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# The Canadian Practitioner and Review.

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## Original Communications.

### HEART DISEASE FROM AN OBSTETRICAL POINT OF VIEW.

BY ADAM H. WRIGHT, B.A., M.D.,  
Professor of Obstetrics, University of Toronto.

The subject of heart disease is very interesting to the obstetrician from many points of view, particularly in connection with marriage, pregnancy, and labor. I desire to consider some of these points in their practical or clinical aspects.

*Should a Woman with Valvular Cardiac Disease be Allowed to Marry?*—I think the answer to this question should be yes, with certain exceptions. Of course, in a large proportion of cases, probably the majority, the physician is not consulted in the matter. Frequently the refusal to sanction a marriage makes no difference in the course of events. I know one case where a young woman was married contrary to the advice of her physician; but, when pregnancy promptly followed, the young bride and her mother fully realized the serious aspects of her condition, and asked a physician to induce an abortion. When called in consultation I refused to consent to any such procedure on account of the absence of serious symptoms. This young woman is now the mother of two healthy children, aged 3 and 1 respectively, and is herself enjoying fairly good health.

In naming the exceptional symptoms which should change the answer from yes to no, I cannot do better than quote from Hanfield Jones: "If there are any serious symptoms of cardiac disturbance present, or attacks of dyspnea, breathlessness, palpitation on exertion, or hemoptysis, marriage should not be sanctioned." I have for some years entertained the opinion

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that a young woman having valvular lesions of the heart, who can carry out her social and domestic duties without any serious symptoms of ill health, should not be prevented from marrying, although I freely admit that child-bearing is likely to aggravate the dangers connected with heart disease. I may say at the same time that I fear the dangers of pregnancy and labor in such patients less than I did some years ago.

*Which of the Heart Lesions is the Most Serious?*—It is generally acknowledged that mitral stenosis is the most dangerous condition. This was pointed out very clearly many years ago by Angus Macdonald<sup>2</sup>; and writers since the publication of his work, such as Berry Hart<sup>3</sup>, Galabin<sup>4</sup>, Fothergill<sup>5</sup>, and others fully endorse Macdonald's views. The rarer conditions of aortic stenosis and aortic regurgitation are dangerous, but not so much so as mitral stenosis. Mitral regurgitation alone is not as a rule a matter of serious import.

*How does Pregnancy Affect the System in Cases of Heart Disease?*—It is apt to disturb compensation, and the backward pressure may primarily overload the pulmonary circulation, causing serious thoracic complications, and secondarily may interfere with the functional activity of other organs, especially the kidneys and liver. Sometimes the general disturbance in the working of the various organs causes abortion, although, I think, not so often as has generally been supposed. In one patient with marked mitral insufficiency whom I attended about ten years ago, the labor was normal, but the child was still-born. She had one child living, aged 9. After the birth of this child she became pregnant four times with the following results: one miscarriage at three months, and three still-births at term, including the labor in which I attended her. I don't know whether the heart disease was responsible for these results. I have attended in labor several other patients with mitral insufficiency without having any serious trouble. About twenty years ago I was called to attend a woman in confinement. I had not seen her before, and when I arrived the labor was well advanced. The second and third stages were completed in a few minutes. I then found a loud regurgitant murmur. I had before that time supposed that this was a serious condition in relation to labor, and I was much alarmed. Since then I have learned by experience that mitral insufficiency is not a very serious condition in pregnancy and labor.

I formerly thought that the loss of balance throughout the system from heart disease was apt to cause that form of general toxemia which produced eclampsia; but, although albuminuria and dropsy are common complications, I am now doubtful about the frequency of convulsions in such cases. In some cases pregnancy appears to produce no ill effects whatever. Dakin<sup>6</sup> says

that sometimes the patients appear to improve during pregnancy, owing to the hypertrophy of the heart natural to this period. This is quite in accord with what I have observed. Some of my patients, especially those having mitral insufficiency, have seemed better during pregnancy than they were before. I may say, however, that sometimes they have lost ground after labor, especially during lactation.

*Treatment During Pregnancy.*—Notwithstanding the favorable issue in a large proportion of cases, every patient should be carefully watched during pregnancy, and should be properly treated when serious symptoms appear. Vinay<sup>r</sup> says he agrees with Jaccoud, Huchard and others that matrimony is not to be forbidden when a lesion in the heart is compensated and no complication has arisen, but he recommends watchful care during pregnancy. He insists on repose, milk diet, aperients, and free and frequent dry cupping to the thorax. Berry Hart, in the article before referred to, recommends rest and the administration of tincture of strophanthus when circulatory disturbance begins. He prefers strophanthus to digitalis, because it is a heart stimulant without increasing its work by contracting the arterioles, while digitalis, on the other hand, does contract the small arteries, and thus tends to throw more blood into the venous system.

Without any further reference to the views of others at the present time I will give briefly the rules which should in my opinion be observed in such cases:

1. Keep the patient at rest without going to extremes. A certain amount of exercise and recreation is frequently, if not generally, beneficial. Enjoin absolute rest, however, if serious symptoms appear.

2. If the equilibrium of the circulation is disturbed as shown by the ordinary pulmonary symptoms of dyspnea, etc., administer cathartics, especially calomel followed by Epsom salts.

The latter is a good, old-fashioned medicine whose virtues are not as highly appreciated in many quarters as they deserve.

One of the best lessons in therapeutics that I ever received came from Dr. E. A. Moore, of Rochester, who visited the Ontario Medical Association about fifteen years ago. He talked to us about Colles' fracture, and other surgical subjects, in a delightful way; but his short lecture of about fifteen minutes on the administration of Epsom salts for the relief of dropsy caused by heart, kidney and liver disease, as well as for other disorders, was to me the most interesting of his utterances. Although I had been accustomed to use salts more or less since early boyhood, I then discovered that I had never learned how to properly administer the medicine. And yet how simple is the secret! It should be given thoroughly, systematically and continuously

until it relieves symptoms, and after that it should be administered for weeks or months, if need be, to prevent the recurrence of the symptoms. I carried out Dr. Moore's instructions for some time, observed the good results and was abundantly satisfied.

For the last ten years or more I have preached and practised Epsom salts (if I may be allowed to use such an expression) whenever and wherever I had an opportunity. I believe that in cardiac disease of pregnancy with serious symptoms, especially if there be systemic toxemia, the proper administration of Epsom salts will accomplish more good than all other remedies (including rigid dieting) put together. Next to saline cathartics I would place strychnine and digitalis (or strophanthus). For marked dyspnea use nitrite of amyl, which affords more prompt relief for this distressing symptom than any other medicine, so far as my experience goes. Frequent dry cupping of the thorax in the region of the heart is at times beneficial, and is always safe.

3. Regulate the diet. A great many still believe with Charpentier, Vinay, and others, that a milk diet in these cases is the best. I have not prescribed a purely milk diet for any condition or disease for fifteen years. I allow, and generally encourage, my patients to drink as much milk as they like, but no more. I will not discuss in detail the important subject of diet, but will briefly indicate what I prescribe and proscribe in the way of food.

Let the patient select from the following: milk, buttermilk, kumyss, tea, water, lemonade, table mineral waters, fish, oysters, most of acid fruits (strawberries doubtful, frequently injurious), green vegetables, including spinach, lettuce, cabbage, cauliflowers; celery, radishes, rhubarb, green peas and beans, green corn on the cob, carrots, onions, pickles, table bread, breakfast rolls, toast, potatoes, a limited amount of pepper, salt and vinegar for flavoring, oatmeal, cornmeal, rice, tapioca and the like. Chicken every other day. Any kind of meat once a week.

Avoid meats excepting as recommended, meat broths, eggs, cheese, asparagus, sweet potatoes, turnips, beets, syrups, candies, sweet fruits, such as grapes, bananas, raisins, pears and preserved fruits.

These rules as to dietary are practically those adopted by Dr. Charles W. Purdy, of Chicago, for patients suffering from interstitial nephritis, and are more especially important where albuminuria is associated with heart disease. If there be no albuminuria meat and eggs may be added to the prescribed list.

4. Give no diuretic remedies excepting water.

5. Recommend the ordinary daily warm bath to keep the skin acting properly, and nothing else. The wet pack, so dear to some physicians, is, I think, useless, and frequently an abomination.

6. It is sometimes advisable to induce abortion. I am very glad to be able to express a positive opinion that this radical method of treatment is seldom required. If marked failure of compensation occurs early in pregnancy, as shown by serious pulmonary congestion, urgent dyspnea and the like, the patient should, in the first place, receive appropriate treatment. If the symptoms become worse instead of better, operative interference may be deemed advisable. Many women, especially Roman Catholics, will not consent to any such procedure. Of course in such instances the patient's decision should be final. It is extremely difficult to lay down definite rules. I may say, without any hesitation, that I am less inclined to interfere in such cases than I was years ago.

The following case, hereafter described as Case III, while it caused me much perplexity, was very instructive:

Patient three months advanced in pregnancy. Had mitral stenosis. Had severe dyspnea on exertion, palpitation, rapid pulse. Similar symptoms had appeared before pregnancy on various occasions. At one time the pulmonary congestion was marked and caused hemoptysis. After careful deliberation, and with considerable hesitation, we decided to wait for one month, and watch the effect of treatment. The patient went on to full term.

7. It is sometimes well to consider the history of the patient in reference to previous pregnancies. If she has been in great peril during a former pregnancy and labor, one might think it unlikely that she could pass through such an ordeal again. I will refer in detail further on to a case where the patient was in grave danger during and after confinement. I fear that another labor would cause her death. What should I do if she came to me to-morrow two months advanced in pregnancy? I don't know, but I would not advise the induction of abortion unless grave symptoms were present. It has been pointed out by Hanfield Jones and others, that many women go through early pregnancies with comparatively little danger, but each pregnancy causes a certain deterioration of the heart muscle, which is more or less permanent; therefore, the danger of cardiac insufficiency becomes greater with each successive pregnancy. I am not certain, however, that this statement is correct in all cases, as I think I have seen more than one patient in whom pregnancy did not cause any deterioration of the heart muscle.

8. We have sometimes to consider the advisability of inducing premature labor. I can speak a little more definitely respecting this procedure. Angus Macdonald was decidedly opposed to it, because it was "likely to do greater harm than good by disturbing the action of the heart and the condition of the lungs." I think there is a pretty general consensus of

opinion among obstetricians who have devoted much attention to this subject, that the views thus expressed are correct. My own experience leads me to believe that the patient has the best chance when this operation, which is always more or less an act of violence, is not performed. I will simply give the rule that we should not induce premature labor in such cases: but I don't think it should be considered absolute. It might happen that some symptoms would arise so urgent in nature that interference should be considered necessary.

*Labor.*—How does valvular disease of the heart affect labor? I am not sure that it produces any visible effect in the majority of cases. I have sometimes looked forward to certain labors with fear and trembling; and, much to my surprise, have frequently found them apparently normal in all respects. Reynolds<sup>s</sup> says that "labor in the presence of cardiac diseases is apt to be rapid, because the soft parts are usually resilient and lax." In my experience I have found nothing to justify this statement.

*Symptoms.*—The symptoms during labor are not generally different from those which are found during the last few days or even weeks of pregnancy. The most serious are dyspnea, hemoptysis, precordial distress and palpitation. (Respiration and pulse are generally much quickened.) The dyspnea and other symptoms are aggravated when patient is in the recumbent posture. On this account the patient is in many cases compelled to sit up wholly or partially even while sleeping.

*Prognosis.*—I have not space to quote authorities to any extent; but I may say in a general way that many careful observers give mortality rates ranging from 10 to 60 per cent. Many writers, who treat the subject carefully in other respects, fail to give statistics. I think it unfortunate that such is the case, because I believe more complete details as to results would show mortality rates much less alarming than those which I have quoted. I believe that the publication of such reports has caused many practitioners to induce abortion when there was no necessity for such procedure.

No statement has surprised me more than that made in three modern American text-books on midwifery, viz., "Jewett's Practice of Obstetrics," by American Authors; "The American Text-Book of Obstetrics," and "Davis' Treatise on Obstetrics," that in cases of mitral insufficiency the proportion of deaths is 13 per cent. In the three books there is little or no evidence as to the origin of the unlucky thirteen. In connection with the statistics referred to I cannot help thinking that various authors have been misunderstood, because they have referred to those cases only where compensation has been seriously interfered with. In addition it is well to remember that some of these

statistics are founded on results obtained during the pre-Listerian era. Judging from what I have observed I am fully convinced that the mortality rates which I have quoted, *i. e.*, 10 to 60 per cent., are altogether wrong, or at least misleading.\*

*Treatment During Labor.*—I have already indicated the medicines which are generally recognized as most suitable during pregnancy. The same line of treatment should be carried out during labor. Give strychninè and digitalis (or strophanthus) to help the heart's action: nitrite of amyl or nitroglycerin (glonoin) for dyspnea and precordial distress. The amyl acts more promptly, while the glonoin acts well when given in small doses for days at a time during the latter part of pregnancy. The application of a cupping glass over the heart helps both dyspnea and irregularity of pulse. Administer chloroform, especially during the latter part of the first and the whole of the second stage of labor.

I find that many obstetricians in Canada think, and I believe the opinion prevails in other parts of the world, that chloroform is dangerous in labor complicated with heart disease. One time I held a similar opinion, but increased experience leads me to believe that chloroform is not dangerous; on the other hand, I think it materially aids in mitigating some of the serious symptoms. Dr. Fothergill, who represents the Edinburgh School, says in his text-book before referred to, that "heart disease in labor is no contraindication for chloroform." He further adds that "those with heart disease need it more than others." It tends to relieve to some extent the dyspnea and the irregularity of the pulse, perhaps largely by preventing straining on the part of the patient. It may be administered even when the patient is sitting up during labor. I think, however, it should be used with caution, and by an assistant who devotes his whole attention to the administration of the anesthetic. Ether, as a rule, however, is positively contraindicated, particularly on account of the pulmonary complications.

The patient should be prevented from straining or "bearing down." At the completion of the first stage it is better, as a rule, to deliver with the forceps. Sometimes it is necessary to let the patient sit up with her head and shoulders held up, or propped up with pillows. In such cases it is sometimes necessary to have the patient in such a position that her buttocks are projecting over the edge of the bed, while an assistant stands on either side, grasping a leg or a thigh and foot so as to prevent her from slipping to the floor. I think it is well to apply an abdominal binder before delivery, which should be tightened

\* Some of our physicians appear to take a less gloomy view than the obstetricians. Osler,† in speaking of valvular lesions of the heart, says: "Pregnancy and parturition are disturbing factors, but are, I think, less serious than some writers would have us believe."

during the delivery of the child. At the same time remember that a free hemorrhage is beneficial, and should be encouraged. The object of the binder is to compensate for the sudden diminution of the intra-abdominal pressure. It should, therefore, be applied above the level of the uterus in such a way that it will not prevent slight uterine relaxations, or, in other words, in such a way as not to prevent free hemorrhage. With the same object in view avoid the use of ergot. Fothergill and others advise free venesection from the arm if symptoms of embarrassed circulation persist.

Hart says that the most dangerous time for the patient in such cases is the third stage. This is probably correct, but it is well to remember that grave danger exists for several days after delivery, and, in fact, very watchful care is required for weeks.

I will now give reports of cases of mitral and aortic stenosis, without any further reference to many cases of mitral insufficiency which I have observed, and all of which ended in recovery.

CASE I.—Mrs. A., aged 26; primipara.—Dr. W. P. Caven's patient; long standing heart disease with aortic direct murmur. Present in consultation; labor tedious; forceps delivery, under chloroform; no special symptoms during first and second stages; placenta retained; hand introduced for removal; considerable hemorrhage; aortic regurgitant developed with slight endocarditis lasting about two weeks; recovered.

CASE II.—Mrs. H., aged 23; primipara.—Had heart disease for several years. Dr. Caven saw her with me when four months pregnant; had both aortic and mitral stenosis; considered the advisability of inducing abortion, but decided against because there were no serious symptoms; went on to full term without much inconvenience; labor somewhat tedious, but uneventful; delivered with forceps after dilatation; good recovery.

CASE III.—Mrs. K., aged 32; 3-para.—Dr. Caven's patient. Saw her in consultation when three months advanced in pregnancy. For two or three years previous she suffered more or less from symptoms due to heart disease. Dyspnea on exertion very serious at times; a few attacks of hemoptysis; mitral stenosis; loud presystolic murmur. Dr. Caven feared results if pregnancy were allowed to continue. I advised waiting at least a month. We decided on so doing with the understanding that I was to take charge of the patient. No serious symptoms afterwards. In fact, she seemed better during the latter half of pregnancy than during the first half. Labor—at full term—uneventful up to end of the first stage; no chloroform administered; delivered with forceps; healthy child; good recovery.

CASE IV.—Mrs. G., aged 26.—Had one child sixteen months old when I saw her about the beginning of third month of

second pregnancy; had a double aortic murmur, also presystolic; no serious symptoms. I did not see her after fourth month. Delivered by Dr. Caven at full term; healthy child; no difficulty.

CASE V.—Mrs. S., aged 32; 2-para.—Dr. Graef's patient. Saw her in consultation early in labor. She had suffered much during pregnancy from dyspnea and marked precordial distress. When I arrived, labor was slightly advanced; os partially dilated. She was suffering much from dyspnea and distress in the region of the heart; was unable to lie down; had a well-marked presystolic murmur; also aortic murmur. Inhalation of nitrite of amyl afforded marked relief. We also administered strychnia and digitalis and a little chloroform. I was unable to remain long; Dr. Graef delivered her with forceps about four hours after I left; child dead; patient appeared to be doing fairly well for some days, but died somewhat suddenly the sixth day after delivery. Patient was a poor woman living in a small house without any conveniences; no proper nursing. She refused to go to a hospital.

CASE VI.—Mrs. X., aged 35; primipara—Had suffered for years from mitral stenosis, and had been under the care of Dr. Caven, who consulted me about the case and requested me to help him in her expected confinement. When labor commenced Dr. Caven was out of town and I took charge. Labor fairly easy for a rather old primipara; no serious symptoms, but patient had two large pillows under head and shoulders; waited about half an hour after full dilation, because symptoms were not urgent, and I was afraid of the perineum: administered a little chloroform; finally delivered easily with forceps. I had a competent and experienced nurse to assist me, and did not call any one in to administer the anesthetic. I would not, however, advise others to follow my example in this respect. At the time of writing, the baby is a week old, and the patient has not had an unfavorable symptom.

CASE VII.—Mrs. C., aged 30; 3-para.—I attended this patient in January, 1898, but I describe her case last because I wish to go somewhat fully into details as to treatment. She had been under the care of Dr. Jas. F. W. Ross, in the pavilion of the Toronto General Hospital. He sent her into the Burnside Lying-in Hospital to be placed under my care during her confinement. She had been suffering for some years from mitral stenosis. I first saw her in the Burnside three days before the onset of labor. She had severe bronchial catarrh with slight hemoptysis at times, urgent dyspnea, and marked precordial distress. Was unable to lie down even for a few minutes, but lay propped up in bed almost in a sitting posture. Her sufferings were great, and her general condition most alarming. After a consultation with Dr. Ross, we decided not

to interfere, but to watch and treat symptoms. Dr. Ross had prescribed strychnine, digitalis and stimulants. I continued on the same line, also prescribed amyl nitrite, to be administered occasionally. Her respirations were rapid, between 40 and 50 at times. Pulse from 120 to 170, sometimes could not be counted. Patient was very carefully watched by the resident assistants, and the head nurse, Miss McKellar. I feared she would not live until labor commenced, but did not feel that I dared interfere. Labor commenced on the morning of January 27th, and continued during the day. The os was fully dilated at 5 p.m. Dr. McEachern administered chloroform, the patient being held in the sitting posture on the edge of the bed by two members of the resident staff, while I delivered with forceps. A binder was put around abdomen, and tightened during and after delivery. Fairly free hemorrhage followed and was encouraged. The dyspnea and distress continued for hours. At times we thought she was dying. We gave strychnine and digitalis and small doses of whiskey, but she was still unable to lie down for some days after delivery. About the fourth day the symptoms became less severe. After that, recovery was somewhat rapid, and in one month she went out of the Burnside fairly well. The baby was healthy, though not large, and became a great pet among the nurses. He left the hospital with his mother, under the properly legalized name of Adam Ross Cooper. The onlookers, and others who heard of the case, were surprised at the administration of chloroform under such circumstances, but as I have already discussed this procedure I will only add now that I believe the chloroform was a decided source of benefit to this patient. I have before referred to the prospect if this woman should again become pregnant. Would it be possible for her again to go through pregnancy and labor, and live? I don't know, but I hope she will never try.

Without any reference to mitral insufficiency, I have recorded these seven cases of serious heart lesions with one death. It is quite possible, if not probable, that this patient might have been saved if she had been properly nursed in a comfortable home or hospital. With the worst possible sort of surroundings and the poorest kind of nursing she lived six days after delivery.

I will briefly summarize my views as follows:

1. A woman having a heart lesion which is compensated should not be prevented from marrying.
2. Abortion should not be induced on a woman with heart disease, unless very serious symptoms are present.
3. Premature labor should seldom or never be induced on account of heart disease.
4. Mitral stenosis is the most serious heart lesion during

pregnancy and labor—aortic stenosis comes next—then probably aortic incompetency. Mitral insufficiency is the least serious lesion.

5. Treatment during pregnancy. Administer the following according to indications: Strychnine; digitalis (or strophanthus), cathartics, nitrite of amyl, nitroglycerin, and regulate the diet.

6. Treatment during labor. Keep up the action of digitalis (or strophanthus), especially during first stage. Give strychnine and stimulants if required, and chloroform. As soon as the first stage is completed deliver with the forceps.

7. Watch the patient carefully during the third stage (the most dangerous time) and for some days after.

30 GERRARD STREET EAST.

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## SPINA BIFIDA.\*

BY GEORGE A. BINGHAM, M.B.

*Fellows of the Clinical Society:*

I have first to thank you for what I consider the exceedingly great honor you have done me in electing me your President. As a charter member of this Society I have from the first done what little I could for the furtherance of its interests, and during the present session I shall esteem it a privilege to do my best in the same direction. Though naturally it is with some timidity that I assume the responsibilities of this position, more especially in view of the uninterrupted line of distinguished gentlemen who have preceded me in office, yet feeling assured of the loyal support of the Fellows, and conscious of the fact that I have an enthusiastic committee to assist me, I am surely justified in the hope that the Society will in nowise retrograde during my incumbency of office. From its inception our Society has prospered, and in reviewing the causes that have contributed most largely to that success, I am reminded of the intensely practical nature of the reports presented, and of the discussions arising therefrom. Brevity and conciseness have also been marked features of our clinical reports. May I urge a continued fostering of these virtues? Indeed, they are necessities if we desire to profit from the great mass of clinical material now placed at our disposal through the medium of our Society.

Before discussing the subject proper of this brief paper, it is fitting that I should refer to the loss we have sustained in the death of the late James E. Graham. The profession at large throughout the Dominion have already testified to their appreciation of his worth, and we, as members of this Society, who have been brought more or less constantly into relationship with him must feel his loss even more keenly. A charter member of our Society, he was always ready to place his services at our disposal, and I happen to know from a personal statement how thoroughly he appreciated the helpfulness of the benefits to be derived from our clinical reports and discussions. In his decease we have lost from our roster an unostentatious but enthusiastic worker and a kindly gentleman. We shall miss his presence at our meetings, but the influence of such a life must be as enduring as the eternal hills.

With your permission, I shall deviate somewhat from the precedent established by my predecessors, and instead of a formal address shall present to you a summary of clinical reports from my case book in connection with the treatment of

spina bifida. The last word has by no means been said in connection with this subject, and it would seem to be desirable to obtain as many reports as possible in regard to the treatment of this condition. Rose and Carless in their excellent manual say: "The majority of these cases are best left alone," etc. Should operative treatment be deemed advisable, they claim, from statistics, the best results from Morton's method. This is in line with the well-known report of the London Clinical Society, and also with the statistics given in Morton's own work, published twelve years ago. Thanks to Mayo Robson, Nicoll of Glasgow, and others, the open method of treatment by excision can now furnish statistics even superior to those claimed by the advocates of Morton's method.

The London Clinical Society which investigated the subject carefully, found a mortality of 38 per cent. after treatment by Morton's method, and yet were constrained to recommend this as the best, in fact, the only justifiable, method of treatment.

Nicoll, who has reported upwards of thirty cases operated upon by the open method, says: "My experience has been such as to convince me that, in the matter of mortality, it would probably not be difficult to produce a series of cases operated on for spina bifida, in which the mortality would compare favorably with that of the operation for the radical cure of hernia. To obtain this result it would be necessary to reject for operation cases in which the sac had burst or was sloughing, and cases with very pronounced hydrocephalus. A moderate degree of hydrocephalus I have found no bar to success."

This great divergence of opinion and practice in regard to the treatment of a grave malformation occurring once in every one thousand births must be my excuse for this brief report.

The cases which I shall summarize are eight in number, and have all, with one exception, been operated on more than a year ago. Seven were meningoceles, one meningo-myelocele; seven were in young children, one in an adult. As to evidence of nerve involvement they may be classified as follows:

One case of paraplegia, with complete loss of control over bladder and rectum (this case, by the way, was fatal, and was a simple meningocele); three cases of club-foot—one single, two double (two of these cases were meningoceles, one meningo-myelocele); two cases of hydrocephalus, both of which terminated fatally (as to previous convulsions, the histories were imperfect and doubtful, and are therefore omitted). Four cases were normal so far as development was concerned, except that in one, the adult, there was marked asymmetry of the head and face.

Of these eight cases there were six cases of *permanent*

recovery and two deaths, a mortality of 25 per cent. These cases were not selected, and in no case did I refuse to operate, simply placing the facts and probabilities before the parents in each case. In one of my fatal cases, the child, a hydrocephalic, was dying when operated upon. Morton's treatment had been used in this case several times; he had just arrived a long journey from the country, and I only consented to operate upon the urgent insistence of the parents. It was a simple meningocele, with the sac ulcerated and leaking in places, and was rapidly closed off with mattress sutures and cut away, the lateral flaps brought over and united. A few minutes completed the operation, and the child lived twenty-four hours. All who saw the case felt sure of a fatal termination within twenty-four hours without an operation. This termination cannot fairly be attributed to the operation.

The other fatal case, a large meningocele, which had previously been tapped, did perfectly for twelve days, then leakage began. This continued for some days and finally ceased. Symptoms of sepsis developed several days after this event, and the child died on the thirtieth day after the operation. This child was hydrocephalic.

As to technique, in my earlier cases the sac was tied off, or, if large, stitched off with mattress sutures; then flaps of skin and subcutaneous tissue were brought over and sutured.

In Case No. 8, where the vertebral deficiency was great, two layers of flaps were made, one consisting of muscular tissue (erector spinæ) and the other of skin and subcutaneous tissue, the former being inverted (as in closing a wound of the intestine) and the latter everted.

Silk was used altogether for the buried sutures or ligatures, except in Case 8, where catgut was used for the muscular flaps.

In every case where the slightest doubt existed as to the contents of the sac, it was deliberately opened before being closed off, no extraordinary effort being made to prevent the escape of cerebro-spinal fluid.

The after treatment is, of course, all-important. The nurse is a potent factor in the success or failure of the operation. During the first week the child should rest on its abdomen in such a way that the wound should be the highest point upon the body, and every precaution taken to prevent infection from excreta, etc.

Those who advocate the open treatment at all, are well agreed as to the methods to be adopted in cases of meningocele. It is in cases of meningo-myelocele that difficulties and differences arise. The nerve elements of the cord within the sac must not be sacrificed, and, if possible, should be restored to the spinal canal. In order to accomplish this, Mayo Robson

advocated that the nerve filament should *not* be dissected from the sac, but that the portion of the sac wall to which the nerve is adherent, should be cut away from the remainder of the sac, and that the nerve and its adherent ribbon of sac wall should then be replaced within the canal. This is the method to which I resorted in Case 8, and the result was entirely satisfactory. Nicoll, of Glasgow, has recently reported a number of meningo-myelocèles, to which he found the sac "so occupied by expanded nerves, that it was impossible to excise even small portions of the sac without injury to the nerves. With the knife he carefully tore such small areas as seemed free from nerve tissue, and gently but pretty thoroughly roughened the whole interior, including the surface of the nerve cords in many parts, and stitched up." The results, he says, have so far been excellent. The sac is replaced by a hard fibrous nodule and nerve function is carried on normally.

Thus we have three different methods by which we may meet the three conditions already mentioned: (1) The simple meningocele treated in the usual way. (2) The sac, containing a moderate number of nerve filaments, treated by Mayo Robson's method of "ribboning" the sac, removing the redundant portion and replacing the nerve filaments within the canal. (3) The sac, filled with expanded nerves, in which case Nicoll simply scarifies the whole interior without attempting to reduce the mass, and trusting to fibrous inflammation to obliterate the sac. There might be a fourth class of cases mentioned, in which the sac is ruptured during the birth of the child. I am not sure as to our duty in these cases. I know of one case in this city in which there is a very definite history of rupture during birth, and which was treated by pressure alone. This child is now ten years of age, is fairly healthy, but not robust. She has a hard fibrous mass, three inches across, in the mid-lumbar region. Her nerve functions are normally performed. A similar case is reported in the *Brit. Med. Jour.* for October, 1897. This case also recovered fully under pressure treatment. I am inclined to think, however, that spontaneous cure in these cases is very exceptional, and that the child should be given the benefit of an immediate operation.

In looking over my cases I have been struck by three facts:

1. I did not decline to operate in any case. I am as yet entirely at a loss as to where to draw the line beyond which the operation is unjustifiable.

2. The presence of nerves within the sac is not necessarily indicated by deformities or paralysis. Reynolds Wilson, of Philadelphia, says: "Imperfect fusion of the vertebral arches is due to early defect in the blastoderm. This depends on some cause which may interfere with the development of other

tissues, connective, muscular and integumental." May this be the explanation of the numerous cases of talipes occurring with simple meningocele ?

3. Leakage may occur several days after operation, but may spontaneously cease; and if great care be exercised no sepsis may result, and the case may go on to complete recovery.

CASE I.—August, 1896. Lumbo-sacral meningocele ; aged 10 months ; no complication ; simple flap operation ; recovery.

CASE II.—October, 1896. Third and fourth lumbar meningocele ; aged 14 months ; no complications ; sutured off sac ; skin flaps ; recovery.

CASE III.—January, 1897. Lower lumbar region meningocele ; aged 12 months ; paraplegia, hydrocephalus ; Morton's method had been used several times ; child evidently cannot live ; operation demanded by parents ; child died after twenty-four hours.

CASE IV.—October, 1897. Fourth and fifth lumbar meningocele ; aged 9 months ; hydrocephalus ; excision six days after aspiration ; head reduced one-half inch in circumference two weeks after operation ; leakage occurred twelve days after operation ; wound again closed under pressure ; symptoms of sepsis and death on the thirtieth day after operation.

CASE V.—November, 1897. Man aged 22 ; cervico-dorsal meningocele, very large ; marked asymmetry of head and face ; excision ; recovery.

CASE VI.—March, 1898. Cervico-dorsal meningocele ; boy, aged 11½ years. single club-foot ; uninterrupted recovery.

CASE VII.—August, 1898. Lumbo-sacral ; aged 5, found a lipoma covering large deficiency in the spinal column, with meningocele protruding. Removed lipoma and brought flaps over ; leakage began on fifth day and continued for a week, when complete recovery took place. Had previously in this case successfully removed both astraguli for double club-foot, viz., T. equino-varus and T. calcaneo-valgus.

CASE VIII.—December, 1898. Lower lumbar meningo-myelocele ; boy, aged 8 months ; double T. equino-varus ; tumor, 4½ x 5 inches. Skin transparent and giving way on surface ; opened laterally after dissecting flaps and found numerous nerve filaments adherent to surface. Removed adherent ribbons of sac with the nerves attached and returned to canal. Closed wound with double line of sutures. Dressing removed on fifth day and found dry. Three days later some leakage, which ceased after a week ; recovery. No paralysis. Talipes easily corrected by plaster-of-Paris ; limbs weak ; not well developed.

## A FEW NOTES ON EAR, NOSE AND THROAT WORK, AS TAUGHT IN BERLIN AND VIENNA.

BY JULIUS E. KLOTZ, M.B., VIENNA.

A year's attendance at the greatest polyclinics of the world in these specialties, besides vastly improving one's knowledge of them directly, and of the relations which these organs bear to each other and to constitutional diseases indirectly, cannot fail to impress the student from Canada with the difference in the methods of teaching as employed in these Meccas of medicine and as used in his *Alma Mater*.

All post-graduate students who seriously devote themselves to the study of diseases of the ear, nose and throat, take the course of operative work on the cadaver, which includes anatomy, physiology and surgery, and pathology to a greater or less extent.

Any number of temporal bones are at one's disposal, and on these the various mastoid and middle ear operations are practised, under the guidance of a "Docent," who also demonstrates the variations in the configurations of the bone, developmental changes and so on. The petrous portion of the temporal bone is sawn into several small cubes and the internal ear chiselled out and examined, and in this careful, painstaking way a most thorough acquaintance with the surgical anatomy of the organ of hearing is acquired.

Pathological specimens of the ear, as well as of the nose, mouth and larynx, are retained for microscopical examination. The gross specimens are also examined with the stereoscope, a very useful instrument to assist us in getting a general impression of the gross pathological changes.

The different polyclinics vary much not only as regards the number of patients and visiting physicians that attend each, but also regarding the therapeutics and modern appliances. A better class of patients visit the Berlin hospitals, there being less poverty there than in Vienna. Here one is struck with the large number of cases of tuberculosis, laryngitis, and syphilis of the mouth and larynx, the constitutional disease taking on its worst form among the poor of this city.

All operations are performed in the Polyclinic or its adjoining operating room. Such students (*i.e.*, post-graduates) who have proved themselves capable of making good diagnoses, are permitted to perform minor operations, including paracentesis of the tympanic membrane, removal of adenoids and tonsils, cauterizing turbinates, snaring polypi, etc., etc.

The more difficult operations which students are sometimes allowed to perform, are those on the mastoid, removal of polypi from the ear, removal of turbinates, opening the antrum of Highmore, curetting the larynx, etc.

A most thorough instruction in the therapeutics of these special organs is given, but not always practically demonstrated in the polyclinics, time and expense being considerations here as well as in America.

Of the more recent drugs at present employed here, meta-cresol-anitol and phenolo-rabium-sulpho-vicinicum may be mentioned in connection with the treatment of ozena. Tri-chlor-acetic acid is very largely used for the reduction of nasal hypertrophies. For removing adenoids Kirstein's ring-messer (knife) is considered the most suitable. Spoon-shaped curettes and forceps are also employed, but are generally thought to be inferior to the ring-knife. In patients who refuse oral instrumentation for this condition, a cold snare introduced through one of the nasal orifices is occasionally used; needless to say the results are not very satisfactory. Iodoglycerine is almost universally employed in the treatment of atrophic rhinitis, laryngitis, and pharyngitis sicca.

The genius of one of the assistants at the Chiari Clinic is responsible for a pair of scissors which are now being much used for the removal of the hypertrophied posterior end of the inferior or middle turbinate in such cases where the wire snare will not grasp the offending member. The cutting surface of this instrument is diamond-shaped, and it may be described as two pairs of scissors placed point to point, the opposing points being united by small screws.

Prof. Lucal has used with considerable success his "Druck-Sonde" for giving vibrations to the ossicles of the middle ear. It is as yet little used and requires great care in manipulation.

Operations on the nose require less skill than those on the ear or larynx. Before taking up operative nasal work on the cadaver, considerable time is devoted to passing sounds into the adjoining cavities of the nose, so as to thoroughly familiarize the practitioner with the location of the ostia of these cells.

Although intra-laryngeal operations are not common, it is necessary to become skilful in the instrumentation of the larynx. This requires considerable practice on the cadaver, or better still, on Frau Gele, of Vienna. This well-known personage is to be seen daily in the General Polyclinic. Post-graduate students pay her one florin (40 cents) per hour to practise touching the different parts in the interior of her larynx with a sound. Intubation is practised on her, and also the removal of foreign bodies from the larynx. These foreign bodies, consisting of glass beads attached to silk threads, are introduced by means of laryngeal forceps and then removed with the same. It is excellent practice, and graduates of the Vienna Polyclinic are much indebted to this estimable lady who for over twenty-seven years has thus ably assisted in the scientific progress of laryngeal surgery.

# Progress of Medical Science.

## MEDICINE.

IN CHARGE OF W. H. B. AIKINS, J. FERGUSON, T. McMAHON, H. J. HAMILTON,  
AND INGERSOLL OLMSTED.

### **A Case of Menstruation from the Ear.**

For several years Lermoyez has been watching the case of a young woman, who has her menstrual periods from the right ear. Her first menstruation was from the auditory canal. Every month, after a prodromal period, characterized by pain in the head and general malaise, there has occurred through the auditory canal a flow of clear blood, non-coagulable. There has never been discovered any lesion preceding or following this flow. The tympanum is intact. The cutaneous vessels of the canal are much dilated, and this leads to the supposition that the hemorrhage is produced by the rupture of some of these. After some three years menstruation has been effected through the genital canal. Little by little, this has been replacing the auricular periods, the latter appearing now only every two or three months.

### **Etiological Diagnosis, by Means of the Skiagraph, of Obstinate Intercosto-Brachial Neuralgias.**

Merklen relates two cases of intercosto-brachial neuralgia manifesting themselves for many years by continuous and paroxysmal pains, which resisted all treatment. The skiagraphical examination of the patients has shown that in one patient the pains were due to compression of the nerve-roots by Potts' disease, with abscess at the level of the third dorsal vertebra; and in the other patient, to an aneurismal dilatation of the posterior part of the arch of the aorta.

### **Relapsing Arthropathies.**

Lannois presents a man forty years of age, who was brought into his office in the month of March in a state of profound cachexia. He was pallid and thin, complained of pains everywhere, and was unable to make any movement whatever. Most of his articulations were, and still are, the seat of deforming arthropathies. The cause of these disturbances is gonorrhoea. The patient contracted this disease first at twenty years of age. Up to this time he had always been in good health. Ten years later he had a second attack, followed by arthritis in the right

knee and in the articulations of the feet. At thirty-three years of age, a third attack was accompanied, almost immediately after its appearance, by metatarsal articular disturbances, disturbances in the tibio-tarsal articulations, and in the left knee. In six months a fourth attack of gonorrhœa brought on arthropathies in the articulations, which had been first affected. Finally in the month of December, 1898, a fifth gonorrhœal attack brought on new arthropathies on the internal surfaces of the two great toes.

Bacteriological examination of the urethral pus and of the urine has never revealed gonococci. In spite of this fact, Lannois declares that there can be no doubt of the importance of gonorrhœa in the causation of relapsing arthropathies and trophic disturbances presented by this patient. Moreover, the articular lesions, their symmetrical character in the feet (which cannot be attributed to want of movement through functional weakness), and the trophic changes in the skin are in favor of some influence from the nervous system. It is probable that the toxines produced by the microbial germination in the urethra and the bladder must be taken into consideration, since they might act either on the central nervous system or on the peripheral nervous system.—Translated from *Giornale Internazionale delle Scienze Mediche* by W. HARLEY SMITH.

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## ORTHOPEDIC SURGERY.

IN CHARGE OF CLARENCE L. STARR, M.D.

### Internal Derangements of the Knee-Joint.

W. J. Walsham (*Brit. Med. Jour.*, July 29th, 1899) deals with the subject of internal derangements of the knee-joint, and throws a great deal of light upon a subject which is often the cause of much anxiety to the surgeon. He classes these derangements thus: 1. Loose bodies. 2. Detachment, or displacement of the semilunar cartilages. 3. Enlargement, with nipping of hypertrophied synovial fringes. 4. Elongation of ligamentum patellæ.

These may have certain symptoms common to all, viz., effusion into joint cavity, a feeling of weakness or disability in the joint, some limitation of motion, pain, and, at times, a feeling as of something slipping in the joint. There is also usually a history of some injury, blow, or sprain. That the condition is more than one of simple synovitis, is determined by the fact that after cure of the synovitis by the usual means, a recurrence takes place when patient attempts to go about.

Loose bodies are as a rule easily diagnosed, as they can

be felt, by both surgeon and patient, to slip about in the joint. That the diagnosis is not always easy, is instanced by two cases in which loose bodies were suspected from oft-recurring synovitis, but could not be demonstrated even after careful search. In the first case, the loose body was located by means of the X-rays, but the second was only found after the joint had been explored, by dividing the patella, when the offending body was found deeply lodged in the intercondyloid notch. Both of these cases recovered completely after operation.

The diagnosis between detached semilunar cartilages and hypertrophied synovial fringes is often difficult. The writer finds the so-called characteristic signs, viz., sudden locking of the joint and projection of the cartilage, rather uncommon, and generally had to base diagnosis on limitation of motion, with more or less clicking or snapping on motion of the joint, together with slight swelling and pain on pressure over the location of the cartilage. In several cases after operation the cartilage was found folded on itself, and thus caused the creaking or snapping sounds.

The signs of hypertrophied fringes are much the same as in displaced cartilages, except that there is never locking of the joints. There is usually slight limitation of motion, and often the fringe may be felt as a soft pad. It is necessary also to remember that there may be more than one fringe present.

The elongation of the ligamentum patellæ is less common than any of the other forms of internal derangement. It may cause sudden locking of the joint by allowing the patella to slip over the external condyle of the femur. When there is elongation of the patella ligament, the patella is found on a higher plane than normal, and looks almost directly upward when the knee is flexed, instead of forward and slightly upward.

In treatment of all these cases except the last group, it may be necessary to open the joint, and the writer states that it may be done freely and without danger, under proper precautions. He then compares the synovial cavity with the peritoneal cavity, and shows that they correspond closely in structure and physiological function, and in cases where, for any reason, a splint which limits the movements of flexion and extension, fails, or is not advisable, owing to the occupation of the patient, the joint may be explored with as little hesitation as the peritoneal cavity now is.

Mr. Walsham reports having opened the knee-joint upwards of twenty times in the last six years without any ill results.

In opening the joint, regard should be had to the following precautions:

1. Preparation of patient. It is most essential that the

patient should stay in bed three or four days, during which time the diet and secretions are regulated and knee surface rendered thoroughly aseptic, and posterior splint applied.

2. Arrest hemorrhage before capsule is opened, and flush joint with mild boric acid solution to get rid of all blood clots and debris.

3. Accurately suture synovial membrane and capsule, preferably with kangaroo tendon.

4. Put limb absolutely at rest after operation on a well fitting back splint.

5. Commence passive motion as early as fourteenth day, allowing patient to walk by twenty-first day.

In regard to treatment of elongated patellar ligament, it is advisable to cut off the tubercle of the tibia, transplant it lower down rather than attempt to shorten the ligament, as the ends fray out when attempt is made to suture them.

#### Operation for Relief of Deformity of Forearm and Hand Following Infantile Hemiplegia.

A. H. Tubby (*Brit. Med. Jour.*, August 19th, 1899) presents a description of an operation for the relief of the flexion and pronation of the forearm and hand, which so often remains after infantile hemiplegia. To overcome the excessive pronation the writer detaches the insertion of the pronator radii teres from the radius, passes the detached tendon through an opening in the interosseous membrane, and reinserts it, after thus winding around the radius, in its old position.

This changes the pronator into a supinator. The flexor carpi radialis, which acts also as a pronator, is divided at the wrist, as are also the other flexors originating from the internal condyle of the humerus. The hand is put up in a semiflexed position, and the forearm supinated for eight days, when the hand is gradually extended daily until straight.

Pronation is not entirely prevented, as the pronator quadratus is left intact. The writer reports satisfactory improvement in two cases.

#### Congenital Club-Foot.

Dr. Henry Ling Taylor (*Pediatrics*, September 1st, 1899) records very concisely the objects and methods of treatment of congenital club-foot.

The objects are to thoroughly correct or overcorrect the faulty position of the foot, and then maintain the overcorrected position until growth has moulded the parts so as to adapt them to their new position, and all tendency to relapse has disappeared.

The methods employed differ in the hands of different men. Dr. Taylor evidently favors the more conservative plan of continuous leverage by means of braces or plaster dressing, correcting first the varus and afterwards the equinus deformity.

He advocates a brace with a steel sole plate, and inside upright bar with a screw stop at ankle by means of which the foot may be turned out. This flexion deformity is also corrected by the same mechanism, the heel being kept in the splint by means of a heel strap which is fastened to adhesive straps attached to the leg. If no progress is made by mechanical leverage an anesthetic is administered and the foot manipulated. If this is not sufficient, the tendo Achillis and plantar fascia, one or both, are divided, and the foot put up at once in an overcorrected position. These means have been found sufficient in the hands of Dr. Taylor to correct nearly all cases under six years of age.

In older and inveterate cases only is it recommended that any extensive bone operations should be done, and then the operation should be considered only one incident in the treatment which will prove inefficient unless the deformity of the foot is overcorrected and so held for a long time.

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## THERAPEUTICS.

IN CHARGE OF GRAHAM CHAMBERS AND J. T. FOTHERINGHAM.

### Fissure of Anus.

Allingham uses the following ointment :

℞ Extract of hemlock.....	5	grs.
Castor oil.....	15	grs.
Lanolin.....	30	grs.

M. Sig.: To be applied to parts after each action of the bowels.—*Jour. of Medicine and Science.*

### Apomorphine in Acute Alcoholic Delirium.

Tompkins calls attention to a new use to which he has several times successfully put apomorphine hydrochlorate. He says that in cases of acute alcoholism with delirium it "gets in its work in minutes, whereas it takes hours for bromides, chloral, and the like to have effect." He pronounces it far superior to morphine in such cases, as it eliminates the poison, while morphine dries up the secretions. He says, however, that its use is generally contra-indicated in genuine cases of delirium tremens, because there is usually weakness of the heart. He cites one of his cases in which he was called about

midnight to see a man in convulsions. The knowledge of the man's habits and the odor of liquor on his breath made the diagnosis easy, so he at once injected hypodermically  $\frac{1}{16}$  gr. of apomorphine hydrochlorate. In four minutes free emesis occurred, rigidity changed to relaxation, and excitement to sleep.—*Merck's Archives*.

### Exophthalmic Goitre.

The sulphate of quinine personally administered with remarkable results, arising from its influence in producing vasoconstriction of the vessels of the head and neck. Fifteen grains of it are given at night after supper, and again a quarter of an hour later. This treatment decreases the tachycardia, diminishes the exophthalmos and the size of the goitrous swelling. Paulesco (*Revue de Ther. Méd.-chir.*, February 1st, 1899).

### Night-sweats of Phthisis.

Siefert's formula is:

℞ Agaricin..... gr. viiss.  
 Dover's powder..... ℥ij.  
 Powdered marshmallow,  
 Mucilage of acacia, of each. ℥j.

Divide into 100 pills. One or two pills in the evening.—*Le Progrès Médical*.

### Epistaxis.

In a case of severe epistaxis, Prof. J. Chalmers Da Costa used Carnot's formula of:

℞ Normal salt solution . . . . 16 parts.  
 Gelatin . . . . . 1 part.

Saturating the cotton with this solution, he plugged the nose in the usual way. The advantage of this solution is that it forms an aseptic coagulum.—*Medical World*.

### Impetigo Contagiosa.

In the juvenile type of impetigo contagiosa, plenty of soap and water at frequent intervals, an application twice daily of a five per cent. boric acid ointment, and a thorough soaking of the scalp with crude petroleum for three successive days will, within a week, destroy all active evidences of the disease. One must, however, often wait several days for the brilliant erythema, which underlies the crusts, to disappear. In the adult type, on the other hand, rather stronger drugs must be used, and one must expect a rather longer treatment before the activity of the process is checked. A four per cent. ointment

of sulphur, or the application of black wash for fifteen minutes night and morning, in conjunction with a five per cent. ointment of salicylic acid and carbolyzed cosmolin, will usually prove sufficient to cope with the bacteriological invasion. Here, again, soap and water and clean towels, razors, combs and brushes are indispensable if one wishes to be free now and all time from impetigo contagiosa. Charles J. White (*Boston Med. and Surg. Jour.*, September 7th, 1899).

### **Trikresol in Alopecia Areata.**

Dr. Granville MacGowan, of Los Angeles, California, thinks he has a more efficient remedy for alopecia areata than any other yet discovered. He has used it in nine cases, with an average cure in two and a half months.

His directions are briefly as follows: Cleanse area thoroughly with benzine. Apply trikresol pure to the scalp. It is well rubbed into the denuded patches and into roots of hairs one-half inch beyond each patch, by the friction of a small swab of cotton tightly wrapped on a wooden toothpick. The burning and pain is borne well, and passes away soon. These applications are made somewhat irregularly, according to the particular local effect produced, but probably on the average every five to seven days till desired result be obtained.—*Pacific Med. Jour.*

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## PEDIATRICS.

IN CHARGE OF ALLEN BAINES, W. J. GREIG, AND W. B. THISTLE.

### **Belladonna in the Broncho-Pneumonias of Children**

An article on this subject appears in the September number of *Pediatrics*, by D. A. Hodghead, M.D., Professor of Obstetrics and Diseases of Children, in the College of Physicians and Surgeons of San Francisco. After employing belladonna with success in an extremely severe case of broncho-pneumonia, the author decided to undertake a series of experiments to thoroughly establish the use of belladonna in these cases. He was also impressed with the need for effort in this matter since the fatalities in this disease frequently amount to sixty and eighty per cent. Twenty-five of the author's own cases were recorded and five cases in the practice of other physicians. Repeated doses of calomel were used in conjunction with tincture of belladonna. In only two cases was the treatment ineffectual. The following case will illustrate the plan of treatment. The patient was a child of six months. A half-grain dose of calomel was given every hour until the bowels moved freely, and one drop of the tinct. belladonna every hour. One and a half grains of

calomel were given, and the belladonna was continued every hour for twenty-four hours and every second hour for a day and a half longer. In twelve hours there was a decided improvement; in twenty-four hours the child was comfortable, from which time it rapidly recovered. The drug has not been found so serviceable in the early stage of the disease, when the mucous membrane is dry and congested. It becomes especially applicable when the disease is well developed and the bronchial secretions are superabundant.

### **Aneurism of the Aorta in a Child.**

A case of aneurism of the aorta in a child aged ten years is reported in *Pædiatrics* for August, 1899, by Dr. Elliott, of Bristol. Patient had been ill for six months before admission, suffering from heart disease, so the parents stated. Before the onset of the present illness had good health. Had not suffered from scarlet fever, rheumatism, or cholera. A loud, rough systolic murmur was heard, sometimes best over aortic area, and sometimes best over pulmonary. Distinct fremitus heard where the murmur was loudest. Apex beat was displaced one inch outward. Aneurism was marked. The temperature was constantly raised. Three months after admission the child died suddenly.

*Post-Mortem* — Slight pericarditis; left ventricle much thickened. The aortic valves were glued together with large vegetations. About half an inch above the right side of the anterior semilunar valve was a ragged hole about two-thirds of an inch long, passing upwards in the direction of the artery. This was the opening of a small aneurism which passed forward and appeared between the tip of the right auricle and the pulmonary artery. No disease in any other part of the body.

After pointing out the rarity of aneurism in children, the author refers to a list of fifteen cases prepared by Mr. R. W. Parker. In eight of these cases there was disease of the aortic valves and in only two was the heart reported healthy. Discussion followed as to the manner in which embolism from a detached vegetation caused aneurism. No explanation could be offered, although there seemed to be no doubt that the detached vegetation was the primary cause.

### **Paralysis in Whooping Cough.**

An inquiry into this condition has been carried on by Homind, and published in the *Thèse de Paris*, 1899. Paralysis in whooping cough is not frequent, and appears usually in severe cases occurring in young children. He divides them into three classes: (1) Paralysis of cerebral origin; the most frequent, about 40 per cent. These may assume the form of

coma or of apoplexy, and may be of the hemiplegic type. Epilepsy may follow as a complication, or aphasia. In rare cases the special senses may be affected, giving rise to hemianopsia or blindness. (2) Bulbar paralysis. Sometimes there is a simple paraplegia, and sometimes the picture resembles Friedreich's or disseminated sclerosis. (3) Paralysis of peripheral origin. A few cases of this form are known. These paralyzes may be traced to two causes, infection and vascular strain.

### **Pericarditis in Children.**

A résumé of this subject by A. Baginsky appears in the "Klinisch-therapeutische Wochenschrift," Vol. V., 1898, p. 1620. Pericarditis is a disease of very frequent occurrence in young children. Baginsky had met 64 cases in his hospital work in Berlin. In 24 cases a polyarthrits was present; 11 were cases of tuberculosis; 11 had pleuro-pneumonia; 7 had suffered from erysipelas and phlegmon; 6 with purulent pleurisy; 5 with a serious form of diarrhea. In six cases measles was the cause. Meningitis, purulent otitis media and diphtheria were also recognized as factors in the causation of the disease.

Baginsky points out that rheumatic affections occur in children much more frequently than is generally supposed. It should be emphasized that grave forms of infectious disease, especially scarlet fever, may also present accumulations of fluid in the pericardium, which should not be classed with pericarditis, however, but which is obviously caused by septic processes. The serous, fibrinous, hemorrhagic and purulent forms of pericarditis also occur in children.

## Society Reports.

### TORONTO CLINICAL SOCIETY.

The second meeting of the year of the Toronto Clinical Society was held in St. George's Hall, November 1st, 1899, the President, Dr. George A. Bingham occupying the chair. For President's address, see page 682.

#### **Pathological Specimen—Appendix Vermiformis.**

Dr. F. LeM. Grasett gave the notes of this case upon which he had operated at the instance of Dr. Fred. Winnett, who was present by invitation at the meeting. The specimen occurred in a lady of middle-life, who gave the history of one or two prior attacks; and on her return home from Toronto she was to have been operated on by her family physician. Dr. Grasett stated that the case had an element of interest from the fact that it was the earliest operation he had ever performed after the initial pain—probably not more than thirty-two hours after. Dr. Winnett's diagnosis had been confirmed by Drs. Grasett and J. L. Davidson in consultation, and an operation advised immediately. There was no difficulty in locating the organ, which was found surrounded by an inflammatory mass, and this mass enclosing the appendix was extracted leaving behind a cavity lined with lymph as large as a man's fist. The patient showed an uninterrupted recovery. Dr. Winnett described the patient's symptoms. There was no pus and no foreign body whatever found in the lumen of the organ.

#### **Muco-Fibrous Polypus.**

Dr. D. J. Gibb Wishart and Dr. G. Boyd presented this patient, and Dr. Wishart described the condition and the operation. The patient was a boy about eight years of age, who came to the Victoria Hospital for Sick Children, suffering from nasal polypus. There was a history of successive attempts to remove the polypus from the nose. The boy states he was operated on once a week for a considerable period, and he came to the hospital in an exceedingly nervous condition. On examining his nose a mucous polypus was quite apparent in the left nasal chamber, and Dr. Wishart made one or two attempts to seize the tumor, but found it impossible. He was then placed under chloroform and the naso-pharynx examined. A large tumor was found projecting into the pharynx. It was

snared out through the nares, and turned out to be a muco-fibrous polypus about three and one-half inches in length. There was only one growth. The boy recovered for about ten days, when he was then found to be suffering from a little elevation of temperature and pain in the left ear, that is, on the same side to which the growth was attached. The drum membrane was punctured, and pus exuded. Temperature at one rose to 104 degrees. Later on—about twenty-six hours afterward—she developed marked tenderness and swelling in the glands on that side of the neck along the edge of the sterno mastoid; that was followed by the same condition on the right side. Temperature fell, but again rose to 104 degrees, and there was tenderness in the left lobe of the ear. From that time onward he made an uninterrupted recovery. Dr. Wishart stated these cases are comparatively and especially rare in children under fifteen years of age. The polypus seemed to be attached to the middle turbinated bone about the usual situation. He was at a loss to account for the occurrence of this polypus. There is the possibility of the boy being the subject of hereditary syphilis, though it was not a marked condition. You cannot find much in the literature pointing to such an origin for muco-fibrous polypus. It is stated by Bosworth that the muco-fibrous polypus never causes facial deformity. There is a lack in the ethmoid bone and a distinct sinking in the region of the frontal sinus. He has a highly arched palate and a peculiar formation of the upper jaw. He also presents a double dislocation of the lens.

### **Hydro-Nephrosis.**

This specimen, presented by Dr. Bingham, occurred in a woman of thirty years, and it was peculiar from the fact that the cause of the condition was obscure.

### **Trephining in Jacksonian Epilepsy.**

Dr. D. C. Meyers read the report of this case. The patient himself he presented to the Society last January. The aura was confined to the forearm, and at that meeting the patient gave an exhibition of bringing on an attack and suspending it. He was a young man about twenty-five, who at five years had been struck on the head with a club, falling out of a tree, but sustained no fracture of the skull. Dr. Grasett did the operation, assisted by Dr. Peters. About two and one-half years ago his attacks began to be more severe, he having as many as fifty in a day, when he consulted Dr. Meyers. Ordinary remedies were first tried, and then an operation was advised. The operation was performed on January 20th, 1899. As the seizures were in the forearm, the trephine was placed

over the cerebral centre for that region, as nearly as could be judged externally, and when the button of bone was removed, two veins were seen crossing the field in the dura mater, and the centre was struck just in front of a fissure of Rolando, at a point two inches below the longitudinal fissure. The dura was healthy in appearance, and there was no bulging. Electricity was applied, with very satisfactory results. A probe  $\frac{3}{8}$ -inch in diameter was inserted one and one-half inches into the brain substance, and it was interesting to note that there were no ill-effects. As a result of the operation there was paralysis of the muscles of the forearm and hand, which was temporary. Thirteen days after the operation power returned in the long flexors of the forearm. The hand was the last part to regain power, and it had not all returned when last seen. Immediately after the excision of the centre and the completion of the operation, on the same day, he had several attacks, and on the following day. The spasms were entirely confined to the paralyzed muscles, and the attacks varied in number from two to eight. He only remained under Dr. Meyers' care five weeks after the operation, and the attacks were considerably less frequent, and decidedly less severe than before the operation. Dr. Meyers saw the patient last on September 7th, that is, eight months after the operation. He says after his return home the fits were more frequent for six weeks. He never loses consciousness. Six weeks ago the fits entirely ceased, and he now uses the left arm for all purposes. There is still some difficulty in the use of the fingers. He has gained about twenty pounds in weight, can attend to his duties on the farm, and he feels perfectly well in all particulars.

GEORGE ELLIOTT,

*Recording Secretary.*

## Editorials.

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### THE MEDICAL PROFESSION IN SOUTH AFRICA.

We learn from the *British Medical Journal* that there are about 500 British medical practitioners in South Africa, and a much smaller number of Dutch physicians. The British are distributed as follows: Cape Colony, 268; Natal, 60; Transvaal, 87; Orange Free State, 41; Rhodesia, 24; Zululand, 6; Swaziland, 3. There are 49 in Johannesburg, 38 in Cape Town, 20 in Durban, 13 in Grahamstown, 12 in Pretoria, 12 in Pietermaritzburg, 10 in Port Elizabeth, 9 in Kimberley, and smaller numbers in other towns in South Africa. Among those practising in that country is a Canadian, well known to many of us, Dr. Paul A. Gillespie, of Pretoria, who is President Paul Kruger's private medical adviser. Dr. Gillespie, a son of Dr. Gillespie, of Cannington, received his medical education in the Medical Faculty of the University of Toronto, graduating in 1891. After practising for a short time in Streetsville and Penetanguishene he went to the Transvaal, where he has been highly successful.

There is at present no medical school in South Africa, and the profession as a body has been so much weakened by jealousies and internal dissensions that the prospects for the establishment of an efficient medical college have been rather poor. It is said that there has been a marked improvement during the last ten years, especially in Cape Town, East London, Port Elizabeth, Durban, and Pietermaritzburg, and it is hoped that the presence of Sir Wm. MacCormac in that country may bring about very important results. If Dr. Roddick's proposed bill becomes law we are likely soon to have reciprocity with Great Britain which will practically mean that a Canadian physician may practise his profession in any part of the British Empire. South Africa is likely to become greatly developed after the war, and may furnish a field for a large number of physicians. If so, Canada, which has manufactured more doctors than she knows what to do with, can send a large contingent to that country.

### THE WAR IN SOUTH AFRICA.

The Government of Great Britain has pleased the civil profession of that country by appointing three consulting surgeons to assist the military surgeons in South Africa. The Secretary of State for War has made a happy choice, which gives general satisfaction. The men selected are Sir William MacCormac, Mr. Frederick Treves, and Mr. G. Makins. Sir William MacCormac, the President of the Royal College of Surgeons, England, is well known to the many Canadians who have attended St. Thomas' Hospital during the last twenty-three years. Before going to London and St. Thomas', he highly distinguished himself in the Franco-Prussian war. Mr. Makins is also a surgeon to St. Thomas' Hospital, and is recognized as one of the best of the younger English surgeons. Mr. Frederick Treves, the distinguished consulting surgeon to the London Hospital, is probably as well and familiarly known to Canadians as Sir William MacCormac.

We believe that MacCormac and Makins sailed November 4th, intending to go to Natal, while Treves sailed November 11th, intending to go to Cape Town and thence to the front in Cape Colony. We are told by the *British Medical Journal* that Lord Lansdowne considered that in asking for the services of leading civilian surgeons the fee to be offered should be on a liberal scale, and each of these three surgeons will be paid at the rate of twenty-five thousand dollars a year, with allowance for horse, etc. The *Journal* adds: "This is not a moment to make a calculation of pecuniary profit or loss, but we think that the medical profession will be gratified to know that the Secretary of State for War has, entirely on his own initiative, made what must be considered a generous offer."

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### DOMINION REGISTRATION.

A meeting of the sub-committee appointed to consider the question of Dominion or inter-provincial registration was held in Toronto, November 7th. Our readers will know that the question was discussed in rather a desultory way for many years, especially at meetings of the Canadian Medical Association, without any definite conclusions being reached up to three

years ago. Since that time a great change has taken place, and a much greater interest in the subject has been aroused in all parts of Canada.

The discussion on Dominion registration at the last meeting of the Canadian Medical Association was the great event of the gathering. We cannot repeat too often that we are greatly indebted to Dr. Thos. Roddick, M.P., of Montreal, for the grand work he has done in connection with this matter. He came to Toronto to meet Dr. Jas. Thorburn, of this city, and Dr. Williams, of Ingersoll, at the time before referred to, and, we understand, the bill that will be brought before the Dominion Parliament at its next session has been finally drafted.

It provides for the establishment of a Canadian Medical Council whose certificate will enable the holder to practise in any province of Canada on payment of the provincial fee. This Council will consist of twenty-four members—three from each province—and will fix the standard of the examinations. It is likely that the Act will cover all physicians who have been in practice ten years at the time of the passing of the bill. Dr. Roddick, in an interview with a representative of the *Toronto World*, said that such legislation was urgently needed because a number of fines had been imposed on medical men for crossing provincial borders to practise. In one case an Ontario surgeon who had crossed the Ottawa River to attend a woman in confinement when she could get no other aid, and had saved her life, was fined fifty dollars.

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### THE MILITIA MEDICAL SERVICE.

One of the most pleasing evidences of the growth of Imperial sentiment in Canada, and of a consciousness, at least, faintly stirring in the public mind, of the duties of the Canadian community to the Motherland and Sister-lands of the Empire, is the increased interest taken in the militia. And in no direction is more marked advance being made than in the medical service. Among those of us who have watched and waited for the signs of dawn in the Militia Department, there is a general feeling of satisfaction at the fact that the Honourable, the Minister of Militia and Defence is a medical practitioner of extended experience :

and there is abroad also a feeling that the interests of the medical service will be safe in his hands. The General Officer Commanding, too, in addition to the energy and tact with which he has proceeded to arouse, from without, public interest in the force, and to remedy, from within, defects and anachronisms of organization and administration, has shown decided appreciation of the uses and needs of the medical service, and has inspired us with great hopes for its immediate betterment. Betterment is hardly the word in that connection, applied to that which has hitherto been non-existent. For it will scarcely be believed that prior to July of this year of grace, no system of rendering aid to the sick or wounded on service had official existence or recognition at headquarters. Beyond the appointing of a surgeon and an assistant surgeon to units, there was nothing—no issue of supplies, no stretchers, no ambulances, no bearers, no training. To be sure, certain regiments, almost solely in cities, had provided themselves, unofficially and at their own expense, with certain supplies, stretchers, etc., and had trained a few bearers, whose existence was not officially known to the Department. Now, for the first time in the history of Canada, an Army Medical Service is authorized and in process of organization. We learn that hereafter, in addition to the purely regimental side of the service, consisting now of one surgeon, one hospital orderly corporal, and two men per company to be trained as bearers, there is to be formed at once an Army Medical Service, consisting of commissioned medical officers, with rank and file to man a certain number of bearer companies and field hospitals. These are to form a corps controlled and administered from within, the head being the Director-General at Ottawa, with rank as Colonel, and the other officers ranking with definite seniority within the corps, and posted by the Director-General on the recommendation of the principal medical officers of the various military districts, as the requirements of the service on mobilization may demand. A large amount of stores, supplies, and equipment for the new corps is being procured at once. Medical officers of the A.M.S. will, we understand, rank as combatants, not having the double title (Surgeon-Lieutenant, etc.) which is still to be taken by officers retaining regimental connection merely; and from both classes of officers, military and technical qualification by

examination is now to be exacted, in addition to the professional qualification of which the license to practise is held to be sufficient evidence. Higher military qualifications are demanded of the officers of the A.M.S. than of the regimental surgeon, and from the new corps, of course, would be drawn in time of active service the officers necessary to man such important posts as Brigade Surgeon, M. O. to staff, P.M.O. of Division, on lines of communication, at Headquarters, in Field, Base, and Stationary Hospitals.

It strikes one as remarkable that though, at an initial and transitional stage, such as the service is now placed in, matters of organization, the drafting of regulations, the administration of the new mechanism, are all of the most crucial importance, the authorities should, so far as is known, have taken no steps whatever to consult with the medical officers of the service. They are the men, at least there are among them men, who, from their experience and knowledge of local conditions, should be, before all others, able to advise, and we would respectfully suggest that, before it is too late, a few of them, whose special knowledge and experience are known to the Department, should be called together for consultation. To be sure, the Department did, some months ago, call together, at various district headquarters, a few of the older men to express their opinion upon the scheme as already formulated in somewhat cut-and-dried fashion at headquarters, but so far as one can judge, nothing was gained by it, possibly from the excellence of the regulations as already drafted. But the utmost care will be needed in organizing, or difficulties will arise on all hands. For instance, when a man has to be sent from his own lines to Brigade or Field hospital, at what point does his regimental surgeon's control or interest in him cease? Is the regimental surgeon likely to gracefully let him go, or will he be allowed to follow him with orders and prescriptions into the hospital tent, where a major of the A.M.S. reigns supreme, and bears sole responsibility to the authorities for the case with all its possibilities in the way of subsequent demands upon the country for pensions or indemnities?

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IN MEMORY OF DR. ROLPH.—A bust of the late Hon. Dr. John Rolph has recently been placed in the Museum of the

Education Department in this city. Dr. Rolph was one of the most energetic and ablest of the Reformers during the old "Family Compact" days, when this meant a great struggle for years—a struggle as often apparently hopeless as it was thankless. But after many years it brought about responsible government in Canada, to which she owes her present proud position, as at once practically a self-governing nation, and a most loyal part of the great British Empire. Dr. Rolph was also the founder of medical education in Ontario, and an abler or more zealous teacher could not be. His remains lie in Mount Pleasant Cemetery without, as yet, a stone to mark the spot. It has been suggested that it would be a graceful and well-deserved tribute to his memory for his friends still living amongst the old Reformers, and the great number of medical men scattered over Canada and the States, whom he educated, to send in subscriptions for this purpose, so that a modest, yet appropriate, monument might mark the spot where his dust lies. Dr. Geikie, Dean of Trinity Medical College, Toronto, would be glad to receive such contributions, and to see that the desire of those sending them was suitably carried out.

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RED CROSS SOCIETY'S WORK.—The spontaneous and hearty outburst of loyalty of the people of Canada found its expression in a desire to do something for the brave volunteers who so cheerfully and readily offered their services in the cause of civil and religious liberty in the Transvaal, and of British supremacy in South Africa. The Canadian Branch of the British National Society for aid to the sick and wounded in war, commonly called the Red Cross Society, having been organized by Dr. Ryerson two years ago, was able without delay to formulate a scheme of unofficial assistance which was promptly and gratefully accepted by the Government and successfully carried out by the Society and its affiliates. Not less than \$25,000 has been raised throughout the Dominion. The money has been expended in the purchase of personal and medical comforts, and a considerable sum has been handed in cash to Colonel Otter for the purchase of supplies in South Africa for the well and sick of the contingent. The fund, known as the National Red Cross Fund, will be kept open as long as the war lasts; 1st, to relieve returning volunteers, who are sick, wounded or out of

employment; 2nd, to forward money to the contingent through the Society's commissioners now at the seat of war; 3rd, if circumstances and funds permit, to contribute something to the relief of the British sick and wounded in the war. Subscriptions may be sent to the Treasurer, National Red Cross Fund, 60 College Street, Toronto.

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TORONTO POST-GRADUATE MEDICAL SOCIETY.—A meeting of the above society for reorganization was held at Toronto General Hospital, October 18th, when the following officers were elected for the ensuing year: Honorary President, H. B. Anderson, M.D., L.R.C.P., M.R.C.S. (Eng.); Honorary Vice-President, H. A. Bruce, F.R.C.S. (Eng.); President, A. D. Stuart, M.B., T.G.H. staff; Vice-President, Colin Campbell, M.D., T.G.H. staff; Secretary, Horace Wrinch, M.D., St. Michael's Hospital. This society was organized in 1898 at the instance of the late Dr. J. E. Graham, the membership being made up of the house surgeons of the various city hospitals and fifth-year men doing hospital work. Meetings are held on the first and third Monday of each month at the various institutions, the evening being given up to the reading and discussion of one paper and the presentation of interesting cases. The first regular meeting was held November 1st at the residence of the Honorary President, on Wellesley Street. Dr. Horace Wrinch presented the paper of the evening, a very thorough study of a case of interstitial emphysema complicating pulmonary tuberculosis in the infant. Sections and photographs were exhibited and a very lively discussion was provoked. Dr. Colin Campbell presented a recent specimen of a case of ectopic gestation with suppuration of the sac. The Secretary was authorized to convey to the family of the late Honorary President, Dr. J. E. Graham, a message of sympathy with them in their bereavement and an expression of the loss felt by the Society at his death.

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COMMENDABLE ACTION.—Messrs. Parke, Davis & Co., of Walkerville, gave antiseptic preparations to the value of \$100 to the Canadian contingent. The firm also placed the names of two of their staff, who have gone with the contingent, on the salary roll at half pay during the period of their enlistment. This kindly action will be greatly appreciated by all patriotic Britons and accentuates the Anglo-American *entente cordiale*.

**PUNISHED FOR SUBSTITUTION.**—A decision of considerable importance was made by Judge Kohlsaot in the United States Circuit Court yesterday. In a bill for an injunction Fairchild Brothers & Foster, of New York, had charged Edward Otto, a Chicago druggist, with substituting a spurious and inferior preparation for "Fairchild's Essence of Pepsine" in several cases where the latter was expressly called for in physicians' prescriptions. The case was hotly contested and hundreds of pages of depositions were taken in New York and Chicago. Judge Kohlsaot's decree sustains the charges made, perpetually enjoins Otto from ever repeating the offence, and taxes him with the costs, amounting to about \$500. This is said to be the first contested case in the United States in which the principle of protection of trade-marks and trade names was extended so as to apply to what is technically known in the drug business as "substitution." Judge Kohlsaot's decision will probably protect manufacturing chemists, physicians and the general public, all of whom have in the past suffered from the fraudulent practices of a certain class of druggists.—*Chicago Times-Herald*, October 13th, 1899. [We extend our congratulations to Fairchild Brothers & Foster in their endeavor to crush the druggists' rankest sin—substitution.]

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**ALVARENGA PRIZE OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA.**—The College of Physicians of Philadelphia announces that the next award of the Alvarenga Prize, being the income for one year of the bequest of the late Senor Alvarenga, and amounting to about \$180, will be made on July 14th, 1900, provided that an Essay deemed by the Committee of Award to be worthy of the prize shall have been offered. Essays intended for competition may be upon any subject in Medicine, but can not have been published, and must be received by the Secretary of the College on or before May 1st, 1900. Each essay must be sent without signature, but must be plainly marked with a motto and be accompanied with a sealed envelope having on its outside the motto of the paper, and within the name and address of the author. It is a condition of competition that the successful essay or a copy of it shall remain in possession of the College; other essays will be returned upon application within three months after the award. The Alvarenga Prize for 1899 has been awarded to Dr. Robert L. Randolph, of Baltimore, Md., for his essay, entitled "The Regeneration of the Crystalline Lens—An Experimental Study."

THOMAS R. NEILSON, M.D.,

Secretary.

## Obituary.

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### GEORGE LOGAN, M.D.

Dr. George Logan, of Ottawa, died after a prolonged illness from cancer, November 17th, aged 69. He was born in Scotland, but came to Canada when a child, with his parents who settled in the county of Oxford. He received his preliminary education in Woodstock, and his medical education in Columbus, Ohio. Shortly after graduating, in 1860, he commenced practice in Bowmanville, where he remained about two years. He went to Ottawa in 1863 and practised in that city until the time of his last illness. He was a kindly, able and cultured man, loved and respected by all who knew him, for many years member of the Ontario Medical Council and one of its past-presidents, and generally recognized as the most prominent homeopathic physician in Canada.

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### SAMUEL DAVID HAGEL, M.B.

It was a surprise to the friends of Dr. S. D. Hagel to hear of his death, which occurred on the morning of November 27th, as few had heard of his illness. He was not in good health for some time, but was able to do his ordinary work until the evening of November 25th, when he first showed symptoms of pneumonia. He sank very rapidly and died on the morning of November 27th, aged 57. Dr. Hagel graduated from Toronto University in 1873, being a double silver medallist, and at once commenced practice in Toronto where he remained until the time of his death.

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## Personals.

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Dr. R. J. Wilson, of Bloor Street, has been appointed an associate coroner for the city of Toronto and county of York.

Dr. Jas. Third, of Kingston, paid a visit to Baltimore in the latter part of October.

Dr. Hiöbert Winslow Hill (Tor. '93), of Baltimore, was married to Miss Goldstone, November 14th, St. Stephen's Church, Toronto.

Dr. J. M. McCallum takes the place of the late Dr. Graham on the University Senate in accordance with the established precedent.

## Book Reviews.

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*Warner's Pocket Medical Dictionary of To-day.* Comprising Pronunciation and Definition of 10,000 essential words and terms used in medicine and associated sciences, with tables of arteries and nerve muscles, arranged for convenient reference. By WILLIAM R. WARNER. Philadelphia: Wm. R. Warner & Co. Price, 75 cents.

This work is to be specially recommended to the student for class-room service, and to the profession at large, when larger dictionaries are impracticable.

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*Diseases of Children.* A Manual for Students and Practitioners. By GEORGE M. TUTTLE, M.D., Attending Physician to St. Luke's Hospital, Martha Parsons' Hospital for Children, and Bethesda Asylum, St. Louis. Philadelphia: Lea Brothers & Co.

This work is one of a series of pocket editions, published by Lea & Co. It contains a vast amount of information in, of course, very condensed form. At the same time desire for brevity has not prevented the authors making a clear presentation of the subject. A short space is devoted to every disease, one would think, to be met with in childhood. The book can not fail to secure appreciation from the overworked student and the busy practitioner.

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*A Text-Book of the Practice of Medicine.* By JAMES M. ANDERS, M.D., Ph.D., LL.D., Professor of the Practice of Medicine and Clinical Medicine in the Medico-Chirurgical College, Philadelphia; Attending Physician to the Medico-Chirurgical and Samaritan Hospitals, Philadelphia, etc. A magnificent octavo volume of 1,287 pages. Illustrated with four colored plates and numerous engravings. Third edition. W. B. Saunders, Philadelphia, publisher. J. A. Carveth & Co., Toronto, Canadian agents. Prices: Cloth, \$5.50 net; sheep or half morocco, \$6.50 net.

We have already expressed a decided opinion of the excellence of a former edition of this work in the following words: "It is an excellent book, thoroughly up-to-date, and a reliable guide to the general practitioner." This third edition contains much new matter and many thorough revisions, and is second to none as a good, safe, and new manual, suitable alike for both student and general practitioner.

*The American Year-Book of Medicine and Surgery*, collected and arranged with Critical Editorial Comments. By SAMUEL W. ABBOTT, M.D., and twenty-seven other Prominent Physicians and Surgeons, under the general editorial charge of GEORGE M. GOULD, M.D. Illustrated. W. B. Saunders, Philadelphia, publisher. J. A. Carveth & Co., Toronto, Canadian agents. Price, \$6.50, cloth.

We regret exceedingly that by an unfortunate accident we have not long before this published a review of this admirable book. We have during three previous years had much pleasure in speaking in the highest terms of this work. If there is any difference between the book this year and that of preceding years, we think the volume for 1899 is the best which Mr. Saunders has thus far published. The book is exactly what it claims to be, *i.e.*, a yearly digest of scientific progress and authoritative opinion in all branches of medicine and surgery, drawn from journals, monographs, and text-books of the leading American and foreign authors and investigators.

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*Materia Medica, Therapeutics, Medical Pharmacy, Prescription Writing and Medical Latin—A Manual for Students and Practitioners.* By WM. SCHLEIF, M.D., Instructor in Pharmacy in the University of Pennsylvania. Lea's Series of Pocket Text-Books. Lea Brothers & Co., Philadelphia and New York.

This volume is another of this valuable series of pocket text-books issued by the well-known Lea firm. It affords a condensed yet comprehensive text-book and reference on materia medica, therapeutics and associated subjects. In addition to discussing the remedial agents in all their bearings, prescription writing, medical Latin, pharmacy and anesthesia are dealt with. Tables of doses, poisons and antidotes and incompatibilities, together with a therapeutic index of diseases and remedies, and a general index conclude a most serviceable text-book.

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*The American Pocket Medical Dictionary.* By W. A. NEWMAN DORLAND, A.M., M.D., Assistant Obstetrician of the Hospital of the University of Pennsylvania; Fellow of the American Academy of Medicine, etc. Philadelphia: W. B. Saunders. Toronto: J. A. Carveth. \$1.25.

This is a small volume, neatly bound in red morocco, containing the pronunciation and definition of some 26,000 of the terms used in medicine and the kindred sciences, as well as over sixty extensive tables, which are very convenient for purposes of reference, both to the student and busy practitioner. It does

not take the place of the larger dictionaries, but simply fills the place for which the author intended it. The first edition was exhausted in six months, therefore the author was induced to issue the second, which he has successfully endeavored to bring up-to-date by inserting the more important new words in medical literature. At the end there is a dose table which contains the new as well as the older remedies.

*Physiology—A Manual for Students and Practitioners.* By HOWARD D. COLLINS, M.D., Assistant to the Attending Surgeon of the Roosevelt Hospital; Assistant Demonstrator of Anatomy, College of Physicians and Surgeons (Columbia University), New York; and WM. H. ROCKWELL, jun., M.D., Assistant Demonstrator of Anatomy, College of Physicians and Surgeons (Columbia University), New York; Member of the Association of American Anatomists. Edited by BERN B. GALLANDET, M.D., Demonstrator of Anatomy and Instructor in Surgery, College of Physicians and Surgeons (Columbia University), New York; Visiting Surgeon Bellevue Hospital, New York. Lea Brothers & Co., Philadelphia and New York.

This number of Lea's Series of Pocket Text-Books is presented to the student in the hope that it may enable him to better understand the larger works on physiology and for the purpose of providing him with more accurate information than he can get from the various quiz-compendes. No claim is made to original research. The larger works on the subject have been freely drawn from, and the matter abstracted put in very lucid language. Histology receives a good deal of attention. The illustrations are good, and will without doubt be thoroughly appreciated by the student, enabling him to more fully grasp the subject.

*Practice of Medicine.* By GEORGE E. MALSBARÝ, M.D., Assistant to the Chair of Theory and Practice of Medicine, Medical College of Ohio, Cincinnati; Assistant to the Lectureship of Clinical Medicine, Good Samaritan Hospital, Cincinnati. Edited by BERN B. GALLANDET, M.D., Demonstrator of Anatomy and Instructor in Surgery, College of Physicians and Surgeons (Columbia University), New York; Visiting Surgeon Bellevue Hospital, New York. Lea Brothers & Co., Philadelphia and New York.

This is one of Lea's Series of Pocket Text-Books in which the author endeavors to epitomize each subject for the convenience of the practitioner and student, in the hope that he may find what he wants more readily than in the more exhaustive works.

in medicine. Etiology, symptomatology, diagnosis and treatment are dealt with in a concise manner but with sufficient fullness to enable the student to grasp the salient points. No attempt is made to deal with pathology, nor are diseases of the skin and nervous system considered. Many subjects are illustrated by engravings, which add to the value of the work. While the book is a good one of its kind and has its uses, the growing tendency on the part of the student to rely upon brief epitomes for his work, to the neglect of the more exhaustive volumes, should not be encouraged. This is not the author's intention. His desire is to place before the physician and student the recent progress in medicine in concise form. This he has ably accomplished.

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*A Text-Book of Materia Medica, Therapeutics and Pharmacology.* By GEORGE FRANK BUTLER, Ph.G., M.D., Professor of Materia Medica and Clinical Medicine in the College of Physicians and Surgeons, University of Illinois; Professor of General Medicine and Diseases of the Digestive System, Chicago Clinical School; Attending Physician to Cook County Hospital. Third edition, revised. Philadelphia: W. B. Saunders, 925 Walnut Street. 1899.

The author of this volume adopts an arrangement of the remedies which is an attempt at being both practical and scientific. The drugs are grouped according to their principal pharmacological affinities. Thus the materia medica, pharmacology and therapeutics of carbolic acid, creosote, guaiacol, iodoform, eucalyptus, boric acid, etc., remedies which are mainly used as antiseptics, are described in one division of the work. The arrangement of these drugs, as well as of those under many of the other therapeutic classes, such as emetics, cardiac stimulants, cardiac sedatives, anthelmintics, purgatives, etc., is an excellent method of presenting the subject. However, there are many drugs which are not so readily classified. For the purpose of overcoming this difficulty the author discards several of the old therapeutic classes and introduces new ones, such as aromatics, motor excitants, motor depressants, etc. We do not think that this procedure has at all improved matters. In the group called motor depressants we find physostigma, conium, amyl nitrite and bromides, drugs which are not pharmacologically closely allied. In addition to the classification there are many other notable features. The chapters on pharmacy form a valuable part of the work. The book contains a large number of diagrams, illustrating the mode of action of various drugs. We can warmly recommend the volume to both students and practitioners.

*The Sexual Organs—Their Use and Abuse.* By J. E. HELLER HERR, Berlin.

Dr. Hett has undertaken to write a popular treatise on this important subject. The author has very pronounced ideas on the subject, and he has presented them in a very concise form. The author states that his reason for writing the volume is to enlighten the public on matters that he considers of vital importance to themselves. Many of the most striking passages in this work are well worth careful thought, and if men would follow the precepts laid down therein, they would, undoubtedly, be better themselves, and be of more use to their fellow-beings.

*Bartholow's Materia Medica and Therapeutics.*

Appleton & Company have just issued the tenth edition of this work, long recognized as a standard hand-book, whether as a text-book for the student or a hand-book of reference for the practitioner. It would seem that as the work is based on the U.S.P., and the next edition of the latter is due in 1900, it might have been well to postpone this edition for a few months, that the host of new remedies might have been weeded out by the U.S.P. first, and those accepted by it placed in this work. Of course, many of them do appear here. The articles on therapeutic agents other than drugs, such as diet, baths, massage, electricity, etc., are such as almost to do away with the need of special texts on the subjects named. The work fully retains its encyclopedic character and thoroughly sound and conservative views, while neglecting no genuine advance in the art of healing by medical means.

*A Text-Book of Embryology for Students of Medicine.* By JOHN CLEMENT HEISLER, M.D., Professor of Anatomy to the Medico-Chirurgical College, Philadelphia. With 190 illustrations, 26 of them in colors. Publisher: W. B. Saunders, 925 Walnut Street, Philadelphia. Canadian agents: J. A. Carveth & Co., Toronto. Price, \$2.50 net.

The aim of the author of this excellent text-book was to make it full enough to be intelligible, without that minuteness of detail which characterizes the larger treatises which contain too much for ordinary medical students. He has also endeavored to present a connected story of human development, but also to make each chapter as nearly as possible complete in itself for the sake of convenience of reference. We think the author has well carried out all his aims. The illustrations are remarkably good, and will materially assist students in their study of what is generally considered a complete subject.

*Saunders' Question Compend.* Essentials of Anatomy, including the anatomy of the viscera, arranged in the form of questions and answers, prepared especially for students of medicine. By CHARLES B. NANCREDE, M.D., Professor of Surgery and of Clinical Surgery to the University of Michigan, etc. Sixth edition, thoroughly revised by FRED. J. BROCKWAY, M.D., Assistant Demonstrator of Anatomy, Columbia University, New York.

*Essentials of Medical Chemistry, Organic and Inorganic, containing also Questions of Medical Physics, Chemical Philosophy, Analytical Processes, Toxicology, etc.* By LAWRENCE WOLFF, M.D., Demonstrator of Chemistry, Jefferson Medical College, etc. Fifth edition, thoroughly revised by SMITH ELY JOLLIFFE, M.D., Ph.D., Professor of Pharmacology, College of Pharmacy of the City of New York, etc.

These two small manuals, or "question compends," are published by W. B. Saunders, of Philadelphia, for the use of students. Their popularity among the students of the United States and Canada may be inferred from the fact that over 175,000 copies of these publications have been sold since the issue of the first volume. The price of each volume is \$1.00. The Canadian agents are J. A. Carveth & Co., of Toronto.

*Sajous' Annual and Analytical Cyclopedic of Practical Medicine.* Subscription entire series only. Six volumes; one every six months. Cloth, \$5.00; half Russia, \$6.00. Monthly supplements sent free during the three years. Philadelphia: The F. A. Davis Company. Fourth volume, *Infants, Diarrheal Diseases of—Mercury.*

The fourth volume in this series maintains the very high standard of its predecessors. It embraces *Infants, Diarrheal Diseases of to Mercury*, and in this wide range the subjects are most ably handled by men expert in their several branches. "The Annual" has lost one of its most valued editors, Professor Geo. H. Rohè, who has been connected with the editorial staff since 1891. Dr. Rohè's contribution to this volume, the article on insanity, is typical of the man. He was an erudite scholar, and a specialist in several branches—the skin, mental diseases, sanitary science, and general medicine. The present article is characteristic in its thoroughness, and remarkable for its terseness. The opening sentence—a definition—insanity means disordered mental function—is undoubtedly concise, and the context is equally clear. He had no time to waste on superfluities, but got to the point at once.

The article contributed to this volume by Dr. Alexander McPhedran, on the diseases of the liver and gall-bladder, is

handled in a very scientific manner. The writer has had long experience in this particular variety of disease, and is an authority on all forms of hepatic and splenic derangements.

Malarial fevers are of such importance, and the isolation of the exciting cause has occupied so much professional attention during recent years, that the very elaborate article by Drs. J. C. Wilson, and T. G. Ashton, of Philadelphia, is most appropriate. The parasites are illustrated, through their cycle of development, in beautifully colored plates. The three varieties which are responsible for the different forms of the disease, are each shown, and their characteristics differentiated. The treatments, as in all these articles, are treated chronologically.

These volumes are unique in this respect, that the different articles present their subject matter in the same manner, *i.e.*, chronologically. This feature is one that undoubtedly impresses itself on the reader, and enables him to picture to himself the position that the different diseases occupied in relation to pathology and treatment at the end of each year. The series should meet with an exceedingly wide sale.

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*The Hygiene of Transmissible Diseases: Their Causation, Modes of Dissemination, and Methods of Prevention.* By A. C. ABBOTT, M.D., Professor of Hygiene and Bacteriology, and Director of the Laboratory of Hygiene, University of Pennsylvania. Philadelphia: W. B. Saunders. 1899. Pp. 311. Cloth, \$2.50.

This book is well printed; clear, distinct type, on good, heavy paper. It is illustrated with some sixty figures and charts. The introductory chapter of eight pages states the reasons why the progressive practitioner should be conversant with hygiene, and adduces statistics of life-saving due to preventive measures: death rates from small-pox reduced by vaccination from 3 to 0.03 per 1000; scurvy and typhus banished; deaths from typhoid reduced from 2.91 to 0.1 per 1000 in Munich by sewage and water supply, and 59 and 60 per cent. in Lawrence, Mass., and in Chicago, respectively, by improved water supply. The next thirty pages, dealing with the "Causation of Disease in General," is divided between the consideration of Predisposing Causes, under which we have the influence of age, sex, race, occupation, density of population, heredity and season; and Exciting Causes, subdivided into chemical, physical and mechanical, animal parasites, bacteria.

It will be of interest to life insurance companies to know that women have a longer expectation of life than men, and Jews than other races. We have many of the time-honored statistics, but amongst new ones we note a striking chart showing the

evil effects of overcrowding—great preponderance of disease in one and two-room houses as compared respectively with three, four and five-room ones—this is especially noticeable in zymotic and lung diseases; but the author points out that bad feeding and other unsanitary conditions are apt to co-exist with the overcrowding.

A consideration of the various transmissible diseases individually occupies the next 150 pages; the diseases named amount up to twenty-nine, twenty-eight of which throw out malarial fever, which is, we suppose, inserted in this connection because of its importance and interest, and is brought technically in because of its "transmissibility" through the agency of the mosquito.

In regard to actinomycosis, some of our health authorities will, in view of the measures they have thought desirable, be rather staggered by the statement that "There is no positive evidence that the disease is transmitted from animal to animal, or from animal to man, or *vice versa*." It is added, however, that it is of course safer to regard subjects of the disease as dangerous, and to isolate them." The author deems it "probable that both man and animals receive the virus from the same external source . . . a parasite upon certain cereals."

The author minimizes too far, we think, the dangers from defective plumbing and drainage; the remarks to which we refer may be found on page 115. We have not time to debate the theoretical statement that "it is difficult to conceive the way," but we do know, as a matter of practical observation, of case after case when both diphtheria and typhoid fever have been prevalent and persistent during the existence of flagrant defects, by which sewer air escaped into houses, and where they have ceased to exist after these defects have been remedied. Mr. Sedgwick Saunders thought that he saw some sore throats and typhoid from escape of gases from sewers. The same thing was noted in commenting upon the difference in the prevalence of two contiguous boroughs in London, alike in all respects except the escape of sewer gas from the manholes and culverts of the more modern but less fortunate of the two. We have spoken emphatically and at length because we think it dangerous for a highly-gifted author to minimize the evils of sewer gas.

We commend to the reader the author's views of the care that should be exercised in disposing of pneumonic sputa.

We think it is confusing to use the word "vaccination" except in connection with the transmission of the vaccine disease. In future editions we hope the doctor will make the printer spell "preventable" as the doctor himself spells it in his preface. We mention this because this good hygienic word is

in danger of being lost by the very prevalent desire of the printer to weaken the "able" into "ible."

We turn eagerly, of course, to find "the latest" about germicides and their practical application. We have here a very full article on formaldehyde, illustrated by figures of various apparatus. We quote certain summarized statements. "Its powers of penetration cannot be relied upon. . . . It is highly to be recommended as a superficial disinfectant. . . . The methods that have found *most* favor are those in which the nascent gas is liberated from its watery solution and from its solid polymerized products."

The book contains a useful and finely-illustrated chapter on Animal Parasites. The work is a useful and pleasing edition to our hygienic literature.

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*Minor Surgery and Bandaging.* By HENRY R. WHARTON, M.D., Demonstrator of Surgery in the University of Pennsylvania, Surgeon to the Presbyterian Hospital and the Children's Hospital, Consulting Surgeon to the Presbyterian Orphanage and the Bryn Mawr Hospital, Fellow of the American Surgical Association. Fourth edition, thoroughly revised and enlarged. With 502 illustrations. Lea Brothers & Co., Philadelphia and New York. 1899.

This book of nearly 600 pages has been very popular with students since the first edition appeared in 1891. This fourth edition has much that is new in it, set forth in a clear and lucid style, and is thoroughly up-to-date. Asepsis, antiseptics, surgical bacteriology, and operations upon the cadaver are short, concise, and to the point. An attempt has been made to crowd a great deal into a small space, and thus some parts suffer by being too meagre. Taken altogether the book is one that can safely be recommended to students.

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*Physician's Visiting List.* Blakiston's Sons & Co., Philadelphia.

The visiting list for the coming year appears in familiar form. It in no way differs from the lists furnished by the same firm for so many years. Nothing could be more convenient or better adapted to the purpose it is meant to serve. As in previous editions the opening pages contain Calendar, Metric System, Dosage tables and other useful information. The books are arranged for 25, 50, 75 and 100 patients per week. Price, \$1.00 to \$2.25.

## Selections.

### The Indirect Treatment of Hepatic Cirrhosis.

Cardarelli (*La Riforma Medica*) deals chiefly with the treatment of milk diet, of which he speaks highly. In the cases in which it does good, the urine increases in quantity, the urea increases, and the uroerythrin disappears. These good effects may not be seen all at once; they may be delayed, especially where there is much abdominal tension. Small quantities (half a litre or even less) should be given at first. If milk cannot be borne, large doses (40 to 50 grammes) of lactose may be given in weak broth. To test the power of absorption, the author recommends an enema containing five to six grammes of salicylate of soda, which may be looked for in the subsequent urine. The most reliable indication for paracentesis abdominis where there is ascites, is the quantity and quality of the urine and the presence of edema of the lower extremities. In performing paracentesis, the author prefers the gradual method of extraction by Southey's tubes.—*Brit. Med. Jour.*

### Sterilization of the Skin.

Senger (*Centralblatt für Chirurgie*), investigating the value of alcohol as a disinfectant for the hands, finds that absolute alcohol will not destroy staphylococcus aureus in twenty minutes. The disinfecting power of this agent increases, however, as this drug is diluted down to 50 or 40 per cent. After this the germicidal effect of the drug rapidly disappears. As a result of his experience, he states that a 50 or 40 per cent. solution of alcohol is a sure bactericide for the staphylococcus. If a mixture of alcohol and carbolic acid is employed the result is less satisfactory than when alcohol alone is used, since a chemical combination results, with the formation of a kind of ether. A mixture of 5 per cent. carbolic solution with 10, 20 or 30 per cent. absolutely pure alcohol is entirely inefficacious.

For three years Senger has employed a method of disinfection of the skin based upon his chemical studies. Two agents were employed which had the power of destroying the cocci, and which entered into a chemical combination which in itself is bactericidal. He employs first a 2 and 5 per cent. warm solution of hydrochloric acid for two minutes, then a  $\frac{1}{2}$  to 2 per cent. warm solution of potassium permanganate for one minute. The resultant brown discoloration of the skin may be removed in a few seconds by sulphurous acid. The action of the hydrochloric acid on the potassium permanganate causes

among other things the development of free chlorine. Oxygen and sulphuric acid are also formed.

According to Kronig and Paul, a 1 per cent. solution of hydrochloric acid with 1 per cent. solution of potassium permanganate acts far more powerfully upon anthrax bacilli than a 5 per cent. solution of sublimate. After bacteriological investigation the author has proven that a 1 per cent. solution of hydrochloric acid at about the body temperature is an extremely powerful bactericide. Sulphurous acid and potassium permanganate are weaker. By means of this method he has been enabled to procure sterility of the hands in 78 per cent. of the cases. He commends the method as the safest and the quickest for thoroughly disinfecting the hands and the skin when infected with decomposed substances.—*Therapeutic Gazette*.

### A Study of Anger.

In a recent number of the *Psychological Review* Mr. G. Stanley Hall gives an interesting account of what we may call the physiology of anger. Anger may be defined as the outward and visible manifestation of emotions which have escaped control and the measure of individual civilization is precisely the degree to which command over these particular manifestations have been acquired. The "gentleman" is conventionally one whose nervous system has been so disciplined as never to elude control in this direction. In a state of nature no control of the kind is practised except in deference to motives of a physical order, but the further we advance on the path of civilization the more the ability to command the emotions is expected and enforced. If this be so it is difficult to avoid the conviction that we have not advanced very far on that road. Each individual has his weak side; in other words, every one is more vulnerable on one point than on certain others. Some people are peculiarly susceptible to ridicule, while others are more disposed to jealousy, a sense of injustice or disappointment. The manifestations of the state of anger vary according to the temperament of the individual, but in all there is grave circulatory disturbance, occasionally so marked as of itself to determine a fatal issue. Those in whom the heart is strong and prompt to react, usually flush at the approach of anger, but the less sanguine, and those whose hearts respond less readily to stimulation, or are unequal to the strain thrown upon them, become pale, though the pallor may be but momentary. In both the force of the heart beat is markedly enhanced, the heightened blood pressure accelerates the urinary and salivary secretions, while the greater demand for oxygen causes active working of the respiratory muscles. The extraordinary strain thus thrown on the nervous system is apt for the time

being to-disorganize the muscular apparatus, leading to tremors and unsteadiness of gait, which, however, may be promptly recovered from. Giddiness, nausea, and other functional disturbances are directly attributable to the sudden change of blood pressure. The sounds emitted by persons under the empire of anger vary, passing from the monotonous cry of infancy, through the animal-like noises of childhood, to the threats and oaths of adult life. In exceptional cases there is a kind of inhibitory paralysis of the sound-producing apparatus, but in general the omission of a noise of some sort seems to be the necessary accompaniment of this state of pent-up energy. The state which we call irritability results from impairment of the inhibitory powers, and is often due to illhealth or to fatigue and loss of sleep. The irritability of convalescence is a sign that the lower reflexes are restored before the higher, for the "department of inhibition" is the controlling power of the organism and the seat of the highest manifestations of the *ego*.—*Medical Press and Circular*.

#### The Nurse as a Specialist.

We have from time to time wondered what is to happen to the nurses in the present rapid development and differentiation of medical practice. We accept the fact of specialism among physicians with varying degrees of equanimity, depending upon our education and prejudices, but with a natural conservatism we are inclined to protest against a like tendency among nurses. Nevertheless the inevitable has happened, and nurses are already specialists. Go to a directory and one is met with the query as to whether one wishes a surgical, or an obstetric, or a general medical nurse, or one experienced in caring for the insane. Each of these varieties is recognized, and no doubt many more will spring into being as the demand arises. The situation is certainly an interesting one, and one to which attention must sooner or later be directed as regards the prescribed course of training. It is evident that certain hospitals offer opportunities which others do not, and that a special training may be had in one which would be quite impossible in another. The result is that nurses skilled in the care of certain types of disease are being turned out in greater numbers year by year, who are likely to find employment only in one branch of medical practice.

This means specialism for nurses, a fact which we should clearly recognize, and not too deeply regret, since it is unavoidable. No doubt this question will finally settle itself, as do many others over which we vainly lament. In the meantime it behoves us to readjust our training schools to meet the coming requirements.—*Boston Med. and Surg. Journal*.

### Medical Experience Is Built Gradually.

Every doctor who sits down and reviews his past life will see that the sum of his knowledge has been a gradual growth, that he has added to it little by little through study and investigation, sifted and weighed it by experience and organized it by use. Something else has grown side by side with knowledge, built gradually by similar processes, and of no less value than knowledge. That something is character.

Character is a spiritual force which enables man to use his knowledge and skill to the highest advantage, the noblest end. All physicians and surgeons who have attained world-wide and lasting fame have been men of lofty character, men whom we instinctively trust and respect, men who inspire us with hope and courage, men whose strong souls radiate an atmosphere of cheer. Talent and ability may and do exist apart from character, but they resemble an unharnessed, ill-guided, wanton force, which is quite as apt to smite and destroy as to aid and benefit.

Character is inherited in the form of moral instincts and acquired through precept and practice. Character may be built up and strengthened by right thinking and right doing, or it may be frittered away by sophistry and self-indulgence. We cannot be too exacting in our moral standards or too rigid in conforming to them. The man who is not building character is wrecking it, yet it is the only real, inseparable wealth which he possesses, and which blesses and enriches his posterity with natural gifts which cannot corrupt and lead astray, as material wealth sometimes does.—*Indian Medical Record.*

### A Case of Triple Personality.

The Pathological Institute of the New York State Hospital for the Insane has recently reported a case of great scientific interest with admirable practical results, occurring in the department of the institute devoted to psychology and psychopathology. The case is a remarkable one of amnesia, the patient being a clergyman, about twenty-six years old, who fell out of a wagon, and, striking upon his head, became unconscious. When he recovered from the stupor, it was found that he had completely lost his memory, and that his personality was lost with it. His mental condition was that of an infant, and in the course of education to which he was subjected, he developed a new personality, totally different from the old. He next manifested the phenomena of alternating personality, and awaking in possession of his primitive personality, and *vice versa*. Neither personality was at all conscious of the other. The patient thus had two consciousnesses, which he possessed

at different times, but between which there was absolutely no communication. The problem was how to unify the double consciousness. This was attempted by preventing him from lapsing into profound slumber, keeping him in a condition between sleeping and waking, and the result proved successful. As a consequence he developed a third personality, which was conscious of the other two personalities, and this finally filled every gap in his memory. Dr. Van Giesen, the director of the Pathological Institute, naturally regards the case with great satisfaction, and expresses the opinion that it shows a decided advance in the domain of psychology.—*Boston Medical and Surgical Journal*.

#### Ichthyol in Phthisis.

Wertheimer (*Münch. medicinische Wochenschrift*, June 13th, 1899) speaks highly of ichthyol internally in phthisis. The writer has administered it to most of his patients for two years. He prescribes it mixed with equal parts of water, giving one to two drops of the mixture after meals, in a tablespoonful of water, and gradually increasing the dose until ten drops thrice daily are taken. Larger doses have no special advantage. Distress in the stomach is an indication that the dose is too large. Wertheimer claims that, after a week or two of this treatment, the cough and expectoration diminish, the temperature falls to normal, the appetite improves, and that there is distinct gain in flesh.—*University Medical Magazine*.

#### Peritoneal Affection Resembling Tuberculosis Caused by the Eggs of Tapeworms.

Helbing (*Berl. klin. Woch.*) in the Free Association of Berlin Surgeons, demonstrated specimens from a piece of omentum which Israel had removed from a patient during an operation for perityphlitis. For several reasons the presence of tuberculous disease had been suspected. Sections of the omentum showed that in the fatty tissue there was an interstitial growth of granulation tissue containing many giant cells. Instead of tubercle bacilli globular bodies with radially striated capsule were demonstrated by carbo-fuchsin staining. These could be recognized as the ova of tapeworms, which had doubtless gained admission into the peritoneal cavity through the perforated vermiform appendix. Miura, of Tokio, has given a short account of an analogous case.—*Brit. Med. Jour*

## Miscellaneous.

### THE STORY OF A SPA.

Superstition, intuition,  
Universal imbibition,  
Disappointment and vexation ;  
Then again sound observation,  
Clinical empiricism,  
Diet rules and regulation.  
Theories of chemist, analytical ;  
Puffs of cure-all, hypocritical ;  
Grateful touts of "perfect cures" ;  
Wealthy, pampered epicures !  
Science scoffing, Fashion smiling :  
Yet the wells are still beguiling  
Men and women for their healing—  
Pace reason—proved by feeling !  
" Powers of nature occult still " ;  
Atoms, cosmic force, or veil ?  
So the cycle we fulfil,  
And the fruit of erudition  
Mystery—like superstition !

—*Quarterly Medical Journal.*

### Sulphate of Duboisin in Paralysis Agitans.

X. Francotte, in the *Journal de Neurologie* for May, 1899, gives the result of his treatment of twelve cases of paralysis agitans with duboisin. In nine of the cases there was a marked amelioration in the symptoms, though, of course, there was no case which could be considered cured. The drug seemed to exercise an especially favorable influence over the rigidity, and in the cases which it helped the tremor was much decreased. The drug was used in the form of granules which contained half a milligramme each ; these were given two, three or six daily, according to the physiological effects. The drug was held at its full dose for a long period of time. Marked tolerance for the drug was not established, and its favorable influence seemed to continue nearly as long as the administration. Two of the cases treated were not improved, and these showed marked intolerance of the drug from the beginning.

### Cock-Sureness in Prognosis.

Dr. Boardman Reed says: "Floating around among the daily papers we have observed a story concerning an old citizen of a Western town, who, twenty-eight years ago, was said to have been given up to die by eight different physicians on account of advanced lung trouble. He has lived to see five of the eight erroneous prognosticators die before him, and, as the story goes, expects to bury the other three. This yarn may or may not be true—probably not; but cases do frequently