewhat thickened. Beneath the arachnoid, and distinct from the piamater was a dense pseudo-membrane almost as thick as blotting paper, non-adherent, uniform in appearance and extending over the whole area and as far as could be followed beneath the skull. The arachnoid was split in numerous places and the false membrane removed. It was not considered advisable to further enlarge the opening, but I am convinced that if the seizures are not relieved a further removal would be justifiable.

It is now eight months from the operation, the child has improved, the fits have decreased in number and severity, a week occasionally elapsing without one, yet at times having three or four slight ones within twenty-four hours.

The effusion of lymph and subsequent organization of a pseudo-membrane is occasionally the product of simple meningitis of infants, as well as of the acute cerebro spinal type. Osler speaks of a pseudo-subarachnoid membrane as an occasional secondary process in pneumonia, described under pachymeningitis internal. In the State Insane Hospital of Washington, out of 1,185 post-mortems, there were 197 cases with "a true neomembrane of internal pachymeningitis." Of these 22 suffered from chronic epileptic insanity. .

The improvement following the case operated upon is sufficiently encouraging to justify the more extensive use of exploratory measures in the absence of a history of trauma.

ERNEST A. HALL, F.R.C.S., Edin.
1301 Davie St., Vancouver, B. C.

EXTRACTS.

THE FREQUENCY OF TUBERCULOSIS IN CHILDHOOD.

The difficulty of applying the local tuberculin tests to school children is, according to H. Nothmann (Berl. klin. Woch., February 28th, 1910), insurmountable, and in no other way can the true frequency of tuberculosis in childhood be ascertained. He, however, considers that it is worth while investigating the conditions obtaining in children in orphan asylums, institutions, clinics, and polyclinics, although he realizes that the morbidity among such children will be higher than it is among the total child population. He has investigated this subject. In Vienna and in Munich the incidence of tuberculosis, as evidenced by the various tuberculin reactions, rises from 7 per cent., 9 per cent., and 10 per cent. (according to the test employed) during the first year of life, to 60 per cent., 68 per cent., and 94 per cent. during the period from 10 to 14 years. In Berlin Müller found 9 per cent. for the first year, 22.4 per cent for the second year, 30.5 per cent. for the period 2to 4, 36.8 per cent. from 4 to 6, and 53.7 per cent. from 10 to 14. Petruschky found in Danzig none in the first year, 50 per cent. from 1 to 6, and 74 per cent. from 7 to 14. Engel and Bauer, working in the Children's Asylum in Düsseldorf, found 16.5 per cent. in the fourth year of life, and a morbidity which rose up to 53 per cent in the fourteenth year. The author's own investigations in the same town showed the following results:

Years of Life.	No. of Cases.	Positive Reactions.	Percentages.
3-5	15	7	47.0
6-7	25	14	56.0
8-9	41	29	70.7
10-11	54	44	81.5
12-14	07	82	84.5
15-17	12	12	100.0

In explanation for the greater number of tuberculous children in his investigations as compared with Engel and Bauer's, he stated that he did not regard a case as negative unless two attempts with Pirquet's test and one with the "dépôt" test (subcutaneous reaction) proved negative, while the latter classified their cases after a single Pirquet test. He does not undertake to discuss the absolute value of the dépôt reaction in detecting a latent tuberculosis. He admits that the incidence will be different in better situated children, but his figures justify him in regarding tuberculosis as a children's disease, and in requiring that the children's doctor should adopt means to prevent its occurrence in children.

INDICATIONS FOR A FRUIT CURE.

Taillens (Journ. des prat., May 7th, 1910) states his belief that in the dietary which the human economy gets in comparison with what it really needs, rich and exciting foodstuffs form too large a part. And if this dietary is indulged in day by day, more particularly during the period of growth, pathological states, especially those associated with what is known as arthritism, will inevitably follow. These results may be noted in the case of families who, having lived simply in the country, modify their manner of life when they better themselves socially. The first generation does not suffer in most cases from arthritism, but it is very noticeable in the second generation, even in infancy, in the form of anginas, urticarias, and chronic enteritis; while in adult life the arthritic diathesis will manifest itself in obesity, migraine, eczemas, and haemorrhoids. If the same dietetic errors are perpetuated to the third generation, the graver forms of arthritism will appear—for example, diabetes, neurasthenia, gout, and renal calculus. The author, while believing in the potent influence of heredity, expresses the view that alimentary hygiene exercises just as great an influence. To counteract the effects of this pernicious dietetic heritage, the author advocates foods pure in proteids and those things which increase the alkalinity of the blood. Among the latter he places

the fruit cure, a form of treatment available for all classes. This treatment is valuable in the case of gross livers who clog the system with a plethora of food and drink, and is useful also for those semi-invalids who awake each morning with headache, with a disagreeable taste in the mouth, and similar symptoms, and who are indeed dyspeptics without being aware of it. The effect of the fruit cure is diuretic and laxative, diminishing the acidity of the urine, lessening intestinal fermentation, and stimulating the action of the liver. The author recommends this treatment also in acute nephritis, when fruit can supplement the dietetic poverty of milk in carbohydrates. The fruits may be raisins, oranges, pears, etc. Under the mixed treatment of milk and fruits the albuminuria lessens, diuresis is encouraged, and oedema disappears. If it is wished to improve the weight of the patient, an average quantity of raisins with a dietary rich in fats and albumens is given. If, on the contrary, it is desired to reduce weight, a large quantity of raisins or raisin juice is to be taken, with a corresponding reduction in proteids and fats. Other fruits as well as vegetables will, of course, be given. The author concludes by saying that his results show that the incorrect use of a good remedy is more often responsible for bad results than the remedy itself.

MEDICAL NEWS

As a result of the semi-annual examinations of the British Columbia Medical Council for registration to practice, the profession of physician and surgeon in British Columbia, the following have duly qualified: Drs. C. S. Bastin, J. Bell, A. Bechtel, M. Campbell, H. Coulthard, D. Davis, D. Donald, F. Ewing, E. Fewster, J. Fowler, S. Holman, A. Hunter, O. Rarge, H. Lindsay, W. McDonald, W. McKay, R. McKenzie, H. McMillan, M. McNaughton, J. McNaughton, H. Marchant, W. Murray, J. Nay, K. O'Neill, L. Patten, S. Peele, A. Price, A. Ridewood, J. Shaw, B. Shinbein, A. Sinclair, N. Telford, S. Wilson.

Dr. F. W. Mott delivered the triennial Huxley lecture at an opening of the winter session of the Charing Cross Hospital Medical School and dealt with the question of the hereditary aspects of nervous and mental diseases. He computed that there were in the London County asylums 2,000 patients who were parents and offspring—brothers and sisters and collateral relations. In the analysis of 1,834 cases made up from 854 families, there were two instances of 6 of a family, three instances of 5, twelve instances of 4, eighty-five of 3 and seven hundred and fifty-two of 2. A fact which stood out prominently in the last illustration was the much greater incidence of transmission from parents to offspring through the female side. There were 44 cases of father to son, 51 cases of mother and son, 58 of father and daughter, and 104 of mother and daughter.

The percentage in which the mother transmitted insanity to the offspring as compared with the father was 67.7 per cent. to 39.3 per cent.

Sir Rupert Boyce, Professor of Pathology at Liverpool, has just returned from West Africa and made the important statement that he had come to the conclusion that yellow fever was epidemic to the West African Coast and that for years it had been mistaken for malaria.

Lord Kitchener, in a recent speech to the students of the Middlesex Hospital, London, stated that owing to preventive medicine the health of the army in India has enormously improved. Inoculation and sanitation have together made enteric fever a rarity; cholera has almost completely banished from military cantonments. The net result of recent medical developments in India is a reduction of 50 per cent. in the ration of sickness and mortality to the strength of the army . . . He stated that there were now two wide fields open for further advance—first the direct prevention of specific diseases by inoculation and by suitable sanitary precautions, including such measures as draining mosquito-haunted marshes; secondly, there is the indirect prevention of disease by building up a human organism with large powers of resistance. This latter task simply means improving the breed of human beings. The reduction of the birth-rate has to balance it up, the greater care for the children born and this means the improvement of the race.

Sir Frederick Lugard has been making an appeal to Englishmen with regard to the proposed Hong Kong University, the primary object of which is to provide a readily accessible institution where Chinese young men may study Western learning and particularly medicine and engineering through the medium of the English language and under the influence of English ideals without losing touch with their own home influence and traditions.

The need for Medical Reform in many respects is felt as much in the Old World as in the New. The most urgent reforms needed may be summarized under the following heads:

1. Full and direct representation of the medical profession on the General Medical Council.
2. A "one-portal" system of examination.
3. The suppression of unqualified persons.

"Work for the good of the coming race and we will have real conservation."—Dr. Robertson.

Dr. Maude Abbott is the first Canadian woman to receive an honorary degree from a Canadian University for merit in

scientific work. An honorary degree was conferred on her at the recent convocation at McGill as a recognition of high scientific standing. In 1906 Dr. Abbott won the position of Governor's fellow in pathology at McGill. A few weeks ago she received the status of lecturer, the degree of M.D., C.M. honores causa. Dr. Abbott contributed a monograph on "Congenital Cardiac Diseases" to Dr. Osler's well-known system of medicine.

In France it is forbidden under severe penalties for anyone to give infants under one year any form of solid food unless such be ordered by written prescription, signed by a legally qualified medical man. Nurses are also forbidden to use in the rearing of infants confided to their care at any time or under any pretext whatever nursing bottles provided a rubber tube. Several other similar and equally stringent laws have recently been enacted by the French government.

The examiners at the recent British Columbia examinations were as follows: Drs. R. E. McKechnie, Tunstall, O. M. Jones, C. J. Fagan, A. E. Walker, W. H. Sutherland.

During the first half of 1910 the births in France exceeded the deaths by 2,180. During 1909, the deaths exceeded births 28,203.

St. Mary's Hospital, which has been doing such good work at New Westminster, is to be closed on instructions from the Had Order in Montreal.

The Saskatchewan provincial government have decided to locate the provincial asylum at Battleford. The government have already secured the land and the sum of $100,000 has been voted by the legislature for the asylum. Building is expected to begin in the spring.

A $50,000 hospital is to be built by the Order of Providence, Montreal, at North Battleford.

"The Medical and Dental Acts Consolidation Bill," under the auspices of the Council of the British Medical Association, strongly urges similar reforms and presents the process cut and dried as follows:—

(1) That at least half the members of the General Med-

ical Council should be directly elected by the general body of medical and dental practitioners in the country, instead of the large majority, as at present, being appointed by the Universities and Corporations, bodies financially interested in the examining and licensing of students and practitioners.

(2) That the General Medical Council should have complete control over the registration and education of medical and dental students, including fixing the standard of preliminary general education requisite for admission to medical study.

(3) That there be a "one-portal" system for admission to medical and dental practice respectively—namely, through a State examination conducted by the General Medical Council under the supervision of the Privy Council.

(4) That the practice of medicine or dentistry by unregistered persons or by companies, and the signing of medical certificates by unregistered persons, be more completely prevented.

It will be observed that the whole effect of these recommendations is to make the General Medical Council a powerful and efficient reality.

Dr. Augustus Stowe Gullen, of Toronto, will represent the medical alumni in the senate of the University of Toronto to which honored position she has recently been appointed.

Three women doctors have passed Royal College of Surgeons (London) examinations and were also granted the D.P.H. They are Miss Hilda Kate Whittingham, Miss Helen Payne and Mrs. Alice Van Ingen.

The Calgary Medical Association and oculists of the city are sending a deputation before the provincial legislature to request that a rigid examination be required of all oculists practicing in the city.

Dr. Black, when speaking before the Moose Jaw Canadian Club, brought up the necessity for a Federal Board of Health.

The Sanitary Review, in the current number, devotes considerable space to a discussion of the question of the pol-

lution of water supplies, referring particularly to Saskatchewan and Alberta. Dr. Hodgetts, medical adviser to the Conservation Commission, advocates also a Federal Council of Health with powers to make interprovincial and international arrangements and regulations for water pollution prevention.

The Board of Managers of the Calgary General Hospital are considering a proposal that the private charter under which the board operates be given up and the hospital put under the direct jurisdiction of the City Council. This change seems favored by the medical men. The city contributes 25 cents a patient per diem and the government an equal amount. The cost per patient is about $1.25.

In Saskatchewan cases of tuberculosis and typhoid must be notified.

Saskatchewan is the only province that has a Bureau of Public Health instead of a Board of Health. The Commissioner of Health has very wide powers.

The Royal College of Physicians, London, England, was founded in 1508 by Henry VII who recognized the necessity of proper training and licence for the practice of medicine. He placed in the hands of the College summary powers of a stringent nature for the purpose of suppressing quacks. These powers are not now properly enforced—if they were London could be rid of quacks and quack medicines. A request is now being made for a Royal Commission to inquire into the whole subject of unqualified medical practice with instructions to inquire into existing legal powers for its suppression and to advise as to the best machinery for future control.

The Clinical Society of Winnipeg elected the following officers for the year 1910-11: President, Dr. J. G. Munroe; Vice-President, Dr. J. E. Lehmann; Secretary, Dr. Oscar Dorman; Treasurer, Dr. Raymond Brown. Executive Committee: Dr. J. H. R. Bond, Dr. W. H. Reilly, Dr. Fred. A. Young.

VITAL STATISTICS

Winnipeg, October.—Births, 283; Deaths, 143; Marriages, 210.

Disease.	Cases.	Deaths.
Typhoid	42	2
Scarlet Fever	133	19
Diphtheria	47	8
Measles	13	..
Tuberculosis	13	4
Mumps	1	..
Erysipelas	2	1
Chickenpox	4	..
	255	34

Of typhoid 22 cases came from outside points.

Calgary—

	1910	1909
Births	109	90
Deaths	87	54
Marriages	61	45

Since the attention of the parents in Calgary has been drawn to the fact that registration is compulsory many who neglected to register the births of their children have done so.

MARRIAGES.

Dorman—Day. Dr. Oscar C. Dorman, of Weston, Winnipeg, was married to Hattie, daughter of the Rev. G. F. Day, of Thorburn, Pictou County, N. S. Dr. and Mrs. Dorman will reside at 1504 Ross Avenue.

OBITUARY

Dr. Arthur Kendall, of Vancouver, died at the Vancouver General Hospital on October 8th.

PERSONALS

Dr. and Mrs. Wardlaw Taylor of New Westminster, are visiting Hamilton, Ont., and Winnipeg.

Dr. and Mrs. Morris, of Vernon, B. C., have been visiting Vancouver.

Dr. Chugan, of Virden, who recently underwent an operation for appendicitis is recovering.

Dr. Hugh L. Dickey, who was recently surgeon at Columbia Hospital, Van Anda, passed the examination for the territory of Hawaii and is practicing in Honolulu.

Dr. A. D. Morgan, of Port Alberni, has been visiting Vancouver.

Dr. E. B. C. Harrington has been visiting Ashcroft, B. C.

Dr. C. J. Fagan, Secretary of the British Columbia Board of Health, has returned from Ottawa.

Dr. Kerr has been appointed physician for the K. R. N. construction camps with headquarters at Midway.

Dr. and Mrs. Crawford of Kitsilanow, B. C., have been visiting Winnipeg and Eastern cities.

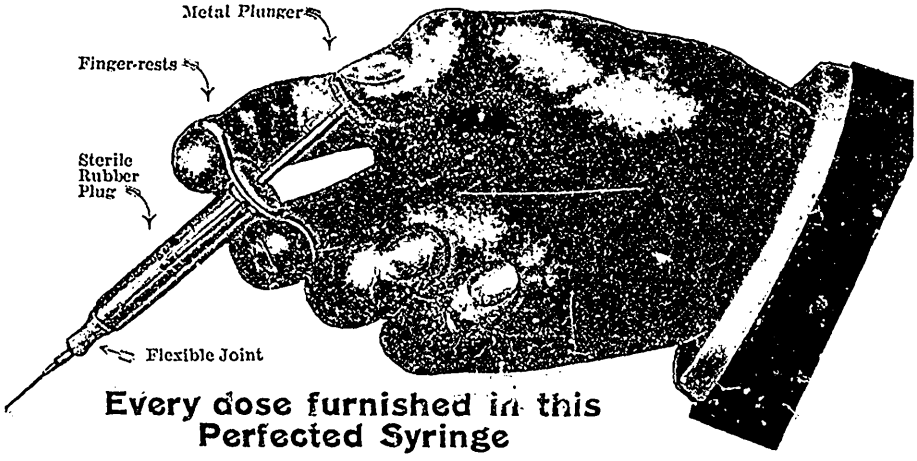
Dr. and rMs. Ewing, of Prince Rupert, have been visiting Vancouver.

Dr. D. S. McKay, Winnipeg, has returned after a month's holiday in Nova Scotia.

Dr. J. McKenty, Winnipeg, has gone to Chicago.

Dr. J. Whyte, Winnipeg, has returned from Killarney.

Mulford's Antitoxin and the New Syringe



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Metal finger-rest with rubber guard at top of syringe prevents any possibility of syringe breaking or injuring operator's hand.

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Synopsis of Canadian North-West Homestead Regulations

Any even numbered section of Dominion lands in Manitoba, Saskatchewan and Alberta, excepting 8 and 26, not reserved, may be homesteaded by any person who is the sole head of a family, or any male over 18 years of age, to the extent of one-quarter section of 160 acres more or less.

Application for entry must be made in person by the applicant at a Dominion Land Agency or Sub-Agency for the district in which the land is situate. Entry by proxy may, however, be made at an Agency on certain conditions by the father, mother, son, daughter, brother or sister of an intending homesteader.

DUTIES:

(1) At least six months' residence upon and cultivation of the land in each year for three years.

(2) A homesteader may, if he so desires, perform the required residence duties by living on farming land owned solely by him, not less than eighty (80) acres in extent, in the vicinity of his homestead. Joint ownership in land will not meet this requirement.

(3) A homesteader intending to perform his residence duties in accordance with the above while living with parents or on farming lands owned by himself must notify the Agent for the district of such intention.

Six months' notice in writing must be given to the Commissioner of Dominion Lands at Ottawa, of intention to apply for patent.

W. W. CORY,

Deputy of the Minister of the Interior

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Each fluidounce contains:

Tincture Euphorbia Pilulifera, 120 minims.
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Syrup Squill Compound, 24 minims.
Cascarin (P. D. & Co.), 8 grains.
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Menthol, 8-100 grain.

DOSE: ½ TO 1 FLUIDRACHM.

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is quite unlike the average cough syrup, as a perusal of the formula will show. It is efficient therapeutically. It is pleasing to the taste. It is inviting in appearance. It is free from the constipating tendency of many otherwise good cough syrups.

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