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THE

Maritime Medical News

A MONTHLY JOURNAL OF

MEDICINE AND SURGERY.

Vol. XIII. HALIFAX, NOVA SCOTIA, SEPTEMBER, 1901. No. 9

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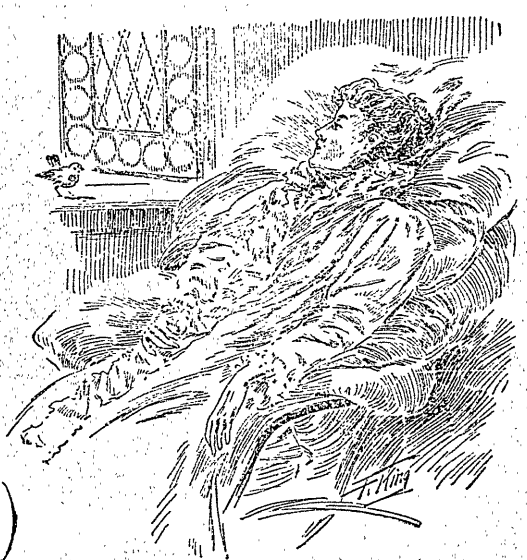

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CONTENTS FOR SEPTEMBER, 1901.

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THE

MARITIME MEDICAL NEWS,

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

VOL. XIII. HALIFAX, N. S., SEPTEMBER, 1901. No. 9.

Original Communications.

ADDRESS IN MEDICINE.*

By H. A. LAFLEUR, B.A., M.D., Assistant Professor of Medicine and Associate Professor of Clinical Medicine, McGill University; Physician to the Montreal General Hospital.

Mr. President and Gentlemen:—

The parable of the unjust judge who finally yielded to the importunities of the litigious widow finds its parallel in the present instance.

Some time in September of last year, on the occasion of the meeting of the Canadian Medical Association in Ottawa, I met the genial president of the Maritime Medical Association, and in an unguarded moment allowed him to sound me on the question of delivering the Address in Medicine at the meeting of the Maritime Medical Association and the Medical Society of Nova Scotia, in the following July. There seemed to be plenty of time to consider the matter, and I gave I fear an evasive answer, trusting in my innermost soul that time would obliterate on both sides the recollection of this interview. My hopes, however, were shattered some months later by receiving a more pressing invitation, and, while still balancing between yea and nay, a second letter arrived informing me that the Executive Committee was to meet in two or three days to make out the programme. I felt that an immediate decision was unavoidable, and somewhat reluctantly telegraphed Dr. Muir an acceptance of his offer. Since then I have had occasion to repent at leisure.

That I am delighted on the present occasion to meet such a representative gathering of my confrères of the Lower Provinces, goes

* Delivered before meeting of the Maritime Medical Association, Halifax, July 4, 1901.

without saying, but I should have preferred to come as an appreciative listener, rather than to attempt to interest you with an address the inadequacy of which I keenly feel and regret.

The choice of a subject that would interest the largest number of my hearers was not the least difficulty to be met, for on such an occasion one must not on the one hand be satisfied with glittering generalities, much less platitudes, nor on the other, treat a particular subject with a detail that might become wearisome, or at least would not be in keeping with the general purpose of an address in the broad field of Medicine. And herein precisely lies the difficulty; for the larger the subject the harder it is to present it in an acceptable and intelligible form.

As the old rhetoricians were wont to say—the greater the extension the less the intention. Many subjects of the greatest professional interest, moreover, which were formerly in the sphere of thought and action of the physician (using the term in its restricted sense), are now claimed as their own by the specialist or the general surgeon. In medical and surgical practice, as in international politics, there are "spheres of influence," which are more or less constantly changing, and fields of thought and action are "gerrymandered" not less than political constituencies. Consider for a moment the inroads that the general surgeon and the specialist have made, and are making, into the "sphere of influence" of the physician. Perhaps the earliest, and to my mind an unjustifiable, transference has been that of syphilis, first to the province of the general surgeon, and then to that of the genito-urinary specialist. In nearly all of its manifestations, certainly in its later and more serious ones, syphilis is essentially a medical disease, amenable to our two best-known specifics, and not requiring operative intervention or instrumentation of any kind. I know that on this side of the water, physicians commonly treat syphilis, but it is not so everywhere, and there is less excuse for an extensive article on syphilis in a text-book of surgery, than for an article on appendicitis in a text-book of medicine. In the case of appendicitis the change of allegiance, so to speak, has undoubtedly been for the well-being of the patient and the good name of the profession, and it cannot be denied that there is a satisfactory contrast between the new style of patient and the old—the old so often with sunken cheeks and eyeballs, thready pulse and distended abdomen, succumbing to general peritonitis under a double poisoning by toxins and heroic doses of opium—and the

new, with almost immediate relief of pain, the avoidance of general peritoneal infection, rapid convalescence and full diet in ten days or a fortnight.

A priori, it would seem that a tuberculous peritonitis with effusion should be as amenable to purely medical treatment as a pleurisy with effusion (which is, in the vast majority of cases, a tuberculous lesion) both being localizations of tuberculous infection to serous membranes, and yet we know such is not the case. It is certainly proved by statistics that opening the abdomen and draining the effusion, not simple tapping, is more likely to be followed by a favourable result than if a purely expectant treatment, perhaps with paracentesis, be adopted.

Cholelithiasis is another affection that the surgeon has laid claim to and in which the most brilliant results have been achieved. Unquestionably it is better that the surgeon should incise the common bile-duct, remove the obstructing stone and neatly sew up the duct, than that the physician should make a "mayonnaise" of the contents of his patient's duodenum by the administration of massive doses of olive oil, in the futile hope of washing out or dissolving, in some mysterious way, the offending foreign body. And if the stone be in the cystic duct, how much more rational it is for the surgeon to perform a cholecystotomy, than to trust to luck that the stone will slip back, or to administer drugs in the hope that by their neans a body measuring half an inch in diameter will be forced through a corkscrew-like tube the size of a crow-quill. A comparison between the size of the average gall-stone and the diameter of the cystic duct is not calculated to inspire one with a blind belief in Providence.

Still more recently surgery has stepped into realms that were once the undisputed territory of the physician.

Ulcer of the stomach, at least in its two most formidable events, hæmorrhage and perforation, has benefited largely from surgical intervention. In the case of cancer of the stomach the surgeon sarcastically remarks that if the physician would only make an early diagnosis he would cure the patient, and in any case he is willing to help the patient—and the physician—by easing the downward path of the patient by a gastro-enterostomy.

One might extend the list by mentioning simple gastrectasis and gastroptosis, and enteroptosis, all of which may at least be alleviated by surgical procedures.

Even ascites from cirrhosis of the liver has found its surgical enthusiasts, and now pulmonary tuberculosis is to be arrested and even cured by a surgical procedure, the production of an artificial pneumothorax by pumping an innocuous gas into the pleural sac. There are some who think that a year or two in the Adirondacks, the Laurentians or Colorado is a less hazardous method of arriving at a similar result.

Aneurism of the aorta is undoubtedly in some comparatively rare cases influenced for good by the insertion of gold wire into the sac, combined with the passage of an electric current through the wire, but I confess I read with some surprise the sweeping statement made quite recently in the journal of a very celebrated institution, to the effect (I quote textually) that "this dreadful malady is usually a surgical disease."

It is true the author of this remarkable statement is a gynæcologist, and we know that gynæcologists are particularly sanguine in regard to operations. The results actually given by the writer do not, however, bear out his contention. In 23 cases treated by the combined wire and electrolysis method, relief of pain and other symptoms occurred in nine cases, or 39 per cent, and possibly life was prolonged, but in 10 cases, 43 per cent., "death was probably hastened." Four cases, three thoracic and one abdominal, were cured, but, says the writer, "here we must speak with reserve, for knowledge of the living patient or proof gained by autopsy are at our command for but two of these cases." No doubt aneurism of the aorta is in the vast majority of instances a hopelessly fatal disease, but cannot many of us point to cases in which the symptoms have been markedly alleviated and life prolonged for many months, even of comparative usefulness, by periods of rest in bed, restriction of diet and drink, and possibly the use of iodide of potassium? Such measures at least have no tendency to shorten life.

It would not need a great stretch of the imagination to conceive that in the not distant future, some daring surgeon should devise a "valvulotome" by means of which a button-hole mitral valve might be safely incised and then dilated, or taking the opposite condition, an instrument for "taking in the slack" and shortening up the *chordæ tendinæ*.

We have long since ceased to be surprised at anything. One might well ask if there is anything else left for the physician. The infections?

Is not the hope of the future in bacterio—and serum—therapeutics, and here again, is it not the bacteriologist, the laboratory worker, who discovers the antitoxins and the curative and prophylactic sera that the physician uses in his daily practice? Moreover, preventive medicine is ever narrowing this field of action, and we may look forward to the state of affairs portrayed some years ago in a caricature of "Punch," where a long procession of disconsolate physicians is represented wandering the streets of the model city "Hygeia" crying with one voice—"we have no work to do."

It may seem strange to you that in an Address in Medicine I should so inconsistently raise the pean of victory for surgery and bacteriology. Believe me, this is not done in an envious or carping spirit, but merely to illustrate the fact that in the matter of the successful treatment of disease, the surgeon and the bacteriologist have undoubtedly made greater strides than the physician, though in the purely scientific aspect of professional knowledge I think it must be admitted that the physician has at least equalled the attainments of his surgical colleague.

The chief advances in medicine (using the term in its restricted sense) have been in the elucidation of obscure points in etiology, the more accurate description of the clinical phenomena of disease, and the improvements of methods of diagnosis.

To a few of these I would especially like to draw your attention. The field being so vast and the labourers so many, it would be impossible to do justice to the whole subject, and I trust you will forgive me if I take as illustrations a few of the more common affections which form the bulk of the daily experience of the physician.

Among these, pulmonary tuberculosis claims the first place on account of its extensive prevalence and the prominent place it occupies in the mortality statistics of nearly every country on the face of the globe. Since the epoch-making discovery of Koch, nineteen years ago, there is surely no one, whose opinion is worth considering, who does not recognize that tuberculosis has been finally and definitely removed from the group of so-called constitutional diseases, to occupy its rightful place among the specific infective diseases.

The recognition of this fact has profoundly modified our views in many directions. Heredity as a factor in the transmission of tuberculosis has lost ground in proportion to the ever multiplying proofs of the frequency of infection, and though it cannot be denied that a

certain bodily condition, made up of many as yet imperfectly defined elements, does form a favourable soil for the growth and multiplication of the tubercle bacillus, it also cannot be denied that an individual inheriting such a bodily condition, if removed from all the known sources of infection and placed in a suitable environment is not more liable to develop pulmonary tuberculosis than his more favourably constituted fellow-being. Many of the so-called hereditary cases of pulmonary tuberculosis are nothing more than examples of family infection, one member after another of a family becoming infected through a period extending perhaps over many years Most of us could cite cases in support of this view; I know of several that can be explained satisfactorily in no other manner. It would be interesting to know whether this method of family transmission, what might be called pseudo-heredity, is to be observed more frequently in the country and in small towns than in the larger centres of population. City folk change their domicile more frequently than the inhabitants of rural districts, and one would expect that family infection would be found more frequently in the case of families who had occupied the same house for a long term of years.

A medical friend practicing in a small village in the Province of Quebec, a health resort for city people in the summer, told me that he had come to the conclusion that so far as his district was concerned, pulmonary tuberculosis, which was quite common there, was in most instances due to family infection in the domicile.

That house infection, whether of members of the same family or of subsequent occupants of the infected house, is a very common factor in the spread of tuberculous disease can hardly be doubted when one examines the maps of districts in certain cities where the infected houses have been plotted, showing the frequency of tuberculous cases in certain houses, while the immediately adjoining dwellings have remained free from any cases of the disease. Public ordinances forbidding spitting in public buildings and factories, and in tramways, railway carriages and other public conveyances, are no doubt very useful, but I am convinced the danger from such sources of infection is infinitesimal compared with that incurred in living from year to year in a house that is, or has been infected by one or more individuals suffering from chronic pulmonary tuberculosis, and until strict disinfection of such infected domiciles becomes the law and is scrupulously carried out, we must not expect to see any great diminution in the

incidence of pulmonary tuberculosis. No doubt if proper precautions were taken by the infected individual in regard to the disposal of his expectoration the danger of infection would be minimized, but knowing how rarely such precautions are systematically observed by the patient or enforced in any but a half-hearted way by most physicians, except in sanatoria, it seems hopeless for the present to expect any diminution of house-infection by this means It might seem superfluous at the present time to insist on the necessity of early diagnosis in tuberculous disease of the respiratory passages, were it not a fact that in so very many instances the diagnosis is still made too late—not necessarily too late for a fair prospect of arrest or even cure of the disease—but too late in the sense that it might and should have been made earlier, and have saved the patient both time and expense in his subsequent search for health. I am not going to weary you with a recital of all the subjective and objective signs that point to early tuberculous infection of the lungs; any properly trained physician knows these.

Failure to make an early diagnosis is due too often to sheer carelessness or hurry on the part of the physician—to errors of omission rather than of commission. A hasty examination, with only a few square inches of the upper part of the front of the chest exposed, or worse still a perfunctory so-called auscultation through two or three thickness of clothing, results in a diagnosis of a "cold" or a "bronchial catarrh," and meanwhile the bacilli are doing their work thoroughly.

A curious thing is that very often the diagnosis is persisted in, though the "bronchial catarrh" has not "yielded to the usual remedies," and something more radical in the drug line is then tried. It ought to be an axiom that any "cold" or "bronchial catarrh" that has lasted a month is to be looked upon with the greatest suspicion, and calls for a thorough examination of the respiratory tract, if that has not already been done.

And indeed, why wait so long? There is, moreover, no excuse for not examining the sputum for tubercle bacilli in all cases of disease of the respiratory passages. If one does not posses the material, or is not familiar with the simple technique, required for this examination, is it not a very easy matter to thinly smear half a dozen microscope coverslips and send them, or perhaps better still a specimen of the sputum in a clean bottle, to the nearest hospital that possesses even the most elementary clinical laboratory? A patient will not object

to a fee for such an examination if it be made clear to him that it is a necessary preliminary not only to the diagnosis of his case but to its successful treatment. Thorough physical examination of the chest and routine examination of the sputa would certainly save a number of patients from a long and too often eventually fatal illness. In a few cases the examination of the sputum may not be conclusive, while the physical signs and the subjective symptoms still point strongly to tuberculous disease. If possible in such cases the patient should be tested with tuberculin—but, I repeat, such cases are rare.

It is to be supposed that once the diagnosis is established, and that early, the patient is to be told frankly what is the matter with him and urged to place himself in surroundings most favourable to speedy recovery from his incipient infection.

Practically this means that he must have rest in the open air, and as abundant a diet as his digestive organs will admit of, preferably in those climatic surroundings which we know from experience afford the largest percentage of recoveries from incipient pulmonary tuberculosis. The first two desiderata, rest and food, can be obtained anywhere and by nearly everyone. It is in regard to the last that the difficulty lies.

Social and domestic questions arise in very many cases that militate against change of domicile, but by insistence these may often be overcome. Speaking generally, one does not usually get well from tuberculosis in the locality in which it was contracted, and yet with those that for one reason or another cannot or will not change their residence much may be done by insisting that if they remain at home they must live as they would do, were they sent to the Adirondacks, the Laurentians, the Canadian Rockies or Colorado.

Before leaving the topic of pulmonary tuberculosis I wish to repeat the opinion already expressed, that pleurisy with serous effusion, the so-called *pleuritis a frigore*, is in the vast majority of instances a manifestation of tuberculous infection. This conception, advanced some twenty years ago by the French clinicians, especially by Landouzy, and based on evidence of a clinical, pathological and experimental nature, is certainly gaining ground. Osler expresses himself decidedly of this opinion. "I confess (he says) that the more carefully I have studied the question the larger does the proportion appear to be of primary pleurisies of tuberculous origin." The evidence rests on the following facts:—

Firstly, in a number of instances, undoubted evidence has exsited of prior or concomitant tuberculous manifestations in the pleuritic patient.

Secondly, in individuals who were apparently healthy before the onset of pleurisy, and who have died during the period of active effusion, the post-mortem examination has proved the tuberculous nature of the pleurisy.

Thirdly, a large number of cases that have recovered from pleurisy with effusion sooner or later present unequivocal signs of tuberculosis, usually of the lungs. This is so common that I never fail to ask a tuberculous subject if he has ever had pleurisy with effusion, and though I cannot give you exact statistics, it is remarkable how often the answer is affirmative. The experimental evidence, however, is even more conclusive.

Guina-pigs inoculated with a sufficient quantity (15 cub. cm.) of the serous exudate succumb in very large proportion to miliary tuberculosis. It is true that even careful microscopic examination of the serous exudate fails in most cases to reveal the presence of tubercle bacilli, but it must be remembered that the bacilli are few in number and the effusion usually copious, so that the inoculation test with massive doses of serum, is more likely to prove positive than the search for bacilli.

The experimental evidence is further strengthened by the fact that a large number of patients with serous pleurisy react to tuberculin, even when there is absolutely no evidence of tuberculous disease in the viscera.

The recognition of the tuberculous origin of serous pleurisy has somewhat altered our opinions as regards the proper treatment to be adopted in such cases, particularly in the matter of the removal of the effusion by tapping. It has been shown that the exudate contains a small amount of tuberculin, and the absorption of this is believed to produce at least a temporary immunity against further extension of the tuberculous process in the tissues.

Certain it is, that serous pleurisy tends, more than any other tuberculous lesion, to run a more or less definite course and to end spontaneously in recovery. If this be so, it follows that tapping ought not to be performed early and often, but should be reserved for those cases in which an excessive amount of fluid threatens either,

immediately, the proper functioning of the circulatory apparatus, or, ultimately, the integrity of the lung from too long continued pressure.

Another corollary is that the subjects of serous pleurisy should, in their convalescence, have the same treatment as individuals suffering from incipient pulmonary tuberculosis, that is to say, hyper-alimentation and a more or less prolonged sojourn in suitable climatic surroundings. In any case it is well to keep such patients under close observation for the first indication of pulmonary involvement.

Turning now to typhoid fever, which next to tuberculosis is one of the most wide-spread of the infections, there is little that is new to be said concerning its etiology. That it is of microbic origin is now universally admitted, and that it is mainly a water-borne and easily preventable disease is no less true, as has been demonstrated on a large scale in several communities. For its appalling prevalence in most of the large centres of population in America, and in many of the smaller ones, we have to thank the apathy, not to say criminal negligence, of our municipal governing bodies in matters relating to the public health. They are too busy granting important franchises for nothing to powerful corporations and letting out public contracts to the highest bidders to have time to give such an unproductive matter as the health of the citizens they represent. Take the city of Montreal, for instance. How can the municipal council be expected to take serious and intelligent action in the prevention of typhoid fever, which is at all times endemic, and too frequently attains the proportions of epidemic distribution in that city, when sectional bickerings and the narrowest ward politics prevent us from having even an approach to adequate accommodation for actual cases of the more virulently contagious diseases?

But, really, the question is too depressing to dwell upon, and I crave your attention for a few remarks on the treatment of typhoid fever in general, and in particular on the diagnosis and treatment of its most formidable event—perforation of the bowel.

A fairly extensive experience of this disease may give a certain personal flavour to what I have to say, and for this I apologise beforehand. In the matter of diet, to begin with, I may say that my opinions have undergone a considerable, and, I trust, a salutary change. That an exclusive diet of milk and animal broths is the ideal one for the enteric patient, is at the present time untenable. Brought up in this faith, I have since many years, entirely abjured it, and in common with

many others of more extensive experience, I am in the habit of allowing the patient to take throughout the course of his illness, such articles as gruel, custard, oranges, jellies, soft-boiled or poached eggs, clear soups and purées, milk toast and even scraped beef, provided always that such food is well borne by the stomach and does not produce intestinal disturbance. Such a dietary appears to be innocuous, and certainly relieves the monotony of frequently recurring libations of milk.

I am a frank advocate of the treatment of typhoid fever by hydrotherapy, according to the method of Brand, or a slight modification of it. None of the objections urged against this method, and they are many, and some well grounded, ought to weigh in the balance against the mass of evidence that points to ultimate good for the greatest number. Hydrotherapy is not, and never has been, claimed to be a specific treatment. It is antithermic, tonic to the cardio-vascular system, sedative and tonic to the nervous system, and eliminative through the renal organs, but it is not bactericidal or antitoxic. Doubtless in the near future the ideal treatment for the infections in general, a reliable antitoxin, will be discovered, and indeed we have the promise of this in the partial success of the recent prophylactic inoculations practised in the South African campaign and in India. Pending this, I refuse to be led away by any Ignis Fatuus of antiseptic or eliminative treatment based, if not on erroneous ideas of the pathology of the disease, at least upon an unreasonable faith in the efficiency of small doses of feebly antiseptic substances upon the length and breadth of the intestinal mucosa and, still more incredible, upon micro-organisms distributed in the deeper tissues, the viscera and the circulating blood.

In the whole field of medicine there is probably nothing that calls for more careful investigation of clinical phenomena, a nicer balancing of probabilities and a greater judgment than the early detection of typhoidal perforation; and its immediate corollary, the advisability or the non-advisability of operative intervention. The early diagnosis, that is, sufficiently early to afford a reasonable hope of success for the surgeon, is fraught with many difficulties, and even the most experienced clinicians have made mistakes, on the one hand diagnosticating a perforation where none was found to exist at the time of operation, or on the other, deciding against perforation which an autopsy subsequently revealed.

Uncomplicated typhoid is, so far as the abdominal symptoms are

concerned, usually a painless disease. It is true that transient meteorism and diarrhœa (especially if profuse), may be accompanied by wandering colicky pains in the abdomen, but the occurrence of sudden, severe, localized abdominal pain in a typhoid patient is to be held as very strong evidence of perforation of the bowel, or at least of a localized peritonitis immediately preceding a perforation. This should in all cases be a note of warning, and if it should be associated with rigidity of the abdomen on palpation, it is difficult not to draw the immediate inference that perforation has actually taken place. There may at this early period be very little constitutional disturbance. Probably the pulse rate will rise, but I am convinced that any reliance on variations of the temperature curve as an aid to the diagnosis is unwise. Nausea and vomiting will not necessarily be present, and to wait for meteorism to develop is not making an early diagnosis. The point that I wish to make, however, is that in making an early diagnosis the inferences drawn from the local signs in the abdomen should outweigh those derived from the general condition of the patient.

No reliance is to be placed upon an increase in the white elements of the blood as an indication of early peritoneal infection. Of this we have had several instructive examples quite recently in Montreal. Delirium or a stuporose condition and excessive meteorism vastly enhance the difficulty of early diagnosis of perforation, and indeed may make it impossible. This, it may be said in passing, is no small argument in favor of hydrotherapy, for delirium, coma and meteorism are of the rarest occurrence in patients who have been systematically bathed.

Given an early diagnosis of perforation, should the patient be given the chance for life that is afforded by surgical intervention? Undoubtedly, yes! in many, probably the majority, of the cases. Medically treated, perforation is practically a hopeless condition from the outset, and surgically treated, the patient has at least a chance of recovery—how much of a chance it is yet too early to say, for we must have a larger experience and more extensive statistics, but even those we have are quite encouraging. It must be admitted that there are some cases in which it is better, however reluctantly, to let the patient die with the peace of mind and body borne of adequate doses of morphia, than to hasten his demise by a few hours for the sake of viewing later at the autopsy, an intestinal suture that is all that it should be, impervious to gas and liquids. These are the cases that

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are the most worrying and in which a sober judgment is most needed. It is difficult to say in a general way what leads the physician and the surgeon to agree upon the non-advisability of operation. Sometimes it may be the rapid onset of signs of general peritoneal infection, sometimes a very rapid pulse or cyanosis, sometimes the age or general condition of the patient, sometimes in prolonged cases, a fear that an operation would be the proverbial last straw. If the patient be in good condition this last consideration need not trouble the practitioner, for it does not appear that the operation, even if it should turn out to be an exploratory one, (which has happened more than once) diminishes the patient's chances of recovery from the typhoidal infection, or materially alters the subsequent course of the illness. Finally, as regards the time for operative intervention, it seems to be the latest opinion that, if possible, the operation should be undertaken not later than twelve hours after the occurrence of the first symptoms, but that the patient should be allowed to recover from the actual, or supposed, shock immediately following a perforation.

I fear I may have become wearisome with details of what may not be a "live issue" with many of you, and that little time is left for other topics worthy of at least a brief mention. Among these, few can lay claim to greater interest than the diagnosis of meningeal inflammations in the light of two comparatively recent, and as yet insufficiently appreciated, methods of physical examination—Kernig's sign and rachicentesis, or, as it is better known, the lumbar puncture of Quincke. Both of these procedures are really very valuable additions to the physician's diagnostic armamentarium, the first enabling him to affirm or deny the existence of meningeal inflammation in general; the second, in addition affording him a certain method of differentiating the various forms of meningitis according to the bacterial species that is the cause of the inflammation.

Kernig, a Russian physician, descried in 1884, a physical sign which seemed to him to be present exclusively in affections of the pia mater, and particularly in those attended with inflammation. This sign consists in a tonic contraction of the flexor muscles of the thighs, when the thighs are at a right angle with the body and the legs extended upon the thighs.

In a healthy individual it is possible to extend the leg completely, or almost completely, with the thigh in such a position, while in a patient suffering from meningitis it will be found that, soon after the

leg has been extended a little beyond a right angle with the thigh, a progressively increasing resistance to further extension is offered by the marked tonic contraction of the muscles at the back of the thigh. If the attempt to extend be persisted in, pain in the lumbar region is produced, and instead of a further extension of the leg being effected, the pelvis will be raised.

The sign may be elicited in two ways, either by having the patient sitting straight up on the edge of the bed, in which case, extension of the leg to a certain point immediately produces the phenomenon, or, with the patient lying flat on his back, the thigh is first brought to a right angle with the body, and the leg then extended until flexor spasm is observed.

It is remarkable that such an easily recognized sign should have attracted but little notice, and that not very favorable, for fourteen years.

A revival of interest in this test was inaugurated by the publication of Netter's statistics in 1898 and 1899. and those of Herrick, of Chicago, in 1899. From these it appears that Kernig's sign was found in ninety per cent. of all cases of meningitis.

In 100 cases of disease other than meningitis Herrick found this sign in only two; in one of these there was a cerebral lesion (subdural hæmorrhage), in the other a local cause of contracture in the lower extremity.

Before applying this test it is necessary to exclude any local cause for flexor contracture, such as arthritis of the knee or hip joints, organic disease of the spinal cord, and sciatica.

Though no entirely satisfactory explanation of this phenomenon has as yet been advanced, it is highly probable that it is partly due to an exaggerated tonus in the muscles at the back of the thigh.

The lumbar puncture of Quincke, is a less simple means of detecting meningeal mischief, but affords at the same time more definite information.

Proposed by Quincke in 1891, this method of diagnosis was not utilized to any extent, in America at least, until five or six years ago, and even now has not obtained the general recognition that its value entitles it too. In a text-book of Medicine published this year in England, I find no mention of lumbar puncture as a means of diagnosis in meningitis. The technique is not difficult. The patient lies in bed on the right or left side, according to the choice of the operator,

with the back well bowed, the knees drawn up towards the abdomen and the head and neck well bent forward. To ensure stability in this position it is well to have a firm pillow, or sand-bag, under the flank and abdomen, and an assistant holding the patient's legs and shoulders, to prevent movement of the spine during the puncture. The lumbar region of the spine is thoroughly scrubbed with soap and water, and then washed over with sublimated alcohol. Having previously disinfected his hands, the operator selects either the second or the third lumbar space, which is usually easily located and may be marked beforehand, and an area of skin the size of a five cent piece over the middle of either of these spaces is made anæsthetic by a sub-epidermal injection of cocaine. An aspirating needle of small calibre, not less than four and one half centimetres long for children, and seven centimetres long for adults, previously sterilized by boiling, is then slowly thrust forward and a little upward and inward into the space selected, one centimetre from the median line. As the spinal dura is pierced a sensation will be felt as if the point of the needle were going through a thin and tense bladder of india-rubber. When this occurs the operator should stop, and almost immediately the cerebro-spinal fluid will begin to flow from the needle, usually more or less rapidly drop by drop, but sometimes in a distinct jet. The fluid should be collected in a sterilized test-tube for microscopical and bacteriological examination. It is not as a rule necessary or advisable to exhaust the fluid with a syringe. The needle is then withdrawn, and the seat of the puncture may be smeared with collodion. The quantity removed varies a good deal, but it is common to get from 10–20 c. c. in cases of meningitis. The chatacter of the fluid as it collects in the tube gives important information, apart from any further examination. If absolutely colorless and clear, it is normal cerebro-spinal fluid; if only slightly turbid and of a very pale straw yellow tint, the case is almost certainly one of tuberculous meningitis and if quite turbid and rapidly depositing a sediment, it is most likely to be either cerebro-spinal, fever, pneumococcus infection, or some secondary septic meningitis In any case, turbidity of the fluid, however slight, is due to cellular elements, and cellular elements mean an inflammatory process, normal cerebro-spinal fluid being free from cells.

Microscopic examination of the sediment shows mainly two types of white blood cells, the ordinary polymorphonuclear leucocyte, or pus cell, and the small mononuclear leucocyte, or lymphocyte, with large

nucleus and a thin rim of protoplasm. It is constantly found that the pus cell is found in large numbers in cerebro-spinal fever and the septic forms of meningitis, while the lymphocyte is almost the only cell found in tuberculous meningitis. Bacteriological examination of dried cover-slip preparations of the sediment shows the *diplococcus intracellularis meningitidis* of Weichselbaum in the case of cerebro-spinal fever, usually in considerable numbers, while a careful search may reveal a very few tubercle bacilli in tuberculous meningitis. In the other forms we find the pus organisms or the diplococcus of pneumonia. In suspected tuberculous cases, the bacilli being usually very few and hard to find, it is better to use animal inoculations, if absolute proof is desired. I wish to insist however, that a very slightly turbid and colored fluid (almost like Montreal water) with scanty sediment containing almost exclusively the small celled leucocyte, is practically evidence of the tuberculous nature of the meningitis.

Lumbar puncture is not a dangerous operation, if carefully and aseptically carried out, and personally I have not seen any harmful results following it, though it is stated that in some cases of cerebral tumor untoward symptoms have been observed from a too sudden lowering of the intracranial pressure.

One would suppose that chlorosis was a disease about which little that was new could be said. We are thoroughly familiar with its symptoms and with its clinical course; its predilection for the female sex, its frequent association with latent pulmonary tuberculosis, or with ulceration of the stomach, and the fact learned from repeated experience, that with rest, fresh air, good food and the exhibition of ferruginous preparations and laxatives the great majority of chlorotics are eventually restored to health. We know further that the blood count in such cases very constantly shows a notable diminution of the hæmoglobin value in the individual red corpuscle with very little, or no reduction, in the actual number of the red blood cells.

Though no definite or satisfactory explanation of the relative poorness of the hæmoglobin in the corpuscles had been given us, we had been taught that it was due to a deficiency in the production of hæmoglobin—a defective hæmogenesis—the underlying cause of which was more or less obscure.

It would seem, if certain recent experiments are substantiated, that our ideas of the ultimate etiology of chlorosis must be entirely modi-

fied. I refer to the work lately carried out in the pathological laboratory of Queen's College, Belfast, by J. Lorrain Smith. The details of these experiments are too technical to be entered into on the present occasion. It will be sufficient to say that the method consists in administering a given volume of gaseous carbon monoxide to the patient and estimating from this the total oxygen capacity of the blood, hæmoglobin having the same degree of saturation for both of these gases. The total oxygen capacity, or in other terms, the total amount of hæmoglobin, having been thus ascertained, the volume of the blood is estimated by comparing a measured quantity with an equal sample of ox-blood, of which the oxygen capacity for 100 cc. has been determined. Applied to the investigations of the different forms of anæmia, this method gave instructive results, the most important of which was, that the total volume of the blood was much more variable than the total amount of hæmoglobin.

It was found that in chlorosis the volume of the blood was increased in proportion to the severity of the disease, the total amount of hæmoglobin at the same time remaining approximately normal. This increase of the normal plasma of the blood is accompanied at first by an increase of the cellular elements, and consequently, since the total hæmoglobin remains the same, we have a diminished amount of hæmoglobin for each corpuscle. In chlorosis, then, there is a condition of hydræmic plethora, which serves to explain many of the clinical phenomena of the disease—the dyspnœa and the rapid action with hypertrophy and dilatation of the heart, necessitated by the larger amount of blood that is to be driven through the pulmonary and systemic vessels. Probably also the functional cardiac murmurs are due to over-distention of the vascular system. Though the author does not mention it, is it not likely also that we have in this demonstration an explanation of the unquestionable fact long ago insisted upon by the late Sir Andrew Clark—though for an entirely different reason—that purgatives which deplete the circulation are of the greatest value in the treatment of chlorosis?

In the sphere of etiological research nothing more brilliant has been accomplished in the last few years than the discovery of the mode of infection in malaria and yellow fever. In the case of malaria we have been able to follow step by step, in both medical and non-medical current literature, the accumulating proofs that suctorial insects are the chief, if not the only, agents in the transmission of this disease from one person to another.

Through the initial labours of Surgeon Major Ross, of the Indian Medical service and the subsequent investigations of Grassi, Bignami and Bastianelli, in Italy, and of the Sierra Leone Commission, it has been definitely established that certain mosquitoes of the genus *anopheles* are the habitual intermediate hosts of the malarial parasites of men, that these parasites undergo certain changes in the bodies of mosquitoes infected by them, and that such infected or as they are now termed—malariated mosquitoes, are capable in turn of conveying malarial infection to human beings. It has further been shown that protection from mosquito-bites is the most effective means of preventing the infection of the individual by the malarial parasite, and that where the malaria bearing mosquito does not exist, malaria as an endemic disease is unknown.

By these researches a flood of light has been thrown upon the distribution of the malarial fevers, and a satisfactory explanation afforded both of the peculiarly localised endemic character of malaria, and of its different incidence in localities possessing the same climatic, telluric and geographical characteristics.

For a similar elucidation of the vexed problem of yellow fever infection science is indebted to the labours of Surgeon Walter Reed of the United States Army and his collaborators in Cuba. In this case the infective agent of the disease is as yet unknown, Reed having conclusively proved that the much talked of *bacillus icteroides* of Sanarelli stands in no causative relation to yellow fever.

The investigations, undertaken during the winter of 1900-01, were directed entirely to the mode of infection and were carried out with a precision and thoroughness that compel acceptance of the results obtained. They form indeed a model for similar scientific research and will be a lasting monument to the industry and competence of their authors. In a carefully selected experimental sanitary station, protected from infection from without by the most stringent regulations and under daily medical supervision, a number of non-immune individuals were subjected, with their full consent, to repeated bites of mosquitoes (Culex Fasciatus) that had previously fed on the blood of yellow fever patients in the second and third day of their illness and had been kept not less than twelve days at an average temperature of 82 degrees. As a result of this experiment four out of five of the individuals bitten developed an attack of yellow fever in from forty-one hours to five days and seventeen hours, while the other non-

immunes who had not been bitten remained entirely free from the disease. In the one negative result, it was subsequently found that the mosquito used in the experiment had not been kept at the temperature required to develop infective power. When this little epidemic of yellow fever had subsided, a sixth non-immune was inoculated with a positive result, making five successful inoculations out of six. In another series of experiments, blood from yellow fever patients was injected subcutaneously into non-immunes, with three positive results and one negative one. Again, to decide whether or no yellow fever is conveyed by fomites from bedding or clothing soiled with the secretions, discharges, or blood of yellow fever patients, non-immunes were exposed for a prolonged period to such possible sources of infection with an entirely negative result in every case. The condiditions under which the experiment had to be performed are so gruesome and revolting, such as the wearing of the unwashed and foully-soiled bed clothing of yellow fever patients, and worse still, that it is a marvel that any human being could consent to be subjected to it. Finally, to determine how a house became infected with yellow fever, a one-room, mosquito-proof, but thoroughly ventilated building was erected and in this were set free a number of mosquitoes that had bitten yellow fever patients. Two non-immunes were then allowed to enter this building and remain only long enough to get bitten several times, about half an hour. One of these men developed an attack of yellow fever in a little under four days. On the other hand two non-immunes slept in this building for eighteen consecutive nights, protected by a wire screen partition from the mosquitoes and both remained in perfect health. It is hardly possible to over-estimate the importance of these very conclusive observations Not only will the prophylaxis of yellow fever be established on a thoroughly scientific basis, but a vast amount of needless and troublesome disinfection will be saved to those who have either actually come into contact with yellow fever patients, or are returning from a locality where yellow fever is prevalent.

I cannot conclude this already too lengthy address without thanking you, Mr. President and gentlemen, for the honour you have done me in affording me the opportunity of addressing you to-night, and while I regret that my remarks have fallen so far short of the importance of the occasion, I assure you that I shall cherish a vivid remembrance of your unfailing kindness and whole-hearted hospitality, and of the very pleasant days spent in and about the beautiful city of Halifax,

A CASE FOR DIAGNOSIS.

By M. D. Morrison, M. D., Dominion Colliery No. I., C. B.

Two main reasons suggest the propriety of reporting the following case:—One, the assistance sometimes afforded even the ablest exponents of our profession by the recital of an experience of the humblest votary; the other, the opportunity offered by the printed page of depositing notes that may hereafter prove a valuable investment.

The title of the article purposes that all I assume to present is the more or less complete clinical history of a case that caused me much thought and, at times, much anxiety; that refused to submit itself to a satisfactory diagnosis even at the hands of two of the leading and most experienced physicians of Cape Breton who were called in consultation on two different occasions; and that represents an ailment extending over a period of eight months, which took its departure in a rather abrupt and unexpected form thus covering up the tracks so mysteriously traced during its career.

Without further preliminaries I shall at once enter upon the detailed account of the case by stating that my patient an engineer by trade, is forty-one years of age, about five feet six inches in height, inclined to be corpulent, and weighed before his recent illnes 208 lbs. For eight years he resided in the State of Pennsylvania, the rest of his life he has spent in Cape Breton where he was born. Barring an occasional attack of quinsy he always enjoyed good health up to July 1900, when suppurative tonsillitis confined him to the house for three weeks. This was immediately followed by a slight attack of acute articular rheumatism which however soon yielded to sodium salicylate and alkalies. But from this period of illness his health steadily failed, suffering particularly from gastric disturbance such as nausea and vomiting, anorexia, excessive thirst; and complaining loudly to his family of his lack of energy, his unaccountable weakness and weariness, and his irresistible despondency. In the evenings cold sensations along the spinal column and the lower extremities would so harass him as to necessitate a fire when the outside temperature was no lower than 60° or 65°. The stomach symptoms became so amazing and distressing that in October he consulted me about his condition. I

recommended a holiday season away from home, and gave him a mixture of pot. bicarb, fl. ext. quassia and fl. ext. nux vomica. He returned in two weeks slightly improved. Soon after, however, the old troubles resumed operations with renewed activity. Complaining now, in addition, of shortness of breath on the least exertion, I made a careful examination and found all the organs functionating properly excepting the stomach, and the heart which appeared to be somewhat weak in action, and to be laboring with muffled sounds. I continued the stomach treatment, washed it out twice a week, and gave tinct. digitalis in ten minim doses three times a day. I noticed no great change in his condition until about December 15th, when he entered on the second and most interesting phase of his illness. The symptoms now took the form of severe chills followed by fever and subsequently by profuse sweating and great prostration. They continued with abating intensity day after day and forcibly suggested malaria in consequence of which quinine was administered in large doses, but without any effect. After the commencement of the New Year a third element entered into the complication, namely, mental disturbance. He referred often and urgently to his headaches, and to a peculiar sensation, experienced during the "hot stage," of the existence of a dual personality, one portion represented by himself and the other by an acquaintance, who during the ordeal happened to be the sufferer, and on whom he himself expended his energy and vitality in unrequited sympathy. Under these trying circumstances, and while thus wrestling with his delusions and illusions, his axillary temperature would reach 104, his pulse 120, and the whole fit reach a crisis in about an hour, ending in a drenching perspiration and a splitting headache. In the second stage of these paroxysms I nearly always noticed an unequal dilatation of the pupils—the left larger than the right. Also, that while the pulse kept strong and good at the wrist the heart sounds became more and more muffled and dull, and indeed most of the time after Christmas were scarcely audible. This condition pushed the question of degeneration of the heart muscle into the foreground with a correspondingly deplorable prognosis.

On Jan. 18, a great change set in which raised the hopes of all interested parties to a high point of expectation. The chills ceased and for two days he felt exceedingly good; no chills or fever; appetite and spirits good. But on the morning of Jan. 20, he referred to a pain in the right side which grew steadily worse. His temperature was

101, and the physical signs of pleurisy presented themselves. This condition persisted until Jan. 28, the pain so severe as to require morphine twice in the twenty-four hours for its alleviation. Until Feb. 1 he appeared to be convalescing nicely, when again he was overtaken by chills and fever, accompanied now by severe attacks of vomiting. A picture of his condition and appearance now would be one of utter misery. His daily programme commenced at about 9 a.m., with creeping and chilly sensations leading rapidly up to a rigor causing his teeth to chatter, his body to pitch from the bed, and that in spite of every effort to supply warmth. After an hour of these antics the scene was changed to the opposite extreme—burning fever, explosive retching, and copious vomiting of glairy mucus startled the spectators. The curtain falls as he sinks back prostrated and soaking with perspiration, his pulse running at 140, and the temperature ranging from 103 to 105.5. After the paroxysm he would be tortured with unquenchable thirst, causing him to drink very large quantities of water—as much as a quart at one draught and that repeated every half-hour and twenty minutes. No expedient on the part of his friends and attendants could withhold or prevent this excessive drinking of water; vehemently would he declare and repeat that water he should have were it to cost him his life. Ice he sneered at; effervescing drinks he contemptuously waved out of sight; sparkling cold water he cried for. This happened daily from 9 a. m. till 2 or 3 in the afternoon when he would lapse into a state of quietude, motionless and tranquil. He generally slept well except on the rare occasions when an attack came on at night.

In our efforts to account for these remarkable phenomena nothing abnormal could be located or detected. An examination of the urine gave a specific gravity of 1010 to 1020; no albumen or sugar; no casts or anatomical elements; reaction acid; urea. 2%; quantity in twenty-four hours 50 to 60 ounces. The most careful palpation by myself and the other physicians could elicit no points of tenderness nor determine any enlargement of stomach, liver, or any of the internal organs. The condition of the heart was inexplicable—no displacement, no pericardial or pleural effusion, fairly good pulse, and yet the heart sounds inaudible.

About March 15, patient began to assume a maniacal disposition during the attack and referred several times to suicidal inclinations and prospects. His countenance about this time became somewhat

jaundiced, and profound anæmia showed up, the conjunctiva becoming pearly white. As constipation had become a troublesome factor I attributed the new symptoms to mal-assimilation and to auto-intoxication. Sleeplesness and excessive irritability added their morbific influence to an already woful state. This was the story day after day until about April 15, when signs of amelioration began to appear. These signs were coincident with the inauguration of hot water baths on the appearance of a chill, the patient remaining submerged during the period usually occupied by the cold stage, and then passing into the hands of two attendants who subjected him to a vigorous "rubbing down." Thoroughly stimulated he was sent to bed and disturbed as little as possible. The chills became less violent, the vomiting sometimes missed, the anæmia improved, and gradually progress towards good health was made, until on May 1, he expressed himself as feeling very well excepting for some weakness of the legs. Curiously enough this is the only symptom that remains to-day of the many he revealed and experienced. At present he is engaged at his regular work, looks well, feels well, weighs 178 lbs., having gained 35 lbs. since June 1.

The foregoing peculiar condition has been variously attributed to malignant disease of an abdominal organ, to ulcerative endocarditis, to cerebral tumor, and to neurasthenia. The complexity of the symptoms, the contradictory evidence they presented, and their obstinate resistance against specific treatment rendered the case a perplexing one, and the handling of it a matter of bewilderment and of vexation of spirit. I have delayed reporting it in order to observe further developments, but at the date of writing (Sept. 6) he assures me he never felt better in his life.

THE

MARITIME MEDICAL NEWS,

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

VOL. XIII. HALIFAX, N. S., SEPTEMBER, 1901. No. 9.

Editorial.

SUBSTITUTION.

We have previously had occasion to refer to a practice which, we trust is not prevalent, but which we are led to understand still obtains in some quarters, viz.:—the substitution by dispensing chemists of some drug or preparation as an equivalent for a somewhat similar drug or preparation prescribed by the physician but not held in stock by the dispenser. The practice is, of course, most reprehensible, and cannot be defended upon any grounds. The dispensing chemist cannot be assured that the substituted drug will produce the result which the physician anticipates from his prescription, the physician is almost certain to meet with disappointment, and the effect upon the patient may be such as to influence most unfavorably the course of the illness. In some quarters the substitution of so-called "equivalents," which, it is needless to say, are always cheaper than what is called for, has grown to be such a nuisance that legislative measures have been undertaken in order to put a stop to it. Thus in the State of Tennessee there is a law making it a criminal offence, punishable by fine or imprisonment, to substitute any drug in lieu of that prescribed by the physician.

We trust that the evil is not widespread throughout our provinces, but it is difficult to form any estimate without definite knowledge being afforded us from various quarters. We invite correspondence upon the subject from any of our readers who have had experience with substitutors and who feel that the time for concerted action has come.

THE "GRAND OLD MAN" OF THE PROFESSION.

The NEWS has been reminded that Dr. Wm. Bayard of St. John, the "Grand Old Man" of the profession in the maritime provinces, recently celebrated another birthday. We have much pleasure in quoting from the *St. John Sun* of August 21st; to the facts given and sentiments expressed we are in hearty accord:

"The Sun offers congratulations to Dr. William Bayard, who is eighty-seven years old today. It would perhaps be more correct to borrow an expression and say that he is eighty-seven years young. Many old men are disposed to withdraw from active service, to think and talk of the past, and to look with disfavor on new ideas and reformations. Dr. Bayard still goes about his medical practice with a cheerful face, an active step and alert mind. In season and out he is stirring up the people to improve the condition of the city, and to take advantage of all the opportunities that medical and sanitary science has placed within their reach. On the platform, in the press by appeals to citizens individually and to the authorities, Dr. Bayard continues to made himself heard on matters relating to public health Young men may be found here and in other places who do these things, but where is there another such active reformer of four score and seven? For sixty-four years Dr. Bayard has been a physician in this city. In that time he has been the leading spirit in many beneficent enterprises. The public hospital is practically his creation. He was foremost in securing the enactment of sanitary laws. The highest positions in the gift of his fellow physicians were bestowed upon him before half the doctors now in St. John were born. The first message ever sent by electric telegraph to this city came to him Yet Dr. Bayard is younger in mind and heart and purpose, more advanced in his ideas, more strenuous in his efforts for the improvement of existing conditions than most of his juniors. So it is proper for good citizens to wish him many returns of the anniversary of his birth."

LABORATORY OF HYGIENE.

The profession in Nova Scotia will doubtless be pleased to learn that the government has established a Laboratory of Hygiene for the province. The duties envolved have been entrusted to Dr. Andrew

Halliday who has been appointed to the position of Provincial Pathologist and Bacteriologist. The work undertaken will be somewhat more comprehensive than that so efficiently carried out for the Provincial Board of Health by Dr. W. H. Hattie.

Dr. Halliday recently returned from Glasgow where he spent nearly a year devoting his time particularly to pathology and bacteriology, where we have learned his work was most favorably commented upon. The work which will be carried on at the Laboratory of Hygiene is what Dr. Halliday has always taken particular interest in and the profession will be more than satisfied in the new appointment.

The following will give those interested some idea of what will be undertaken in the Laboratory:

1. Examination of sputum for tubercle bacilli, pneumococci, etc.
2. Examination of swabs from the throat in suspected cases of diphtheria.
3. Examination of specimens of blood in suspected typhoid by means of the Widal test.
4. Microscopic examination of blood films, blood counts, etc.
5. Urine—quantitative estimation of albumen, urea, etc., and report on microscopic characters of deposits.
6. Reports on pathological fluids, tumors, uterine scrapings, etc.
7. Sanitary, chemical, and bacteriological examination of water, sewage, etc.
8. Milk—estimation of fats, solids, etc., and bacteriological examination particularly for tubercle and typhoid bacilli.
9. Foods—ordinary sanitary examinations for injurious preservatives and other noxious substances.

It is particularly requested that clinical notes be forwarded *in all cases* along with specimens. In cases of suspected typhoid it is very important to state the day of the suspected fever as without this information it is impossible to give an opinion in a doubtful case. It must be remembered that the reaction most frequently appears about the *seventh* day of the fever, although it not infrequently occurs as early as the fifth day but it may be delayed to the second week.

Information as to securing specimens and presenting the same will gladly be furnished on application to the laboratory.

No fee is charged for any of these examinations but where it is undertaken for a patient who is perfectly able to pay it is expected

WYETH'S Granular Effervescing

Each Dessertspoonful contains 30 grains of the salt.

SODIUM PHOSPHATE

A Remedy for Constipation, Obesity, Rickets, Jaundice, Etc., Etc.

Sodium Phosphate is Unexcelled:

Sodium Phosphate has long been the favorite purgative, inasmuch as it acts gently but surely, has little or no taste, and is easily taken by children and delicate persons. In the present form—the effervescent—it is a delightful remedy, constituting a refreshing sparkling draught of bland action.

1. As an Hepatic Stimulant with beneficial effect on the appetite.

1. Sodium Phosphate is a mild but certain hepatic stimulant, and relaxes the bowels both by promoting an excretion of bile and by acting directly upon the mucous membrane of the intestines. It does not cause "griping," nor does it derange the stomach or excite nausea; unlike many other purgatives, it has a beneficial effect upon the appetite and digestion, stimulating the flow of gastic juice and increasing assimilation.

2. As a Treatment for Diabetes.

2. Diabetes is treated with decided advantage by means of the Sodium Phosphate. Not only are its cholagogue properties beneficial in this malady, but also its well-known power of arresting the secretion of sugar in the liver.

3. As a "Nervetone" in cases characterized by Debility, Spermatorrhœa, etc.

3. Phosphorus is a fundamental constituent of nervous matter, the substance of brain, spinal cord and nerves. Hence, the usage of the present compound in diseases characterised by a deficiency of "tone" of the nervous system in Debility, Spermatorrhœa, Impotence, Locomotor Ataxia, Neurasthenia, etc., is strongly to be recommended. In Asthma and the debility of the advanced stages of Phthisis it is serviceable. In such cases it acts as a restorative and respiratory stimulant.

4. As a Purgative in cases of Exanthematous Fevers.

4. In grave, exanthematous fevers, where a purgative, to be safe, must be simple and efficient, the Sodium Phosphate can be relied on. In such cases its cooling, saline qualities render it grateful and refreshing to the patient.

5. As a cure for Biliousness, Constipation, Jaundice, Diarrhœa, Dysentery, etc., especially in children.

5. Sodium Phosphate, causing a marked outflow of bile, whose consistency it renders thinner, is an incomparable remedy for Biliousness constipation, and, above all, for Jaundice, especially in children, on account of its absence of taste, and its efficient but unobjectionable properties. Diarrhœa and Dysentery in children are effectively controlled very often by the action of this salt in cleansing the mucous membrane of the lower bowel, and evacuating in a complete and unirritating manner the rectum and large intestine.

DOSE.—For children, to relieve diarrhœa, constipation, etc., a small dose only is necessary, ½ to 1 teaspoonful according to age and effect desired. As a purgative in adults, one or two dessertspoonfuls. As an alterative in gout, obesity, hepatic derangement, etc., one dessertspoonful morning and night. As an excellent substitute for Carlsbad water (which depends largely for its beneficial effect upon the presence of this salt) may be obtained by adding a dose to a tumbler of water and taking it gradually on getting up in the morning. ☞ The glass cap on our Effervescing Salt bottle, when filled, is equivalent to one dessertspoonful, and also embodies a time device adjustable to any hour at which the next dose is to be taken.

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that a fee of $1.00 will be voluntarily tendered. This is left to the discretion of the medical man attending the case.

All communications and specimens should be addressed to Dr. Halliday, Nova Scotia Laboratory of Hygiene, Halifax Medical College, Halifax.

Matters Personal and Impersonal.

Dr. C. D. Murray of this city, is laid up with empyema of the antrum at the Victoria General Hospital.

Dr. Louis Singer, surgeon on the French cableship "Contre Amiral Caubet" was recently called to France by cable announcing the serious illness of his father. We are sorry to announce that before the doctor reached home, his father, who was a captain in the French army had passed away, the cause of death being diabetes. The many friends whom Dr. Singer made in this city will sympathize with him in his bereavement.

Dr. H. D. Weaver of this city, who recently returned from Toronto after having taken a special course in electricity, has a splendid new electrical equipment fitted up in his office. This includes a ten plate static machine with X-ray attachments, Crooke's tubes, etc., and also a medical battery containing forty-four modified Leclanche cells and possessing all the latest improvements for applying a galvanic or faradic current to the body. Dr. Weaver will be able to carry out X-ray work for diagnostic purposes promptly, and from what we have seen, satisfactorily; and also any electrical treatment that may be suggested by the attending physician.

Society Meetings.

CANADIAN MEDICAL ASSOCIATION.

The 34th Annual Meeting of the Canadian Medical opened at Winnipeg, Manitoba, on the morning of the 28th of August and continued for the two following days. There was in attendance over one hundred and seventy-five members from all parts of the Dominion, the second largest gathering in the history of the Association; but the meeting itself has been pronounced the most successful of any yet held under the auspices of this Association. There were several visiting doctors from the United States.

Dr. H. H. Chown of Winnipeg, the President, occupied the chair while Dr. F. N. G. Starr of Toronto, discharged the duties of Secretary.

In the absence of Chief Justice Killam, Dr. J. H. O'Donnell, one of he oldest practitioners in the West delivered the address of welcome. He referred to the conditions present in 1869 when Winnipeg was an outpost of civilization, and gave interesting references to Drs. Cowan, Curtis, J. Bird, Beddom and Bund who were already in the West when Dr. O'Donnell moved there in 1869. His address was very much appreciated by the members of the Association.

Dr. R. W. Powell of Ottawa, the past President of the Association, then introduced Dr. H. H. Chown, the President-elect.

Dr. Chown on rising to reply was received with hearty cheers, testifying to the high esteem in which he is held by his fellow-practitioners throughout the Dominion. He briefly thanked the Association for the honour they had conferred upon him at the meeting in Ottawa one year ago.

Dr. Starr, the Secretary, presented his Annual Report. It referred to the meeting at Ottawa last year, to the attendance of 153 members, which was an increase over former meetings in that city, to Dominion Registration and to the formation of a Physicians' Protective Association.

Dr. Edebohls of New York and Dr. Sutton of Pittsburg were welcomed to the convention and requested to participate in the discussions.

THE QUESTION OF MEDICAL DEFENCE.

This was introdrced by Dr. Russell Thomas of Lennoxville, Que. who had been delegated by the St. Francis District Association, to present this subject to the Canadian Medical Association. He made a strong plea for the formation of a Medical Defence Union and thought that all were agreed of the necessity for such. He supported his contentions by citing two or three cases already well-known to medical practitioners in Canada and after showing that such Defence Unions wers a success in England, he concluded by outlining the plan of medical defence already in vogue and supported by the St. Francis District Medical Association which he was authorized and prepared to hand over entire to the Canadian Medical Association. The discussion of this important matter was deferred until later on on in the session.

ADDRESS IN MEDICINE.—"THE QUESTION OF MEDICAL EDUCATION."

Dr. J. R. Jones of Winnipeg delivered this address. In opening his remarks he referred to the unsolved problems of medical education, the importance of which were especially manifest in view of the establishment of a Dominion Medical Board. Uniform or equivalent curricula, he thought, would greatly facilitate paving the way for the accomplishment of this object. He thought that the great aim of the Canadian Medical Association should be to create a Dominion Medical Board upon such a sound and enduring basis that the qualifications could be registered in every province of the Dominion. They should not only be Canadian but Imperial, capable of registration in Great and Greater Britain. There should be no special education for the profession of medicine and the defect in the preliminary education of medical students should be corrected. The standard is not high enough. Many students came into the medical college, their minds totally unprepared, undisciplined, not competent to engage in the different studies of a profession to advantage. Dr. Jones would not eliminate Latin but would go a step farther and advocate a more general knowledge of Greek, as Greek was *par excellence*—the language of science. He quoted from two eminent authorities, who favor the retaining of "classical education" as training for professional studies—Dr. Alexander Hill, a member of our profession who is Master of Downing College, Cambridge, and Professor Jebb of Berlin. He referred to medical matriculation examinations and deplored the

lamentable defects in the English paper, the most neglected subject in our primary schools. From an experience of many years as an examiner at the University of Manitoba, Dr. Jones has concluded that the teaching of English takes a very subordinate position in our schools. The defect was a universal one; and it was obvious that if English should become a prominent subject of the medical matriculation examination every student ought to be able to express his thoughts coherently and intelligently. The didactic lecture came in for adverse criticism, and defects and useless wastes of time, which could be more profitably employed, were pointed out. Persistent work in the dissecting-room under the guidance of an experienced demonstrator, who will describe, discuss, and constantly orally examine the student is a rational and effective method of teaching anatomy. Medical Jurisprudence and Sanitary Science were not properly taught.

Dr. Jones supported the "case" method of teaching; and from personal experience he favors the English system of clinical clerkships and dresserships as the most feasible, practical and thorough for the development of medical teachings. He referred to the question of Dominion Registration and pointed out two serious objections to Dr. Roddick's Bill: First, the great number of the representatives of the Council, entailing expenses beyond at least, our immediate resources; and second, the fact that one of the contracting parties to Dominion Registration may secede and the elaborate fabric, the work of many years, tumble to the ground. The able paper of Dr. Jones was received with much gratification by the Association.

Dr. R. B. Nevitt, Dean of the Woman's Medical College, Toronto, in moving a vote of thanks to Dr. Jones for his able paper, stated that he had placed his finger on the weak point of Medical Education. Dr. S. J. Tunstall of Vancouver seconded the motion for the vote of thanks and also congratulated Dr. Jones for the excellent manner in which he presented his subject.

DOMINION REGISTRATION.

Dr. T. G. Roddick of Montreal, who had so long and so ably advocated this much-to-be-desired measure, delivered a stirring address on the subject, ably reviewing the subject of Inter-Provincial Registration from the time of its inception to the introduction of his Bill at the last session of the House of Commons. The special committee appointed on this subject had not yet reported, so the discussion was

postponed until the committee had a chance to meet and report later on in the session. Dr. Roddick now seems to hold to the opinion that the suggestion of Dr. Britton of Toronto, that representation by population, for Ontario at least, would be advisable.

INFECTIOUS PNEUMONIA.

Dr. W. S. Muir, Truro, Nova Scotia, read this paper. He reported four cases, all of which had occurred between the 1st and 13th of April of this year, in the same house and in the same family. The first occurred in a child of ten years, the disease terminating by crisis on the 6th day, the child making a good recovery. A sister aged fourteen contracted the disease; terminated by crisis on the 9th day, but followed two days after by left-sided pleuro-pneumonia. This proved fatal. The third occurred in a sister of fifteen years of age, beginning with a pain on the left side and terminated on 10th day by crisis and recovery. Number four developed pneumonia, but recovery was quick, the patient being about in two weeks. There was no influenza in the town at the time. Dr. Muir spoke of the organism of pneumonia, its cultivation and detection.

FIRST DAY—*Afternoon Session.*

PRESIDENT'S ADDRESS.

As this was the first time that the Canadian Medical Association had met in Manitoba, Dr. Chown referred briefly to the future of that important province. Although less than ten per cent. of the arable land was under cultivation, Manitoba's farmers would this year have a crop estimated at 85,000,000 bushels of grain. He then referred to the work performed in Winnipeg for the purpose of making that city a healthy one, and in spite of the level nature of the land, an excellent system of sewers had been introduced through all the streets; and efficient arrangements had been made for regular flushing of the sewers by means of tilting basins at the upper end of each main sewer. As Winnipeg has two rivers at her door the problem of removing sewage was easily and safely solved, Dr. Chown then referred to the water supply and said that the people of Winnipeg enjoyed as pure water as could be found in the world. An examination of the city water would show that there was in it only nine to thirty colonies of bacteria. The water is taken from an artesian well seventeen feet in diameter and forty-eight feet deep, and although they have been pumping for months a supply of from two to three million gallons per day there is not the evidence of any diminution of the amount flowing

in. This well is supposed to tap an under-ground passage which runs from Lake Manitoba, and as this Lake is 130 miles long the supply is inexhaustible. The under-lying rock formation in that section of Manitoba is a magnesia limestone and, consequently, the water contains a large amount of the carbonate of lime and of magnesia and is too hard for satisfactory use in boilers and hot-water appliances. This is overcome by using Clarke's method of softening by precipitation of these carbonates through the action of lime water; and the softening plant is unique on this side of the Atlantic. Dr. Chown then referred to the question of Tuberculosis and thought that Koch's tentative denial of the oneness of tuberculosis of man and tuberculosis of cattle still needs the proof of non-inoculability from cattle to man. He instanced cases of young farmers free from tuberculous taint living in newly-built houses harboring no bacilli and separated by long distances from their neighbours, in whom tuberculosis constantly makes its appearance; and we have here, an experiment on a wider scale, and if you can eliminate heredity, house infection and contagion from other causes, to what cause can you describe the origin of these outbreaks?

Medical Education, the plan of Dominion Registration as introduced by Dr. Roddick, Malarial Fever, Proprietary Drugs, the Progress in Surgery and the Future of Bacteriology and Hæmatology were subjects ably dealt with; and in concluding Dr. Chown felt that a duty rests upon the Medical profession to get at the true cause of all forms of disease and rescue the public from both the honest fanatic and the ignorant pretender by doing not only all what these claim, but doing more and doing it better.

Sir James Grant of Ottawa, moved a vote of thanks to the President and characterized the address as extremely interesting and instructive. Dr. J. L. Bray of Chatham seconded the motion.

EPIDEMIC CEREBRO-SPINAL MENINGITIS.

Dr. James McKenty, Gretna, Manitoba, presented this paper, which gave an account of an epidemic occurring in North Dakota during the winter and spring of 1893. It occurred within an area extending fifty miles from east to west and twenty miles from north to south and was comparatively definitely limited. About 70 persons were seriously ill and almost as many others suffered from mild manifestations of the disease. Of the 70 cases twenty-five ended fatally,—a mortality of about 35%. In the practice of Dr. McKenty there occurred some thirty cases, a brief record of twenty-two of these

being kept. The average age was seventeen years; the youngest fifteen months; the oldest thirty-eight years. The duration of the disease extended from twelve hours to fifteen weeks. No post-mortem was made in any case. Dr. McKenty then described in detail the clinical aspects of several cases.

SPLENIC ANÆMIA, WITH CASE.

Dr. A. J. Macdonnell, Winnipeg, contributed this paper with the history of the case. This was an exceedingly rare disease. In 1898 the number of cases recorded did not exceed thirty, but since that time there has been fifty additional cases reported. R. N., aged 27 years; environment good; has never had malaria; habits and mode of life good; positively never had syphilis. The present illness began in August 1899. Felt heavy on the right side with a feeling of fulness and weight. In January 1900 gave up work on account of muscular weakness. There was no vomiting. The patient consulted Dr. Macdonnell in March 1900, walking into his office with considerable difficulty. There was no enlargement of lymphatic glands. Enlargement of the stomach could never be percussed or palpated. Liver dullness was practically normal. There was no jaundice or pain in the liver region. The patient succumbed to the disease but no post-mortem was held. Another case occurring in a patient aged seventeen was reported. Dr. Bell made a blood-count in this case which at different times ranged 3,540,000, then 3,600,000, then 3,400,000, with 7,602 white-blood cells. In this case all the other organs were normal. And there seemed to be no predisposing cause in this case. Dr Macdonnell stated that only ten autopsies had been made on people dying from this disease. He referred to the conditions found post-mortem in these cases. The treatment for these cases was stated to be rest, diet, and vigorous doses of arsenic. The mortality is set down at 20%. As far as operation is concerned, physicians will not be satisfied until it is clear that the patient recovers from the operation as well as from the disease. If we are sure of our diagnosis, then surgical intervention is deemed advisable.

PHYSICAL DEVELOPMENT.

Dr. J. N. Hutchison of Winnipeg, read a carefully prepared paper on Physical Development. The paper did not deal with anything new but called attention to and emphasized certain facts of considerable importance. He considered that children were sent to school at too early an age and as a result there was danger of brain

overwork. He insisted upon the necessity of having healthy parents and deplores the system of education which develops the mind at the expense of the body. He was an advocate of periodical lectures by duly qualified physicians to separate classes of boys and girls on the subject of sex; but the primary responsibility in this matter, he placed upon the parents. There would be real progress in the prevention of tuberculosis when people the subject of the disease recognize that they should not marry. The paper which was listened to with close attention closed with a reference to the problems of those unfortunates who are neither mentally nor physically qualified for the duties of life.

REPORT OF CASES TREATED WITH SUPER-HEATED DRY AIR.

Dr. W. H. Pepler of Toronto introduced this subject in a paper which cited his experience and observations in the treatment of certain cases by this plan or process. He briefly described the apparatus and the method of treatment. It only takes twenty minutes to reach a heart of 300 degrees F. The average duration of the application of the heat is forty-five minutes. The physiological and therapeutical effects noticed were referred to, as dilatation of blood-ves-els etc. He administers the treatment one hour after meal time with due regard that there shall be as little as possible excitement and exertion. He has not seen any ill effects from the treatment. He first gave notes of the case of a patient, a man aged thirty-five years, who had suffered for some time from varicose ulcer of the right leg, with considerable pain. This patient had a treatment of 35 minutes duration and was able to walk home with very little discomfort. After three times, in ten days, the ulcer was very much reduced in size. The second case was a patient twenty-two years of age who had been troubled with rheumatism for two years past. A temperature of 320 degrees was employed with good satisfaction. Several other cases of rheumatism and eczema were reported. The treatment in each case proved highly satisfactory, patients never complaining of any discomforts and all expressing satisfaction with the treatment. Dr. Pepler subjects a considerable portion of the patient's body from a temperature of 280 to 320 degrees F. The results are often not apparent for some time after treatment.

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Dr. McAdam of Battleford, asked Dr. Pepler if he had ever tried the treatment with high temperature, where he had any doubts of the condition of the heart.

Dr. MacDonald of Brandon referred to a case which had come under his observation in which there was heart trouble. Perspiration occurred freely but with no effect in a depressing way upon the circulation. Treatment in this case was continued for two weeks but he had never determined that there had been any effect upon the heart although there was a small heart lesion at the time.

Dr. Pepler in reply: He could not speak personally as to any deleterious results from weak heart. Of course there were many cases reported where heart trouble was present. He personally had never noticed any heart or head symptoms in his cases. He thought with care there would be no bad results.

ORTHOPEDIC TREATMENT OF DEFORMITIES AND DISABILITIES RESULTING FROM DISEASES OF THE NERVOUS SYSTEM.

With special reference to tendon transposition.—By Dr. B. E. McKenzie, of Toronto. He spoke of disabilities and deformities resulting from paralysis, some of which were commonly regarded as hopeless but the conditions of a great majority of them were remediable and should receive a considerable amount of attention. He was at some pains to explain the respective motion of joints, particularly the ankle-joint and knee-joint, especially calling attention to the normal conditions of equilibrium, and then showed how the muscles of some of the groups at times become paralyzed and the balance and equilibrium thereby destroyed. Mechanical treatment was often necessary and often efficacious as well; massage and electricity had their respective places, but he made particular reference to the method of treatment that had been in vogue for twenty years and had been introduced on this continent by Dr. Parish, of Philadelphia. He went carefully into an explanation as to how muscles can be transferred from their usual point of action, and then he gave an account of several cases in which he had successfully accomplished this. In his opinion, amputation of a limb because of apparent disability should seldom or never be resorted to.

In answer to Dr. McAdam, Dr. McKenzie disapproved of jackets in treatment of curvature of the spine.

Dr. Clarence Starr, Toronto, stated the subject was of great interest to him, as he was interested pretty largely upon the same lines of

surgery. Dr. McKenzie had indicated a large number of cases of paralysis which can be wonderfully helped by operative procedures. Dr. Starr thought that Dr. Bowlby, of Boston, deserved a great deal of credit for the work he has performed in this connection.

Dr. H. B. Small, of Ottawa, referred to a case Dr. McKenzie had operated on. In this case previous to operation, the boy had great difficulty in arising from the sitting posture, and when walking he had to rest every few yards. After the operation he was very much improved and when Dr. Small last saw him, about a week ago, he could walk very easily and never had to support himself. The improvement during the last four or five weeks was especially very marked.

(To be concluded in next issue)

NEW BRUNSWICK MEDICAL SOCIETY.

The twenty-first Annual Meeting of the New Brunswick Medical Society was held in the Council Chamber, Moncton, July 16 and 17, 1901. In the absence of the President, Dr. S. C. Murray of Albert, the Vice-President, occupied the chair. After the adoption of the minutes of the previous meeting, Dr. Murray referred to the loss sustained by the profession in this Province by the death of several of its members, and then referred to the advisability of the formation of a Medical Defence Union, pointing out the benefits derived from such organizations in other localities, and urging upon the society to give this matter its serious consideration. As a result of the presiding officer's remarks the following motion presented by Dr. Thomas Walker, St. John, was unanimously adopted:

Resolved, That the New Brunswick Medical Society looks with favor upon the formation of a Medical Defence Association in the Dominion, and the members here present pledge themselves to aid in every way in the carrying out such a scheme, provided such an association can be formed on a fair and equitable basis. The secretary was instructed to forward a copy to the Canadian Medical Association.

The Treasurer's report showed the society to be in a flourishing condition.

The Registrar's report shows that there are in the Province 246 registered practitioners, 7 of whom were added during the past year. A number of other facts of importance to the profession in the Province

were referred to. A number of interesting papers and discussions were presented at the sessions of the meeting and all proved most interesting and merited the time devoted to them by members of the Association.

The following programme was carried out:

"Early diagnosis and treatment of Tuberculosis, with reports of cases cured."—J. H. Ryan, Sussex.

"Discussion: 'What should be done by the Profession and by the State for the prevention and treatment of Tuberculosis?'"—Opened by Thomas Walker, St. John.

"Acute Stenosis of the Larynx,"—O. J. McCully, Moncton.

"Multiple Osteo-Myelitis following Typhoid Fever, with report of case."—G. A. B. Addy, St. John.

"Lacerations of the Perinæum."—T. Morris, St. John.

"Evolution and Theory of the Obstetrical Forceps."—J. C. Webster, Chicago.

"Operations for Prostatic Diseases."—James Bruce, Moncton.

"Rheumatism of Eye."—J. R. McIntosh, St. John.

"Smallpox,"—W. L. Ellis, St. John.

A luncheon tendered to the visiting members of the Association at the Hotel Minto by the profession in Moncton was well patronized and thoroughly enjoyed, and many of the members present availed themselves of the opportunity to thank the local members for their efforts to ensure the success of the meeting.

The following officers were elected for the ensuing year:

President.....S. C. Murray, Albert.
Secretary.....W. L. Ellis, St. John.
Treasurer.....G. G. Melvin, St. John.
Trustees: Drs. R. L. Botsford, J. W. Bridges, A. J. Thorne.

It was decided to hold the next annual meeting in St. John.

The following committee of arrangements was appointed:—Drs. Inches, J. Christie, T. D. Walker, S. Skinner.

Obituary.

Dr. J. H. Morrison.—The city of St. John has lost one of its clever and popular physicians in the sudden death of Dr. J. H. Morrison which took place on the 13th inst. Dr. Morrison had been in delicate health during the past two years and a half, and the continued strain

of a trial in the circuit court, during a large part of which he had been on the stand subject to close examination, proved too much for his weakened condition. Early Thursday morning, the 12th inst, he awoke unwell, but partially recovered, though not sufficiently to attend court. Dr. Inches saw him about ten o'clock when he showed no dangerous symptoms. Shortly afterward he became unconscious, and to all appearances moribund. Artificial respiration was resorted to, and during the evening he appeared to rally slightly, only to fail steadly during the night.

Joseph H. Morrison, M. D., Ph. D., was born in St. John October 26th, 1854. He was the son of Rev. Daniel Morrison and Margaret Turner. He was educated at the high and normal schools of New Brunswick; Bellevue, college, New York; Guy's hospital, London; Royal Ophthalmic hospital, London; Hotel Dieu, Paris. He taught in various high schools in this province prior to begining the study of medicine. He graduated from Bellevue college in 1878, and shortly after was appointed vice-president and professor in natural science in the Pennsylvania State Normal School. In 1881 he went to Manitoba, and for some years was identified with the social, educational and political department of Western Manitoba, after which he went abroad, pursuing his studies as a specialist.

Dr. Morrison was married in 1881 to Ida, daughter of T. W. Keirstead of Rothesay, N. B. She died in 1887, leaving one daughter, now fifteen years of age. His second wife was a daughter of the late James L. Dunn. Two children survive this marriage, aged respectively four and two years.

During his career in special practice in eye, ear, nose and throat diseases, Dr. Morrison gained a high reputation and standing in his profession throughout the maritime provinces. But Dr. Morrison's activities were not confined to his professional work. He was an ardent politician well informed in public affairs, full of courage and energy, and a clever public speaker. Not in the political field alone was he generous of his time and talent. Like his fellow doctors, his skill was at the command of those who could not pay. Many churches and societies remember with gratitude the freehandedness with which he helped them by his popular illustrated lectures. Disappointment has fallen upon those who hoped for his recovery and looked for the fulfillment of the promise of other years. But most of of all the sorrow falls upon the wife and children, who have the sympathy of the whole community.

Dr. JAS. A. MCCARRON.—The death of Dr. James A. McCarron of St. John, took place at the General Public Hospital on the evening of Aug. 22nd, after a few weeks' illness. He was a native of St. John and practiced his profession there the greater part of his life. He was educated at the University of New Brunswick; Laval, Quebec; and at Dublin. He was unmarried and about sixty years of age.

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