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A CASE OF ACUTE PRIMARY THYROIDITIS.

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THE following case, which occurred during my term of service at the John H. Stratford Hospital in this city, seemed to present enough peculiar and interesting features, to warrant its being placed on record.

Mrs. E., *et.*, 41, Anglo-Saxon, admitted July 19th, 1902, complaining of weakness; cephalalgia, chiefly frontal, but also down the nape of the neck; anorexia; constipation; and pain in a goitre with increase in its size.

Personal history. The patient is a married woman of thirty-one years. She is the mother of three children. Her general health has always been good, having had no illnesses other than those peculiar to childhood. She has always been able to do her own house work.

For about twelve years back she has had a "swelling of the neck," roughly speaking of about the size of a large lemon, situated nearly in the middle line anteriorly, which had never given rise to any trouble other than the discomfort occasioned by a tumour in that situation. She had, however, noticed that when working hard, or when walking fast there was some dyspnoea, and also some palpitation of the heart.

In the spring of the present year, the patient had moved into a house where typhoid fever had been particularly prevalent during the fall previous, and where well water was the only source of supply for drinking purposes.

For the past few weeks she has been suffering more or less continually from headache, especially in the occipital region, her appetite has been gradually failing, constipation becoming marked, and chilly sensations have appeared, without however any distinct rigor. There has never been any epistaxis.

Present Illness. On the 17th inst. the headache became worse, and the goitre which had previously given no trouble became somewhat tender and swollen. She was seen by her medical attendant, and on the 19th inst. was sent into the hospital with a diagnosis of probable enteric fever.

Present Condition. General: Face pale, with red patches the size of a silver dollar over each malar eminence, eyes somewhat prominent,

slight tendency to sordes, intellect slightly dulled, but no active delirium. She is most comfortable when lying on her back, with head slightly elevated by pillows. Temp., 103 deg. F. Pulse, 120. Respiration, 30.

Gastro-intestinal System: Tongue coated with thick white deposit. It has a distinct somewhat fine tremor, such as is often seen during the onset of typhoid.

Anorexia marked, but no tendency to emesis.

Abdomen is flat, and slight generalized tenderness is present.

There are no rose spots, and no iliac gurgling.

Spleen is distinctly palpable, just below the left costal border. The percussion dullness is similarly enlarged.

Respiratory and circulatory systems, normal.

Neck: A large multilobular cystic thyroid gland is present, with the largest collection of cysts apparently springing from the isthmus, and projecting forward and downward between the sternal portions of the Sterno-Cleido-Mastoids. This portion of the mass is about the size of an orange. Springing from the upper boarder of the left lobe is another smaller mass forming a distinctly separate nodule about the size of a walnut. At the upper border of the median mass is a small area where, on deep pressure, decided tenderness can be elicited. There is no hyperæmia of the skin, nor adhesion of it to the underlying mass, nor can fluctuation be distinctly made out.

Diagnosis. The diagnosis apparently lay between typhoid fever, with inflammation of the cystic thyroid as a complication, and acute primary thyroiditis.

The history and appearance of the patient strongly favored the former, as did also the rareness of thyroiditis as a primary affection, and its comparatively common occurrence secondarily to the infectious fevers.

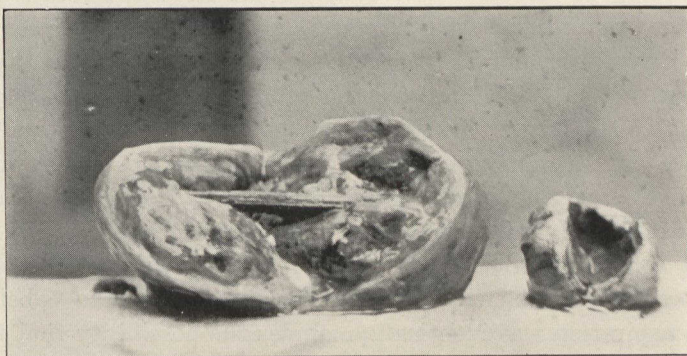
A blood specimen was taken and tested for the Widal reaction, but with an entirely negative result.

A hypodermic needle was then introduced into the most prominent part of the cysts, under strict aseptic precautions, and mucoid substance, slightly stained with blood, was withdrawn.

Course. For a week the temperature remained at about the same level, presenting, however, remissions down to 100 deg. F. The Widal reaction remained absent, and the pain in the neck disappeared under ice applied locally. At the end of this time the continued absence of rose spots and of blood reaction rendered the diagnosis of enteric fever less likely. A needle was again introduced into the cyst, and this time thick

mucopus was withdrawn. The cyst was then thoroughly laid open under cocain anaesthesia, the pus—about an ounce and a half in quantity—evacuated, and the cavity swabbed out with pure carbolic acid followed by alcohol. The temperature immediately fell to normal, where it remained, and the cyst cavity rapidly filled up with granulation tissue.

After treatment.—As there was still quite a large multicystic mass present, which caused some dyspnoea especially on exertion, and as there was slight prominence of the eye-balls, though none of the other symptoms of exophthalmic goitre were present, the removal of the cyst was decided on, and was carried out two weeks later under chloroform anaesthesia. The method adopted was that of enucleation of the cyst from the surrounding capsule of gland substance as described, and so successfully carried out by Dr. F. J. Shepherd, of Montreal. The opera-



Multiple Cystadenoma of Thyroid. In larger collection of cysts note caseous debris, filling the old abscess.

tion presented no especial difficulties, the enucleation being easily brought about, and the haemorrhage from the capsule slight and easily controlled. The "dead space" was packed lightly with iodoform gauze, which was removed in forty-eight hours. The wound healed throughout by primary union, and the patient was discharged on the tenth day.

I had the opportunity of seeing the patient again about two months afterwards, and the result was exceedingly gratifying. She had gained ten pounds in weight, suffered no more from the palpitation and dyspnoea, and the exophthalmos was entirely absent.

The specially interesting features of the case were :

(1) The apparently idiopathic nature of the inflammation. There was absolutely no history of trauma, nor was there any evident point of entrance for the pyogenic organisms.

(2) The remarkable similarity between the symptoms and those of a severe case of early typhoid.

(3) The simplicity, ease, and safety of the enucleation operation as compared either with partial or complete thyroidectomy.

In reviewing the literature of the subject, I am able to find very few and imperfect references to the condition. Various text-books make the assertion that thyroiditis is rare, usually occurring in the course of typhoid fever or some other infection, that the condition is very uncommonly primary, that when it does so occur it usually goes on to resolution, and that suppuration in these cases is decidedly rare.

Tavel, of Berne, writing from Kocher's clinic, has issued a monograph (1) entitled "Über Die Ätiologie der Strumitis" in which he divides the cases into two groups:—(a) those depending on direct infection, (b) those of hæmatogenic origin. Doubtless my case was of the second-class, but the point of entry for the infection is more difficult to determine.

According to Lebert whose classical article was published in the *Krankh. der Schild-drüse* (2), suppuration ensues in 60 per cent. of all cases of thyroiditis, and 25 per cent. of all cases are fatal. From the cases reported in recent literature, the proportion of suppuration would not seem to be so large. In this connection Kocher (3) reports twenty-four cases of strumitis, (presumably suppurative) in eleven of which aspiration, electrolysis, or interstitial injections had been carried out, and in six more other definite predisposing causes were present. In my case although aspiration was practised, still it was only under absolutely aseptic precautions, and the fact that the temperature range, before and after the aspiration was identical, precludes the possibility that the suppuration depended on the aspiration.

As an example of the hæmatogenic group above noted may be taken Oulment's (4) report of a case of suppurative thyroiditis, followed by pyæmia and death, occurring during the menstrual period; in which he expresses the opinion that the infection may have come from the uterus.

Cases of primary thyroiditis terminating in resolution are apparently more common. John H. Bradshaw (5) reports a case of this character which ran an afebrile course. Before the *Societè Medicale des Hepitaux*, M. Gallard (6) reported a case, also apparently of primary inflammation of the thyroid, accompanied by fever and rapid pulse. This case terminated in resolution, though there were several attacks of palpitation and tachycardia (128-140 per min.) subsequently. In the *Brit. Med. Jour.* is reported (7) the case of a child who had been suffering from a nasal catarrh, and who developed sudden enlargement of the thyroid, with a temperature of 103 degrees. Treatment by leeching, etc. brought about resolution. Here the infection may have been from the pharynx.

Suppurative cases, when allowed to go unoperated on, may bring about peculiar results. Thus Remaine (8) describes a case of spontaneous cure of a goitre brought about in this way, and Lejars and Leroy (9) have reported a suppurating cyst of the thyroid with adhesions to and ulceration of the cervical blood-vessels.

In America, Delafield (10), Musser (11), Lydston (12), and Ransohoff (13) have reported cases. Of Ransohoff's cases, one followed one week after convalescence from typhoid, while the second followed the breaking off of the point of a needle while making an injection. In this case evacuation of the abscess was followed by sinus formation, which persisted for some months. This complication is a fairly common occurrence and is due apparently to the difficulty of securing collapse of the thickened cyst wall. Thus in my case although the cavity had apparently filled by granulation, when the cyst was afterwards removed, the abscess cavity was seen not to be healed but to be filled with a caseous debris. This condition is well shown in the accompanying photograph.

Ransohoff lays great stress on the danger of violent hæmorrhage, following the evacuation of the pus, and says that "from no other abscesses are recurrent hæmorrhages so common". This feature was not marked in the case above reported. If it should occur, especially when one considers the danger of sinus formation following in any case, partial or complete thyroidectomy would seem to be justifiable.

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ASPIRIN IN GLYCOSURIA AND DIABETES MELLITUS.

DR. R. T. WILLIAMSON, of Manchester, writing in the *British Medical Journal*, of Dec. 27, speaks highly of the value of aspirin in the above conditions. He commences with ten grain doses two or three times a day, increasing to fifteen grains four or five times a day.

CONTUSION OF THE ABDOMEN.*

By GEO. S. RENNIE, M.D., L.R.C.S. Edin., L.R.C.P. Lon

ABDOMINAL contusion with its accompanying symptoms and sequelæ is, to my mind, a most important subject, but one that is not discussed or written upon as frequently as it should be. It is for this reason that I wish to draw your attention to this injury, in order that interesting cases of this kind may be reported. I find on looking up the literature very little on this subject, and I may say my own experience with injuries of this kind is very limited, and I shall only report two cases of interest. The first one, A.C.M., is, strictly speaking, a contusion of the abdomen with complications, as the history will show; the second was a contusion of the abdomen with also a lacerated wound, but this second case is so closely allied to the subject of my remarks, that I trust you will pardon my giving its history under the heading of this paper.

Case 1—A.C.M., on the night of Feb. 23rd, was at work coupling cars when he slipped on the ice, and fell between two cars as they were coming together with great force; he was standing sideways and was caught in the coupling about the middle of the body. The coupling was made and his clothing and abdomen were caught in the coupling. He was conscious and called for help; his fellow workmen tried to liberate him from the coupling by opening it with the dogs provided for this purpose on opposite sides of each car, but this they were unable to do, using all their force; and in order to liberate him it was necessary for the engineer to back up by signal, when he was released.

He was conscious all the time, suffering extreme pain, and stated that his eyes were starting out of his head. He was given $\frac{1}{4}$ grain of morphia hypodermically, and sent to the hospital. On examination it was found that the patient was severely bruised from the lower margins of the ribs down to the pubes; on the right side over the os innominatum, the skin was broken, and there was very severe bruising, the bruising extending also into the thighs, the right one being severely bruised over the great trochanter; no marks of violence on the back.

He had hæmorrhage from the ears, nose and mouth, although there was no violence applied to the body above the lower ribs or below the upper part of the thighs; he had extensive subcutaneous hæmorrhages in the conjunctivæ of both eyes, they being chocolate in color; and extensive hæmorrhage into the eyelids and tissues around the eyes, extending down over each malar bone.

*Read before the Hamilton Medical Society.

His perinæum was ruptured and a portion of the rectum protuded. This was returned and the perineum stitched with silkworm gut. He had purpuric spots all over his chest. Temperature 96 4-5, pulse 99, Complained of much pain in the abdomen, feeling of nausea, pain in eyes, and felt as if they were starting out of his head. Hot compresses applied to abdomen, morphia, strychnia, and spts. frumenti given for the first few hours.

Feb. 24th. Temp. 100, pulse 120, bowels moved after an enema, complains of pain and nausea, hurts him to breathe, abdomen looks much worse as bruising becomes more apparent. Feb. 25th. Temp. 99½, pulse 100; bowels moved after an enema, great pain in abdomen with nausea; takes milk, beef tea, and stimulants at regular intervals. Condition, remained about the same, temp. normal, pulse 100, to March 1st, when whole abdominal wall appears to be pulpy, shakes on movement like a bag of jelly; whole abdominal wall simply bathed in pus, bowels move regularly. March 3rd., abdomen is somewhat distended. Recti muscles seem to be separated and patient experienced a sensation like as if something had given way. Patient feels nauseated, takes nourishment regularly but breathes very rapidly at times, and bowels move regularly. March 5th., large superficial slough on abdomen, he feels weak and exhausted. March 8th, cannot retain food, vomits immediately after; temp 99, pulse 120. March 11th., patient getting nutritive enemata, abdominal wall has lost its pulpy, jelly-like appearance; he is restless and dispondent; temp. 99, pulse 126. March 13th, patient has grown weaker, slough separating from the abdominal wall, pulse weak, takes a little nourishment by mouth, occasional reaching and vomiting; bowels move regularly. March 15th, patient very weak and cannot take nourishment; temp. 99½, pulse 150, is unconscious for some time before death.

Report of autopsy upon the body of A. C. M., aged 35, March 15th, 1902.

External Appearance. Body is that of a male 5 feet 8 inches in height, considerably emaciated. The abdomen is sunken and covered with small hæmorrhagic spots. There is considerable staining of the anterior and external surfaces of the right flank and hip, the result of bruising received *ante mortem*. The left flank and hip are stained anteriorly, apparently from the same cause. The entire abdominal surface from the lower costal margin to the pubes is in an ulcerated condition, showing evidence of an attempt at repair. Posteriorly, hypostatic congestion is noticed. There is a purplish discoloration upon

the dorsum of the right foot over an area of 3 by 5 inches. A slight scar is seen in the perineum $1\frac{1}{2}$ inches in length. The conjunctivae are hæmorrhagic, but show evidence of partial absorption of the effusion. Rigor mortis is not well marked.

The usual incision made and the abdomen opened.

Abdomen. On examination of the abdominal parietes the muscular layer is observed to be completely separated from the cutaneous and subcutaneous tissues. There are a few recent inflammatory adhesions on the left side of the incision in the neighborhood of the umbilicus, extending downwards and outwards. Otherwise there was no attachment between the muscular layer and the cutaneous and subcutaneous layer. Minute hæmorrhages involving the whole of the abdominal wall exist in the subcutaneous and muscular tissues. On the peritoneal surface of the abdominal wall there are very numerous hæmorrhagic areas, while in the more dependent parts the staining is diffuse, some of the discoloration being comparatively old, while other areas are of more recent production. In the pelvis, the staining is very diffuse, much more extensive and evidently of longer duration. There is considerable extravasation between the bladder and the pubic arch.

Abdominal Viscera. The great omentum does not occupy its usual position in front of the testes, but is entirely invisible. The coils of intestines appear flattened and more or less discolored in dependent parts. The sigmoid flexure is much longer than normal, W shaped, and much more darkly stained than the rest of the intestines. The remainder of the intestines, so far as can be seen, with the exception of the two darkly congested knuckles, in dependent positions, present a fairly normal appearance. In the mesentery there are numerous small hæmorrhages, mostly of recent date. Four inches from the ileo-cæcal valve there is a tear in the mesentery two inches long, with edges healed and showing signs of repair of some duration. Above this tear are signs of recent hæmorrhage in the mesentery. Some post mortem biliary staining is noticed in the region of the gall bladder, involving the coils of intestine in the vicinity of the hepatic flexure.

Gall bladder, two and one half times normal size and distended with fluid. Examination reveals no obstruction in the duct.

Spleen, dark, somewhat enlarged, weight $6\frac{1}{2}$ ounces.

Liver, normal, except for a few bruises along the anterior surface of the lower edge of the right lobe. Some post mortem staining; weight $62\frac{1}{2}$ ounces.

Left kidney, slightly larger than normal. Some old hæmorrhages upon its surface. Capsule strips readily. Slight hæmorrhage under the capsule. On section, cortex appears thin and somewhat congested.

Right kidney, normal in size. Superjacent peritoneum is filled with blood clot, some of which is recent and some of old standing. Capsule strips easily. Some underlying hæmorrhage. On section, the cortex is seen to be narrow and there is some dark fluid blood between the pyramids. Calices full of clear urine.

Descending colon is contracted.

Thorax.—Where the thorax is opened the left lung is seen to be compressed into the apex of the left pleural cavity, and an opening two inches long is observed on the left side of the diaphragm, immediately to the left of and slightly anterior to the vertebral column, through which the stomach, great omentum, 14 inches of the transverse colon, a portion of the descending colon and the transverse mes-colon have passed. There are some recent adhesions between the viscera and the pleura. The left lung is firmly adherent to the parietal pleura along a surface extending backward from the axillary line. The lower lobe is collapsed, atelectatic and shows hypostasis, the upper lobe is pale and emphysematous.

Right Lung, emphysematous along the anterior border. Considerable hypostasis posteriorly.

Pericardium, contains normal amount of fluid, no adhesions.

Heart, somewhat smaller than normal and well covered, particularly on the right side with a deposit of fat. Auricles and auricular appendices, normal. Left ventricle, firmly contracted and empty, somewhat smaller than normal. Right ventricle, slightly contracted, normal. Tricuspid valve, cusps slightly thickened on free border. Pulmonary valves, normal. Mitral valves, present thickened borders and surfaces. Patchy atheromatous change is seen. Aortic valves, normal. All the valves of the heart are normal in function and appear perfectly competent when subjected to the hydrostatic test. Aorta, patches of atheroma above the openings of the coronary arteries.

Case No. 2, L. J. Patient was a strong, robust man. When working in a factory at 9.30 a. m., July 24th, he was engaged in putting a belt in place with a pole, when the pole became caught in the moving belt, and the end of it came with great force against him, and penetrated his abdomen on the left side of the middle line and about three inches below the costal margin.

The patient was sent to the hospital and prepared for operation. On examination there was found a contused area about 3 x 4 inches below the left costal margin, extending from which there was a wound running obliquely downward for about three inches. The index finger on being pressed into this wound, entered the abdominal cavity. The

wound was enlarged in a downward direction, and on examination of the abdominal viscera, a tear was found in the descending colon, from which fæcal matter had escaped into the abdomen. This wound passed transversely across the bowel for three inches. This opening was closed by using fine silk and Lembert sutures. The abdominal cavity was then carefully examined for other injuries. A large portion of the great omentum was found badly contused; this was ligatured and then cut away. No other injury was found to any of the abdominal viscera. The abdomen was then thoroughly irrigated with sterilized water, a glass drainage tube was placed in position, and the abdominal wound closed with silk worm gut sutures.

The drainage tube was cleared by means of a syringe every hour for the first eight hours, as the discharge was fairly copious and slightly tinged with blood. The patient's condition following the operation was fairly good. A quart of saline was given per rectum.

During his illness his temperature and pulse practically never went above normal. The tube was removed two days after the operation, and the loose sutures that were put in position at the time of operation, tied. Ten days after the accident, an abscess formed in the abdominal wall, at the site of the contusion mentioned at time of the first examination. This was opened and a quantity of pus escaped, the cavity was drained, and was healed in ten days. The patient made an uninterrupted recovery, was discharged from the hospital, August 27th, one month and four days from the time of accident, and returned to work ten days later.

Now let us review these two accidents, and their results. Case 1 is most interesting, but unfortunately, terminated fatally. In this case it was quite impossible to diagnose the conditions found at the autopsy; we had the history of the severe force causing the accident, the injury was apparent, his bowels moved regularly, and he took nourishment regularly, had for a time practically normal temperature, and his pulse for days was not rapid. Even if the condition of affairs could have been diagnosed, it would have been impossible, in this case, to have operated with success, as the abdominal wall was simply bathed in pus, and the tissues underlying macerated in it. Under these conditions, it would have been impossible to have done an aseptic operation unless it had been done directly after the injury. If an operation had been performed at this time, I do not consider that it would have been successful, as the tissues of the abdominal wall sloughed later on, and consequently there would have been a septic condition set up intra peritoneally.

Taking these things into consideration, and taking for granted that an operation could have been done aseptically, and without later infection

of the peritoneal cavity, it would have been impossible from what was found at the autopsy, to have saved this patient's life, because it was with great difficulty, even post mortem with that large incision, that the abdominal organs could be removed from the chest cavity; the hole in the diaphragm having to be considerably enlarged. One rather striking point in this case is the course the food had to take before reaching the rectum; passing from oesophagus in the abdominal cavity, it passed into the chest cavity, into the stomach, passing from the stomach it entered the small intestine in the abdominal cavity, passed through the small intestine to large intestine, from abdominal cavity to chest cavity in transverse colon, and back to descending colon in abdominal cavity, he taking nourishment daily and his bowels moving daily for a period of twenty-one days.

The second case, L. J., points directly to the advisability of operating and operating early. In this case we might just as well have found the intestinal injury presented without any wound of the abdominal wall. In this case there was an extensive contusion and quite sufficient to have caused the rupture of bowel or some abdominal organ.

It might be well to refer briefly to the causes, symptoms and treatment of cases of this kind; kicks of horses, railway casualties, and run-over accidents probably account for the great majority of cases of visceral rupture, the external signs in many cases may be slight, while the internal wounds may be extensive.

The symptoms of abdominal contusion with involvement of viscera, are fairly uniform. The temperature falls below normal, skin cold, anxious expression, rapid, thready pulse, rigidity of abdominal walls, localized tenderness, often retention of urine, and frequently apprehension of death.

We have the history of the accident, and the symptoms as mentioned, which are those of shock and abdominal rigidity;—muscular rigidity of the abdominal wall is pretty constant in visceral injuries. Keenan found it in 84 per cent. of his cases, Hartmann regards muscular rigidity as so positive a sign that he makes an exploratory incision even in absence of other signs, and justifies his statement by reporting ten cases of which nine were operated upon successfully, and in all of which visceral lesions were found. In the remaining case which refused operation, death ensued and an internal perforation was found post mortem.

Besides muscular rigidity, we have abdominal tenderness, varying according to the site and degree of local injury to the abdominal walls. It is present over the local contusion, and this deprives it of much value in diagnosis.

Vomiting is present in most cases as was with A. C. M., case 1, but of the cases I have been able to review, vomiting appears to be no sure indication of serious damage to the stomach or intestines. Blood streaked stools likewise may be suggestive, but not absolutely diagnostic. Blood in the urine, on the other hand, is a much more reliable indication of lesion of the genito-urinary tract.

Abdominal distention is generally a later development, and may point to the advent of peritonitis. Signs of free hemorrhage within the abdomen point rather to lesions of the mesentery or solid viscera.

The diagnosis of visceral lesion can only be made by exclusion, and to be complete you must make an exploratory incision; this procedure should be advocated when doubt exists.

The progress depends upon the organ injured, the character of the injury, the presence of multiple lesions, the presence of infection, the character of the infecting agent, and upon the age and general resisting power of the patient.

Makins gives a table of 292 cases showing the relative frequency of injury to the different visceral organs; of these the intestines were the seat of injury in 23.59 per cent., the bladder in 5.61 per cent., the mesentery in 3.57 per cent., the spleen in 11.23 per cent., the liver in 16.85 per cent. and the kidney in 3.32 per cent.

To sum this subject up, from the information I have been able to gather, and from cases of my own, I would say:

1 Contusions of the abdominal wall are deceptive in their character as regards the viscera.

2 The seriousness of the case is often overlooked.

3 Exploratory operation is not only safe, but is our only means of arriving at a correct diagnosis, and should be performed in the majority of cases showing evidence of internal injury.

4 Operate by all means early.

Dr. Palmer's many friends will be glad to learn that he is around again, after the severe attack of septicaemia which he contracted while performing an operation. The present indications are that his hand will regain a large measure of its usefulness.

FOUR CASES OF HERNIAE.

By THOMAS J. F. MURPHY M.D.,
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THE following four cases were operated upon at the Victoria General Hospital and may be interesting.

C. D., 58 years, stevedore, came to the Victoria General Hospital, July 1st, 1901. He gave a history of a small hernia which had existed for about 13 years and which had suddenly become enlarged after exertion. He had used all manner and kinds of trusses and had been sent to hospital by Dr. Hogan for operation. On examination, we found a scrotal hernia, on the right side, quite as large as the patient's head, his condition amounted to total disability. In the recumbent posture it was impossible to reduce all of the hernia, although there was no constriction at the inguinal opening. The patient had been treated the year before in this institution for bronchitis and emphysema, he was very fat and had a large pendulous abdomen, general condition pretty fair, the patient demanded an operation, and we explained the danger and difficulty to him, but he persisted acting on an idea taken from an article entitled "Note on mortality after operation for large incarcerated herniae" *Annals of Surgery*, Jan., 1900. I placed the patient in bed with the foot of the bed slightly elevated, and kept him on very low diet. In six days the hernia could be easily reduced, operated on July 8th, 1901. Chloroform was used first on account of the emphysema, but was soon abandoned for ether. He took the anaesthetic badly, was never thoroughly under and coughed, gagged and strained all through the operation. The sac was opened and ligated as high up as possible and resected together with the testicle and cord. The hernial orifice was closed, much after the Bassini method, with the difference that the external oblique was attached to the ligament so as to leave a little of the latter overlap to which was attached a portion of the sheath, of the Rectus. Kangaroo tendon was used for the muscles and the skin was closed with silk worm gut, a drain of the same material being left in on account of the amount of fat present. I was also afraid of skin infection for there was a slight excema present in the creases. The skin sutures and drain were removed on the eighth day. Slight serous and fatty discharge persisted but care was taken to preserve the integrity of the buried kangaroo tendons by injecting a four per cent solution of formalin through the sinus left by the drain. The patient was kept in bed and the discharge persisted from the sinus. On August 9th, cystitis set in which lasted 10 days, on September 11th opened sinus and swabbed out with pure carbolic followed by alcohol. Oct. 18th, another attack of cystitis, followed, on Oct. 22nd, by an attack of phlebitis of the left leg. Patient discharged cured on November 12th, 1901. At the present

moment November 21st, 1902, the patient is in good condition. There is no recurrence of the hernia and the abdominal wall seems strong. The patient has been working at his business. I intend to particularly follow up this case and will report again upon it.

Mrs. S. W. aged 45 years, married, came to Victoria General Hospital, June 5th, 1900, complaining of oblique inguinal hernia and cyst of the round ligament, the hernia had troubled her about 10 years, about three weeks after the appearance of the hernia, the cyst began to grow until it had reached its present size, which is about that of an average orange. Bassini operation, June 18th, 1900, was done and the cyst removed, patient was discharged cured, July 17th.

Mrs. A., married, multipara, admitted to the Victoria General Hospital, April 4th, 1901. This case resembled the other in almost every particular and will not be reported in detail, she was rather run down and was not operated upon until April, 28th 1901. Discharged, cured, May 25th, 1901.

E. W., male, 9 years, admitted August 13th, 1902, complained of tubercular disease of the right hip joint, and inguinal hernia owing to the patient's crying and straining a good deal. it was thought advisable to operate on the hernia, operation Sept 24th, on cutting upon the sac, no cord could be found, on opening the sac, the cord was found to be in the centre of, and not connected with the sac except at the lower portion where it joined the testicle. The veins were easily separated and had no investment of any kind in the sac. There was a little omentum which was returned. We were careful in closing the peritoneal opening not to constrict the veins too tightly. The sac was excised, and the operation finished after the Bassini method. Subcuticular stitch of silk worm gut was used, over this collodian. Stitch removed on 7th day. Case has since done well.

The following case occurred in private practise. Mr. G. R. 92 years of age, male, had had hernia for 40 years, became strangulated, August 10th, 1901, operated August 11th, 1901. Dr. John Stewart assisted me at the operation which was done under eucaïne, the bowel was easily reduced and some of the omentum cut off. The stump was sewn into the internal ring and made to act as a plug. No attempt was made to do a radical cure, as the tissues were thin and feeble and not possessed of much vitality. The old gentleman was very unreasonable and hard of hearing, and had been troubled for years with enlarged prostate. He urinated over the dressings, he took the dressings off twice, the skin sloughed slightly but soon healed. Cystitis set in. He recovered from the hernia only to die of the cystitis six weeks after operation.

TONSILLAR HYPERTROPHY, ITS OPERATIVE TREATMENT, AND THE COMPARATIVE VALUE OF THE DIFFERENT METHODS:*

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THE faucial tonsils are two glandular organs, situated one on each side of the fauces, between the anterior pillar, formed by the palato-glossus muscles, and the posterior pillar, formed by the palatopharyngeus muscle. The function of these glands is not definitely known, some inclining to the belief that they have some secretory principal of use to the system, others that they are sentinels of defence against bacteria of various kinds. The latter view is supported by Goodale, who introduced carmine into more or less hypertrophied tonsils, and on later removing the gland, absorption of the carmine was found to have taken place. At any rate, enlarged cervical glands are frequently found co-existing with enlarged tonsils, and in many instances, disappear after removal of the tonsils.

Tonsils are normal structures, but when projecting beyond the faucial pillars, may be said to be pathologically enlarged. There are many cases of diseased faucial tonsils which cause very marked systemic disturbances, but which do not project beyond the pillars. They may, however, on becoming inflamed, project well out, and their contents, which is often a foul caseous material, can be seen appearing at the mouth of the crypts. Disease of the supra-tonsillar fossa, a cavity of varying size, situated at the top of the tonsil, and immediately behind the plica semilunaris, almost invariably accompanies this form of tonsillar disease.

There are various names given to enlarged tonsils, according to their existence and internal appearance. Thus we may have the cowlled tonsil, so called by Moure, in which the upper border of the upper part of the anterior faucial pillar, the front boundary of the supra-tonsillar fossa, forms a sort of cowl or covering for the enlarged gland, a small and hard tonsil is not infrequently seen in adults suffering from chronic pharyngitis. The honey-combed, or ragged tonsil, (Lennox Brown) contains cul-de-sacs, in which caseous or calcarious secretions are found. The overhanging tonsil is another variety, which differs from the ordinary prominent tonsil, in that there is a projection downward toward the laryngo-pharynx. There are also tonsils which project but little, and are enlarged in an antero-posterior direction presenting a comparatively flat surface internally.

*Read at the meeting of the Ontario Medical Association held in Toronto, June 1902.

I would divide hypertrophied tonsils into two distinct classes for operative treatment.

- (1) Seventeen years and under.
- (2) Over seventeen.

In the former and up to twenty or twenty-five years of age, I have but on one or two occasions, failed to find sufficient hypertrophy of the pharyngeal tonsil, (adenoids) to require removal. Adenoids may exist without enlarged tonsils, but up till puberty, or a few years beyond, enlarged tonsils are practically always associated with adenoids. I know this is not the opinion of all, but it has been my experience in my own practice, and I have seen it with hardly an exception, in the Central London Throat and Ear Hospital, where such cases are seen by the thousands.

The indications for removal of tonsils are, in my view, as follows :

- (1) Cases of deafness with very large tonsils.

There are, in all probability, adenoids associated with the faucial hypertrophy, and these are removed also. Anatomically the tonsils alone cannot interfere with the ventilation of the Eustachian tube, but they may, by impairing the dilators of the tube interfere with its functions.

- (2) Cases of enlarged tonsils in debilitated children or adults.
- (3) Cases of frequent attacks of tonsillar or peritonsillar inflammation.
- (4) Cases of enlarged tonsils whose structure is filled with caseous material, which causes impaired nutrition and foul breath, as well as causing or keeping up a chronic pharyngitis or a secondary laryngitis.
- (5) Cases of enlargement, sufficient to impede speech, respiration, or deglutition.
- (6) Cases of small submerged tonsils, whose structure is often one suppurating mass, and associated with supra-tonsillar disease.

There are many healthy children, who have enlarged tonsils, that cause no symptoms whatever, and in the natural course of events, these would atrophy. If frequently seen these *may* be left alone, as Nature *may* look after them. We must, however, be careful that a patient does not grow *into* symptoms, while growing *out* of his tonsils.

The anaesthetic is one that has caused a great deal of discussion.

In children, where practically adenoids always co-exist, Nitrous Oxide Gas, given in the upright posture, is the ideal anaesthetic. There are two essentials however, to good results with it,—

- (1) Skilled Anaesthetist.
- (2) Rapid and thorough operator.

Everything connected with the operation must be systematized, as no delay can occur, else the anaesthetic will not be sufficient. In very

young children, say under four years of age, $N_2 O_2$, is not well born. Chloroform is best used given sparingly, and not so that the laryngeal reflex is lost. In young adults and those of more mature years, if the guillotine, galvano-cautery or galvano-cautery snare, be used, cocaine twenty per cent. will do away with a great deal of the pain. In cases hereafter mentioned, in which the punch forceps and cold snare are used, I think gas, again, the ideal method, though with the snare only one tonsil will, as a rule, be removed by one administration. I have had no experience with Hydro-bromic ether. I unhesitatingly condemn the removal of enlarged faucial and pharyngeal tonsils, in young children, without anaesthesia.

DIFFERENT METHODS.

(1) *Guillotine.* This is by far the most universally used instrument. Its advantages are thoroughness and rapidity with which the operation can be performed. There are cases however not suitable for the use of the ring knife, viz.—

(1) Submerged tonsils, except when projecting during an acute attack of inflammation, when they may very properly be removed.

(2) Cases of enlarged tonsils in people above 17 years of age.

In cases where the tonsil is very large and spongy, one is probably safer not to use the guillotine. There are many kinds of guillotines, each bearing somebody's name. Generally speaking, that of McKenzie will be found to answer very well. These accompanied by forks or prongs, to lift the tonsil before cutting, offer no advantages that I can see. If the Anæsthetist pushes the tonsil well towards the middle line, and the operator presses his instrument well externally, practically all of the gland will be removed. Stewart Low has recently devised a handle for a tonsillotome by which the handle is prolonged into a hook permitting the ulnar side of the hand to secure more leverage in pressing the blade cutward. Complete removal of the gland, while anatomically possible, is very rarely performed.

It is very poor surgery to remove a small piece of the tonsil, expecting the remainder to shrink away. Haemorrhage is more to be feared from removing too little than to much. A tonsillitome having an opening into which the gland closely fits, gives better results than one too large, when the pillars may be wounded. Those cases, in which the tonsil projects downwards into the laryngopharynx, require a special application of the guillotine. If one presses the instrument, as in the ordinary way, he will amputate only the upper part of the gland, while if the tonsillitome be placed upside down, and well to the base of the tongue, it can be made to encircle the tonsil from below, and then gradually

turning the instrument on its side, it will be made to fit well up to base of the gland. Frequently in cases when the anterior and posterior pillars are adherent to the gland, separation of these structures allows the gland to come out as it were, and be more readily and completely removed.

(2) *The Cold Snare.* In this instrument we have a very safe and thorough method of removal. The wire must be No. 8 at least, and the instrument such that the tonsil is crushed rather than cut. There are snares being sold here that actually cut like a knife, both by the wire and the end of the snare. I have had two cases of severe and alarming hæmmorrhage with this instrument. We use the snare in those cases where we fear hæmmorrhage, (*i. e.*) over 17 years of age. Sometimes the snare will not remove sufficient, and Bosworth advises the use of the snare again, trimming as it were the field of operation. In my own practice, I prefer the Dundas Grant Tonsil Punch, which is more rapid and quite as safe, for subsequent trimming. Of course the snare is only of use when the gland projects well out between the pillars, and they are not adherent to it.

I have had no experience with the hot snare, and cannot see the advantage of it. It leaves a very sore throat, and frequently severely burns the faucial pillars. In using it, care must be taken to increase the current while going through the gland, as the wire rapidly turns cold.

(3) *The Punch.* Here the tonsil is practically crushed off. There is no fear of hæmmorrhage. A number of applications can be rapidly made, and practically all the gland enucleated. It is the only instrument of any use in these cases of diseased though not enlarged (submerged) tonsils. That designed by Dundas Grant has the advantage of being used for both sides without reversing. In the hard small tonsils of adults, it is of particular use, as well as in those long flat tonsils, where it is almost impossible to get sufficient in a Guillotine. Recently cases have been recorded, in which tonsils in this description are enucleated almost entirely. The gland must be pulled out, and with scissors or small forceps, the external surface of the gland is reached, and the tissue removed piecemeal.

(4) *The Galvano Caustery Puncture.* This is a very tedious method of removal. It requires a number of sittings, and is very frequently followed by severe peritonsillar inflammation. It is said to be absolutely void of all danger of hæmmorrhage. Dr. Wishart has mentioned cases to me in which very severe and alarming hæmmorrhages followed slight cauterization. There are some patients who absolutely refuse anything like a cutting operation on the throat, and it is in these cases and in these alone, that I would adopt this method of procedure.

Complications at the time of or following the operation:—
(1) *Hæmmorrhage*. Considering the frequency with which the operation is done, especially with the Guillotine, death from hæmmorrhage is very infrequent, while severe and alarming bleeding is far more common. Age exerts a very marked influence on hæmmorrhage. Those over seventeen years are much more liable to have excessive bleeding, than those of younger years. Still it has probably occurred to most of you to occasionally find severe loss of blood in operations on young children. This may be due to the size of the gland, with an abnormal blood supply, or to a tendency of bleeding, inherent in the individual, such as in hæmophilics. In the former, the means to arrest the hæmmorrhage are by styptics, such as adrenaline, tinct. ferri. perchlor; a paste made according to Grunwald by rubbing gallic and tannic acid into a small ball and applying this to the bleeding point; pressure by the fingers, one inside the mouth and one outside. Instruments for this purpose are of little practical use, and are far inferior to digital pressure. MacIntyre, in one instance, succeeded in stopping the flow, only by suturing the anterior and posterior pillars, thus covering the tonsil space almost completely. If the hæmmorrhage be due to cutting a very large vessel, pressure forceps properly applied and left on, may suffice, or it may even be necessary to tie the carotid artery. The blood supply is from the dorsalis lingue from the lingual, the ascending palatine and tonsillar from the facial, the ascending pharyngeal from the external carotid, the descending branch of the internal maxillary, and a twig from the meningeal. In cases where it is necessary to adopt the latter method, the bleeding is so severe, that the patient will bleed to death before the vessels are controlled. A specimen found by Dr. Wishart in which the artery projects well internally, would, if severed in any way whatever, cause the patient's death before anything could be done. Care must be taken that the patient does not swallow the blood, and thereby lead to a sense of false security, or that some blood reaches the larynx, causing suffocation.

Bleeding, however, may not come on at the time of operation, but follow even as late as two weeks. Avoidance of all exertion, and any food tending to tear, such as crusts of toast, etc., should be insisted upon, moreover the greyish eschar, formed a few days following the amputation of the gland, should be left to come away itself. Attempts to remove it may excite a severe hæmmorrhage. In using too large tonsillitomes, one may wound the faucial pillars, and cause a very annoying hæmmorrhage, requiring pressure forceps or cauterizing to control it. One must not mistake this for a tonsillar hæmmorrhage. Careful inspection must therefore always be made to see the bleeding point. An instance occurred in my practice recently, in which I removed with a cold

snare, both tonsils, which were very large, from a woman 69 years of age. Five days after the operation, her mouth suddenly filled with blood and I was sent for hurriedly. No bleeding point was to be seen, on looking into the mouth, but with a laryngoscopic mirror, a lingual varix, of which she had plenty, was seen to be covered by a recent clot. The bowels were freely opened and latter the galvano-cautery applied to the enlarged veins, and no further trouble ensued. If any one here has never had trouble with bleeding, following tonsillotomy he will some day remove an apparently insignificant tonsil, the immediate result being such, that all his energies will be taxed to keep the patient from bleeding to death. Daly, quoted by Lennox Browne aptly says "He who has never had a haemorrhage has yet to meet his Sedan."

In haemophilics all the above means should be adopted, but all will probably fail. The best way is the most rational, *i. e.* by enquiring into family history and refusing operation.

Medicinal treatment is usually not required, following this operation, though for nervous patients Pot. Brom. may be given with advantage, and in all a gragle of Pot. Permang will be found grateful. Small pieces of ice kept in the mouth are of service as is also plenty of ice cream.

SPECIMEN CASES OF TONSILLAR DISEASE.

Three cases of tonsillar disease in my practice, have been of particular interest to me, so I will give you very brief notes on them.

1. A. B. Bank Clerk, age 36, complained of hoarseness of varying intensity, of three months duration. He suffered frequently from sore throat, and had lost twenty pounds in weight within three months. The tongue was very much coated, breath foul, pulse and temperature slightly above normal. The oro-pharynx was markedly congested, the faucial tonsils were slightly enlarged, while the crypts were blocked with caseous material of a very foul odor. A probe passed upward into the supra-tonsillar space showed it to contain a foul greenish yellow mass. The larynx showed general congestion of the mucous membrane, some thickening on the vocal cords and a deposit of muco-pus in the inter arytenoid space. With Grant's Tonsil Punch, I removed the suppurating mass between the faucial pillars, and with a sharp curette thoroughly cleaned the supra-tonsillar space. An antiseptic gargle was used, and within six weeks, the laryngitis was well, and the patient had regained his weight. This is really an instance of auto-intoxication.

2. A. H. Girl. Age 14. Very large tonsils and adenoids. On amputating the left tonsil, a gush of pus came out. The cut surface of the tonsil was hollowed out to contain pus. The other tonsil on being cut into, after removal, showed a small quantity of pus. The pus in

both instances was very foul, and gave no indications whatever of its presence. I took the case to be one of chronic abscess of the tonsil.

3. H. A. Age 10. Boy. For years had been bothered with Eneuresis, that nothing seemed to stop. I was not aware of this until his father informed me of the cure some weeks later. His throat was filled with enlarged tonsils and adenoids, which I removed. The result was a complete and permanent cure to the Eneuresis. The adenoids may alone have been the cause, but I cannot determine this point.

In conclusion I may mention that I have endeavored to confine my remarks to the ordinary cases of enlarged tonsils, as seen by all of you very frequently, and I have therefore omitted mentioning cases of enlarged tonsils, of a specific, tubercular or malignant nature.

I append a letter I received from my friend and teacher Mr. Lennox Browne to whom I wrote for his views on some points connected with the operative treatment. The letter was unfortunately not received until after my paper was read at the Association Meeting.

"My view on the treatment of hypertrophy of the faucial tonsils are, I think, clearly set forth in the fifty edition of my systematic work, "The Throat and Nose and their Diseases," published in 1899.

"But I have pleasure in definitely answering your several questions.

"1. *Tonsil Guillotine.* The tonsillotome I employ is a modification by Liston of that known as Physick's but in the present day incorrectly named Mackenzie's. This modification consists in the blades of the cutting knife being two-edged to an angle instead of semi-circular. The point of the two-bladed knife seems to better catch the tonsils as it is projected through the ring and prevents any chance of the blade slipping over as it is sometimes apt to do when the tonsil being large and flat is not strangulated as it were by the ring; and by the way it is always better to have a tonsillotome with the ring rather under the size as the gland is in that case better forced through the opening and a fuller amount removed. For it may be stated as an axiom, that in tonsillotomy, the operation may fail through not removing enough but never from removing too much.

"2. *The Cold Snare.* I think you have seen the cold snare employed at the hospital; it is excellent for very large tonsils where hæmorrhage is likely to occur, and is even worthy of more frequent general adoption especially in advanced adults in whom the coats of the vessels are less elastic. The wire should be thick so as to crunch and not so thin as to clean cut. The only drawback is that it is not easy to employ the instrument under nitrous Oxide Gas or other forms of anaesthesia; but although the operation with it is rather long, lasting some thirty seconds, it is not really painful to the average patient if cocaine

has been employed; and again by the way, in all cutting operations when I use cocaine, I dissolve that drug in a tincture of Witch Hazel which lessens the possibility of secondary hæmorrhage on reaction from the cocainization.

"3. *Heated Snare.* I never employ the heated snare for enlarged tonsils. It is more painful than the guillotine at the time, more painful afterwards, and possesses no advantage whatever over other methods. I do not suppose you ever saw it employed at our hospital.

"Under this head I include (5) galvano-cautery, for I confess to having hardly heard of the thermal cautery being employed much less recommended.

"4. *Punch Forceps.* The punch forceps are useful for small tonsils, especially when these are the subject of chronic lacunar inflammation or of leptothrix. In the latter case I always make an after application of Lactic Acid, 60 per cent.

"6. *Tonsil Slitting.* I rarely find this necessary, but little encysted (cold) abscesses of the tonsil, occasionally to be seen, should be freely laid open and touched with chronic acid, or lactic acid, on the end of a cotton wool probe after scraping. My tonsil knife with the limited cutting edge of an inch at one end and sharp spoon at the other is a useful instrument for this purpose.

"I have said nothing as to profuse or secondary hæmorrhage after tonsillotomy. It has been very rare in my hands, but should it occur I would recommend a course suggested to me by Dr. Macintyre (of Glasgow) and described in my book, viz., to pass a needle with a long whip-cord ligature through the anterior faucial pillar, the stump of the tonsil, and the posterior pillar, the two ends are then to be tied and cut off short.

"Regarding this point of hæmorrhage I think a frequent cause thereof is the wounding of the pillars, which very liable when a scalpel is used, and is effectually guarded against if the hint as to the size of the guillotine ring in proportion to that of the tonsil is observed, and on this ground alone the advantage of the tonsil guillotine over the old tonsil knife is emphatically demonstrated."

"For the same reason of inflicting wounds leading to hæmorrhage I deprecate the employment of forks sometimes to be seen in the lists of French manufacturers but I hope now-a-days only in museums of antiquities."

Mansfield Street, London W., May, 1902.

Since writing this letter, Mr. Lennox Browne has died, and laryngology has lost one of its most brilliant workers.

SOME NOTES ON EXAMINATIONS FOR LIFE ASSURANCE.*

By JOHN L. DAVISON, B.A., M.D., C.M., M.R.C.S. Eng.

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OUR worthy President asked me to make a few informal remarks on the examination of applicants for life assurance; thinking my experience during the past five years may enable me to say a few words that will be helpful to the profession in their daily work as life assurance examiners.

The importance of examinations for life assurance to the profession will be apparent to you when I tell you, that in Canada in 1901, no less a sum than \$170,000 was paid as medical fees for examinations, while in the United States the sum was over three and a half millions. Again, let me state that so great a hold has the principle of small and steady savings, as expressed in life assurance, taken upon the public that many medical colleges in the United States have seen the necessity of adding to their curriculum a course on medical examinations for life assurance. I have no doubt the same will before long obtain in Canada, and then our young men will go out better prepared to work this department of the field of labor.

I spoke a moment ago of the importance of this field of labor from a financial standpoint. We medical directors at the head office know that there is often delay and some worry connected with the work, but the pay is certain, the issue of life and death is left out, and for various other reasons, the work is not so harassing or arduous as ordinary medical practice.

The importance of careful work is even greater in another direction; I mean the protection of the companies and, through them eventually, of the public. May I make this assertion? I believe that if every examination was conducted in the best and most scientific manner possible, with the status of medical science as it to-day is, and the full information placed in the hands of the head office, life assurance would be about one-third cheaper than it now is.

Competition in life assurance, as in all other walks of life, except in the practice of medicine, is now so keen that rates are at the very lowest possible figure, while the cost of obtaining business has greatly increased within the past two or three decades. So that the business done now does not make anything like the same showing in profits to the shareholders or policyholders that it did twenty-five years ago.

* Read before the Ontario Medical Association, June 4th, 1902.

The perfunctory manner in which examinations are sometimes made does not reflect credit upon the profession. Instances frequently crop up of absolute carelessness on the part of examiners. Happily, I may say that the great bulk of examiners recognize their moral responsibility, and do their best to place the necessary information before the company. I have myself been examined for assurance more than once in such a way as to assure me that the officer could not have detected even a gross and very evident lesion of the heart, lungs, or kidneys.

Let me take up now a few of what seem the most startling and easily avoidable errors.

Examination through the clothing: this cannot be done. With the definite technique of modern physical examination the heart and lungs cannot be examined properly except next the skin. Even the thinnest and most tightly fitting under-vest interferes to some extent with proper examination. Would any one of you, supposing you feared a lesion in your own heart or lungs, think that your doctor had done his whole duty if he had not examined you carefully next the skin. What would be your opinion of his honesty, or scientific knowledge, or trustworthiness, if, as I have seen done in examinations for life assurance, he had put a stethoscope, or his ear outside an overcoat, or outside a vest, or outside a starched shirt. Why, then, should the examiner be so careless when a contract involving, it may be, tens of thousands of dollars depends upon his report of the applicant's heart or lungs?

The most dangerous heart murmur is not always the loudest; indeed, I think the reverse is the rule. The loudest wheezing or sonorous rale of a bronchitis or asthma is innocuous compared with the earlier manifestations of pulmonary tuberculosis; the one might be heard through a coat or vest, the other assuredly could not.

Then, again, the naked torso often reveals many signs of great importance in regard to the question of long life. The general appearance of premature old age, as shown by the condition of the skin and tissues, the visible pulsations of the brachial, axillary, or subclavian arteries, suggestive of arterio-sclerosis, the most deadly of pathological changes in the blood vessels, the *caput medusæ* strongly significant of liver trouble, the enlarged abdominal veins, the diffuse, displaced or heaving or flapping impulse of the heart, the presence of herniæ of various kinds, the scaphoid unsymmetrical chest, imperfect expansion, alar scapulæ, *et al, ad infinitum, et ad nauseam*, give valuable evidence of an impaired constitution, or of a likely early death.

You may say all this is unnecessary to speak of, and you may absolutely believe what you say, but I know that many examinations

are made in such a way that none of the things I have mentioned would be discovered, and, therefore, would not be reported to the medical referee at the head office.

A case in point: Mr. A. B. was reported to me as an A. 1 risk. The report was passed on, but fortunately the policy was not issued before I was asked to examine the man for further insurance. What did I find? First, double inguinal hernia, none reported; second, marked degeneration of the blood vessels as shown by visible, tortuous, pulsating, hardened and thickened arteries in different parts of all four limbs. Third, a liver in the first stage of cirrhosis, enlarged, tender, etc. Fourth, enlarged abdominal veins, plainly marked. Fifth, a hypertrophied left ventricle, with accentuated aortic second sound. This was very natural after the findings in the blood vessels. Now, that examiner had not seen any of the above signs, and why? because he had not looked for them, had not stripped the applicant, had not, in fact, examined him, but had merely written answers to the questions proposed, and by reason of his great carelessness had answered the most important of them absolutely incorrectly.

As to this stripping, the patient may say "Oh, bother," or may demur more strongly and may insist that Dr. Blank did not strip him when he was examined for Blank Company, but if you show him the necessity for doing as you ask he will assuredly respect you more than he would had you made a slipshod, or prefatory, and superficial examination. If he sees that you, who are the custodian of the company's interests, deal loosely with that company, how will he expect you to deal with him in a case of illness

Remember, also, that your position is exactly the reverse in examining for assurance to what it is in your ordinary daily practice. A patient does not often minimise either personal or family weaknesses, if he come of his own accord to consult you and hopes to obtain relief. But, what memories the applicants for life insurance have! The marvellous lapses of memory shown by them should be given no milder name than lying. If they want a policy many applicants will take hurdles just as fast as you put them at them. Have any of you ever known an applicant to answer that he was a hard drinker? I have not, but I have rejected many cases for known alcoholic intemperance. Twenty or thirty drinks a day dwindle down to "an occasional drink." Attacks of pleurisy or pneumonia are given as "colds," Childbirth, over-work, broken heart, female disease, malaria, *et al*, take the place of tuberculosis. Previous rejections are forgotten, and "No" promptly answered to the question, the applicant not knowing that for mutual protection and for the prevention of fraud in this regard the main in-

insurance companies of the world have a system by which a rejection is registered and information regarding such rejection is at the disposal of all other companies. These few instances will show you the mental attitude of the applicant, and you should be on your guard to meet and ferret out all equivocal answers and give the company the fullest information possible.

The use of alcoholic stimulants : May I give a word of warning in regard to the use of alcohol. Fortunately the drink habit, especially in this country, is gradually growing less, but withal, the number of deaths annually attributable to alcohol is greater than any statistics can show, as is well known to all physicians. Directly, or indirectly, it is doubtless responsible for nearly as many deaths as that scourge, "The White Plague"—tuberculosis. So that the duty of the examiner is to probe carefully to find if there be any dead bone in this direction. It may not always be politic, or even desirable, to put all you know upon the open report, but the head office should know all you know, regarding the habits of each applicant for life assurance. This subject could be enlarged upon indefinitely ; suffice it to say that if there be one subject upon which the head office wishes to be correctly informed it is upon this one.

Just one or two points : state the average amount taken. Answers may be "very seldom," "occasionally," "now and then," "when he feels like it," "no habit," "not for three months," etc. These are vague and unsatisfactory answers. A social drunkard may meet twenty friends a day : he may feel like it every two or three hours or less. "Not for three months" may mean the interval between sprees. "No habit" may mean that he doesn't go to bed on his hands and knees four times a week, etc.

The worst form of drunkard is the "lone" drunkard, or "sneak" drunkard, so well described by Kipling in his "Plain Tales from the Hills"; who, unsuspected for years by anyone except, perhaps, his wife, as Green says, takes a bottle into his room and drinks himself into insensibility. Then, there is the man who drinks on an empty stomach ; this is deadly. No need to speak to a body of men such as are before me on the baneful influence of such stimulation upon the gastric mucosa, liver, heart and blood vessels.

The Gold Cure : Insurance companies look with great suspicion upon reformed drunkards. Time and family history would be factors in determining what form of policy, if any, could be issued. If there was any taint of alcoholism in the family, rejection would be certain.

Beer and spirits: There is not much difference as to the deleterious effect of beer and spirits, provided the quantity taken be excessive; each producing its own evils in its own particular way. I would say that in this country, considering climate, race, temperament, the strenuous life, etc., the man who stimulates regularly two or three times a day is an impaired life. He would be better with much less, and in the overwhelming majority of cases with none at all. To sum up in a word: indulgence in alcohol tends to shorten life.

Arterial sclerosis, apoplexy, paralysis and chronic Bright's. The whole period might be profitably spent in the discussion of any one of these, but as they are first or second cousins we may group them. I mentioned the quartet to call your attention to the question of heredity in regard to them. It is accepted as a principle that the conditions which lead to arterial sclerosis may be transmitted, and the evidence of it runs in families as long life runs in certain families, or as paralysis, apoplexies, heart failures, and aneurysms run in other families. Huchard speaks of hereditary aortism. Aside from accidents, life is usually terminated by this slow process of arterial sclerosis (Whittaker), so that the group must be looked upon from a life assurance standpoint as having a strong element of heredity, and therefore the family history in this direction is of great importance. So careful search should be made as to the appearance of diseases due to arterial degeneration in the forbears of the applicant. The old saying of Oliver Wendell Holmes that we should be very careful in the selection of our ancestors is worthy of being placed among the notable sayings of the world. Osler's happy expression "Vital Rubber," as applied to the amount and quality of elastic tissue one has in his arteries, will, I think, live forever.

Let me note that the question has been argued as to whether chronic Bright's, that *bête noir* of life insurance companies, is not primarily a disease of the arteries.

I have but glanced at these questions in order to show how the head office is obliged to look upon the question of heredity, a word of awful meaning to millions. Maudsley has put it well. He says, "There is a destiny made for a man by his ancestors, and no one can elude, were he able to attempt it, the tyranny of his organization." In a history of prostitution to which I have had access, a most interesting work I may say, I found the following:—Frau Jurke was a chronic drunkard, born in 1740, died in 1800. She had 834 descendants, of whom 709 were traced. Of the 709, 106 were illegitimate, 142 beggars, 64 were charges to the State, 181 females were prostitutes, 69 were committed for crime, and in all the descendants of this one drunkard cost the state in a

period of 75 years the sum of \$1,250,000. "It had been better that a millstone, etc." Can a man escape from being born to have black hair, or to be six feet high, or to have an ear for music, while his neighbor has blonde hair, is five feet six and has an ear which is as leather, so far as the procession of musical sound is concerned? How much more, then, can he escape the inheritance of lack of vital rubber in his arteries, psychical stigmata, such as a tendency to alcoholic excess, insanity, chorea or criminal impulse.

So, we have the question of family age coming in. The applicant may be well-nourished, rosy, happy looking and to the unskilled eye of the agent a most excellent risk, but the earmarks of early death are upon him, the visible temporal or radial arteries showing sclerotic changes, in the puffy under lower lid, in the overfull capillaries, in the high-tension pulse, in the hypertrophied left ventricle with its accentuated second aortic sound, while the urinary examination shows low specific gravity, large quantity with or without small amount of albumen or casts. The man was born to this probably, or he may have to a great extent acquired it.

I mentioned the agent a moment ago. A most valuable man in life assurance is the worker in the field, but he is human. He is not a physician and cannot see inherent marks of weakness and short life, cannot appreciate the meaning of such matters as we have just been considering, and, above all, he wants his client to pass.

May I say here that the most disagreeable part of a medical director's duties at the head office is the eternal warfare which he must wage with certain agents for new appointments. At least, it is so to me. It is a pleasure and a relief to initial a death claim compared to getting into a discussion with an agent on multiple appointments, etc. Let me say, also, that I believe all companies support the medical officers to the utmost. I know ours does, and discourages multiple appointments even at a loss of immediate business.

There are very many other points which I would like to discuss but time forces me to close. Just one or two remarks in brief:

(1) Write private letters to the medical director at the home office, giving any information which will be of service. Such letters are greatly appreciated and are held strictly confidential. You may not wish to put everything you know upon the open report; indeed, it would often be impolitic and undesirable to do so, but the General Post Office is always at your service. Do it at once so that the policy may not be issued before your information is available.

(2) Do not rate an applicant first-class if he has a bad family history. I have spoken of heredity largely to this end. When rating the applicants second or third give reasons, even such reasons as general appearance of weakness, or want of endurance will be of service in aiding the head office to determine what form of policy may be issued. It prejudices the head office against the applicant if the medical officer rates him first, when family history, under-weight, habits, or any other reason show him to be really a second or third class life.

(3) Be careful to give details of previous illness. For example, A. B. was reported to me as ill six months ago. No details were given. Correspondence ensued, and it was found that A. B. had suffered from appendicitis six months ago and no operation. This want of care in giving details of necessary information brings about correspondence, which is irksome both to head office, though they have typewriters at hand, and to the medical officer, who must see that he has been careless in his report.

(4) Tuberculosis: The pendulum of popular and professional opinion has swung too far out on the side of infection in tuberculosis. Heredity is an important, a very important factor in this disease. State very carefully family history, as showing heredity. As to infection, state when the relative had the disease, whether the applicant lived in the same house, whether he or she was exposed by constant attention upon or contact with the sufferer. In case a husband or wife, when they began to occupy separate rooms, and all points which will enable the medical director at the head office to decide as to the danger from infection in any given case.

(5) Syphilis: Life Assurance Companies invariably reject syphilitics. My own impression is that they are never safe lives. Even with the most careful treatment, the disease is liable to show itself in after years.

(6) A work recently published by P. Blakiston & Co., by Charles Lyman Greene, of St. Paul, on the Medical Examinations for Life Assurance, is invaluable to any man who makes even one examination a year.

SIR FREDERICK BORDEN HONORED.

THE council of the College of Physicians and Surgeons of Ontario has conferred the College License, *honoris causa*, upon Sir Frederick Borden, M.D., Minister of Militia for Canada.

CURRENT MEDICAL LITERATURE.

Conducted by A. J. MacKENZIE, B.A., M.B.

BACKACHE IN WOMEN.

IN the "*Medical Times and Hospital Gazette*," November 15th, Bedford Fenwick states that there are four principal causes for this very common condition in women, viz. :

(1). Displacement of the uterus, most commonly retroflexion, and especially if this be associated with enlargement of the organ, either from sub-involution or from the presence of a new growth, and that the direct cause of the pain is due to the dragging on the uterine ligaments, which, in cases of prolapsus of an enlarged organ, must be more or less considerable. The utero-sacral bands extend from the bodies of the second and third sacral vertebræ, and thus the constant dragging causes this pain. The treatment is replacing the uterus and keeping it in its normal position. This the writer does with success in many cases by the use of the Hodge or Zwanske pessary.

(2). Pressure on the sacral nerves, due very frequently to constipation. For this the treatment has been very frequently outlined. Fenwick proposes the following :

Ferri Phosph gr. 2
Extr. Belladonn gr. $\frac{1}{4}$
Extr. Nux Vom gr. $\frac{1}{4}$
Extr. Cascar. Sagrad gr. 2
M. pro pil. i ; ter die post cib. sumend.

(3). Muscular atony. The pain is felt in the lumbar and dorsal regions; generally found in anæmic persons of sedentary habits. The treatment is the ordinary systematic routine, with gymnastics, massage and electricity for the local condition.

(4). Affection of the cervix uteri, especially its dilatation by some new growth, the pains bearing an analogy to those of the first stage of labor. The treatment is surgical.

THE HEART IN PNEUMONIA.

IN the *Post Graduate*, November, Wainwright calls attention to some of the effects of pneumonia on the heart. It is the right side that is of importance, the changes being analagous to those found in the left side in other conditions. At autopsy the right cavity of the heart is found dilated and in it a firm clot, usually organized. In no other

disease is this found. The right heart has to contend with a congested area, de-oxygenized blood, solidified lung tissue and emphysema. Defective conditions of the right side predispose to pneumonia. In dilatation the backward pressure leads to stasis and suppression of secretions in the portal area, and we get diagnosis of typhoid, etc. The accentuated pulmonic second sound is the guide for the administration of stimulants, it is a confession of failure of the heart, and the call for aid. Do not wait for a feeble first sound and rapid weak pulse, or it may be too late. Combine heart stimulants with vaso-dilators, digitales, strychnia and alcohol with mercury, the nitrites, belladonna, etc.

BACTERIOLOGY OF THE BLOOD.

IN the Australasian *Medical Gazette*, for October 20th, Dr. Stacey, Pathologist of the Sydney Hospital, reports the results of the examination of a number of cases to determine the bacteria present in the blood in various forms of infection. He summarizes his results as follows;

PNEUMONIA.—Of 17 cases examined pneumococci were found in seven, and in three only of these before death. In the other four the blood was not examined during life; possibly, if it had been, the organisms would have been found. Of the three cases in which it was found during life, six hours was the longest period before death ensued. Its presence is thus inconsistent with very many hours of life. The blood was examined in several very bad cases which eventually recovered, no organisms being found, so that their presence or absence is of some prognostic value; but, all the same, a great many cases of pneumonia die without becoming septicæmic. In one fatal case recorded in the table pneumococci were present in the blood and in the pus of the sphenoidal sinus, but there was no evidence of pneumonia.

ACUTE INFECTIVE PERIOSTITIS AND OSTEOMYELITIS.—In the three cases recorded, staphylococcus aureus was present in pure culture in the blood and in the pus of all the abscesses. In one case it was not present very early in the illness, but appeared later. This patient lived about five weeks; the other two died within a week.

CELLULITIS.—Of this, six cases were examined and organisms found in every case. In three, the staphylococcus aureus; in one, streptococcus; in one, staphylococcus albus (? streptococcus; see introductory remarks); and in the other one, the staphylococcus aureus during life, but when examined after death streptococcus and staphylococcus albus. All were fatal, the staphylococcus aureus killing quite as rapidly as the streptococcus.

DIPHTHERIA.—In the fatal case examined there was a mixed infection of the throat, viz:—Klebs-Loeffler and staphylococcus, but the blood was devoid of organisms.

EPIDEMIC CEREBRO-SPINAL MENINGITIS.—Only one case examined; no organisms were present.

ENTERIC FEVER.—Two cases examined and in both typhoid bacilli were present. In one case the patient died, seven days after they were found, of septic peritonitis following perforation. The other case (at time of writing, 22 days after) is still alive and thought to be recovering; so that their presence in the blood does not necessarily mean a fatal issue.

PUERPERAL SEPTICÆMIA.—Of the three cases recorded only one was purely septicæmic, the other two developing abscesses in other parts of the body, thus being pyæmic as well. In one the streptococcus was found. In the other two, staphylococcus albus (? streptococcus; see introductory notes). The patients lived on an average several weeks after becoming infected; they invariably become intensely anæmic.

PYÆMIA.—Two cases recorded, one following upon lateral sinus supuration, and the other puerperal. The blood was sterile in each case; it must at one time earlier in the illness have contained organisms, as shown by the presence of abscesses scattered throughout the body.

PLAGUE · No specific cases mentioned in the table, but a dozen or more patients were examined, plague bacilli being found in several; these (as is always the case) proved fatal. Many cases, die, however, without becoming septicæmic.

TREATMENT OF RENAL LITHIASIS.

IN the "*Bulletin Général de Thérapeutique*" Oct. 30th, this subject is treated by Robin under three headings.

- (1) Treatment of nephritic colic.
- (2) Treatment of renal lithiasis properly so-called.
- (3) Treatment of the diathesis.

(1) For the first, the indication is first to calm the pain, and in order that the sufferer may have a mixture on hand for this purpose the following is prescribed :

Bromide of Potassum.....	6 gr.
Cherry laurel water.....	10 m.
Syrup of Etier.....	20 m.
Chlorhydrate of Morphine.....	1-20 gr.
Hydrolat of Valerian.....	120 m.

To assist expulsion diuretics are given, the vegetable diuretics being chosen.

(2) Treatment of the lithiasis.

The waters of various springs are to be drunk either at these places or at home. The writer discusses the virtues of various sources, and warns against such as by their power of rendering the urine alkaline, tend to cause deposits of phosphates which enlarge the calculi.

The indications are :—

(a) The water should be well tolerated by the stomach and cause no malaise.

(b) The patient should void in the urine, within two hours, the greater part of the water ingested.

(c) It should induce the secretion and excretion of well marked red uric acid precipitate.

(d) It should induce free motions at least twice a day.

(e) The patient should drink no other water and avoid coarse or acid foods or fruits.

(3) In the treatment of the diathesis, regimen, hygiene and medicament are to be considered. The regimen should contain two parts of vegetable food for one of meat or eggs ; red meats, veal or lamb, alcohol, sweets and pastries are outlawed.

Exercise must be regular, suitable and enjoyable. As medicament piperazamè and its derivatives sidonal, globularine, etc., are advised.

THE MIMICRY OF PREGNANCY BY TUMORS.

IN *American Gynecology*, November, Dr. Howard Kelly points out that the following elements enter into the cases as misleading diagnosis :

(1) The patient may be very fat, making it most difficult to palpate and percuss an abdominal enlargement with precision.

(2) The vagina may present a more or less characteristic violet discoloration.

(3) The cervix may be soft.

(4) The breasts may be enlarged, painful and may contain fluid.

(5) There may be a cessation of menstruation with more or less nausea.

(6) The linea nigra may be well defined.

(7) There may be a regular enlargement of the abdomen more or less closely corresponding to the calculated period of pregnancy.

(8) The mass may closely resemble a foetus in the abdomen presenting a head, body and limbs.

(9) The subjective sensations of pregnancy may be a prominent, and to the patient a factor decisive beyond argument, as to the existence of a pregnancy.

(10) A perfect abdominal ballottement may be present.

A diagnosis can always be made by a thorough examination which pays close attention to all the important signs of pregnancy.

First and foremost is the fact that the heart sound is always absent, and the pulsations in the tumor will not be mistaken for a foetus if the observer is careful to notice that they are synchronous with the radial pulse. This sign alone is decisive.

In the second place, even taking the list of mimicking signs given above, no one case presents them all and the omission of one or other of the usual important signs should put the observer at once on his guard. For example, it is a most suspicious fact when the menstruation has continued through the supposed pregnancy, and I find that physicians treat this sign too lightly, telling the patient that they know of a number of instances in which menstruation has continued. This contradicts my experience.

Again the presumption is strong against pregnancy when there is an unaltered hard cervix and the burden of proof rests heavily on him who assumes the contrary.

A more careful examination for ascites, as distinguished from fluid in utero, will reveal it in most cases if the area of dulness are marked out in four postures, erect, lying dorsally, and on right and left sides.

A recto-abdominal bimanual examination under a brief anesthesia of gas will always clear up the diagnosis and reveal the uterine tumors or the small uterine body with ovarian tumors.

Lastly, a better knowledge of abdominal palpation in advanced pregnancy will almost always avoid error in diagnosis.

Other factors which often help in the diagnosis of these mimicking cases are the age of the patient and the length of time the tumor is known to have existed.

The absence of the regular enlargement of the womb, or the non-occurrence of labor, running weeks or months over the calculated time.

The existence in a single woman of an intact hymen.

In all instances of error which have come under my notice the mistake would not have occurred if a thorough examination had been made, using an anesthetic if necessary, and paying attention to all the signs of pregnancy.

ANEURISM OF THE AORTA

DR. OSLER says in the *Maryland Medical Journal*. December: Aneurism of the aorta may be grouped into those that give signs and those that give symptoms. An aneurism of the intra-

pericardial portion of the aorta may give neither signs nor symptoms. An aneurism of the transverse arch usually gives both, as it is readily understood when one recalls the confined space between the manubrium and the spine. Aneurism of the terminal portion of the arch or the thoracic aorta usually gives symptoms, but no signs.

TYPHOID FEVER AND DRINKING WATER.

AS a result of investigations outlined in the *New York Medical Journal* November 29th, Leckert summarizes as follows:

(1) All rivers, creeks, brooks and lakes located in populated districts of the United States and Germany have long since become permanently infected with the typhoid bacillus.

(2) The chief carrier of typhoid germs into the human system is the drinking water of cities and towns.

(3) All cities and towns which are compelled to take their drinking water from lakes, rivers and brooks are in duty bound to clean the same by central sand filtration at the water-works.

ORTHOFORM IN THE DIAGNOSIS OF GASTRIC ULCER.

IN the *New York Medical Journal* November 29th, 1902, Murdoch states that orthoform offers a means of diagnosis of gastric ulcer from the fact that it relieves the pain due to this condition, but as it, acts only by coming in contact with a surface from which the mucous membrane is removed it does not relieve in ordinary indigestions; and so differentiates conditions whose symptoms are very similar in some cases. It may be given in eight grain doses in cachet and is practically non-toxic, while the fact that it is but slowly absorbed makes it more effective.

ICE FOLLOWING ABDOMINAL SECTION.

IN the November number of the *American Journal of Obstetrics*, Simpson advocates the use of ice applied to the abdomen to control peritonitis following abdominal section. The success following the application in cases with the typhoid signs of a well-developed general peritonitis, viz., pain, elevation of temperature, vomiting, distention, tenderness and suspension of peristalsis led the writer to use it as prophylactic measure in cases in which this complication was feared with gratifying results. A layer of ice, four inches thick, covering the abdomen from the ensiform to the pubis, was kept in position—separated from the skin by a thin gauze dressing—in some cases for four or five days.

Experiments on dogs proved that the application of ice to the abdomen was effective in lowering the temperature even deep in the pelvis as

much as four degrees centigrade; proving it possible by this means to produce at the seat of inflammation a degree of temperature which greatly retards the growth of pathogenic bacteria, and which contracts the blood and lymph channels, thus relieving the congested vessels and checking the serous weeping into the cavity, and that too without effect on the general temperature or detriment to life or tissue.

PERITONEAL TUBERCULOSIS.

IN the November number of the *American Journal of Obstetrics* Hall cites a number of cases in which peritoneal tuberculosis acquired a special interest from the similiarity of the symptoms of those of other troubles. In on case the patient, October 27, had suffered five attacks of appendicitis—so-called—in three years, each varying in length from ten days to three weeks, and leaving a thickened mass in the right iliac region which slowly disappeared. Operation revealed most extensive ravages of tuberculosis. The mass is due to agglutination of the intestines.

Other cases resemble tubo-ovarian disease or fibroids of the uterus and the diagnosis may be very difficult without operation, or again, encysted dropsy may simulate ovarian cyst. The differential diagnosis may be aided by keeping a three-hour temperature chart for a time when the destructive afternoon rise will suggest tubercular trouble, but operation, happily is indicated for either condition and at once clears up the diagnosis. The writer advises the use of the vaginal route for drainage where possible, thus avoiding the tendency to obstinate fistulous openings.

THERAPEUTICS OF SOME SKIN AFFECTIONS.

DR. W. B. BROWN, writing in the *Post Graduate* for August, has a few useful notes on some diseases of the skin.

Scabies.—The skin should be scrubbed well with soap and water and a flesh brush. The application should be applied twice a day for three days, the same clothing being worn. The ointment should then be washed off, and some bland powder applied. The treatment may require to be repeated. The following is a good ointment:

℞ Potass. Carbonat, ʒss.
Sulph. Sublim, ʒi.
Adipis, ʒiv.

℥

Sycosis Barba.—There are two forms of this disease: One is due to an ordinary pus producing organism, and the skin is acutely inflamed, there are a number of pustules, and very little induration around these. The

other form is due to the fungi of ringworm, and the condition is more limited, more sharply defined, markedly infiltrated and nodular, the pustules are firmer, the inflammation is indolent, and the fungi is found on the hairs. These may be epilated, if the process be not too painful. It should be shaved every second day, or kept close cut. In very acute cases the following may be used :

℞ Bismuth. Subnitrat. ʒii.
Acid. Salicyl. grs. xv.
Adipis, ʒi.

℥

This may be followed later by a stronger ointment such as :

℞ Ung. Hydrarg. Ox. Rub. ʒii.
Ung. Sulphur. ʒiv.
℥ Ung. Zinc. Ox. ʒii

This salve may be employed from the first in most cases. The ointment should be bound on the parts at night.

Acne.—There are the simple and indurated types. A comedone compressor may be required, the digestion should be regulated, the use of hot water on the skin should be forbidden, night and morning a simple toilet soap and cold water, green soap in indolent cases, and the following white lotion :

℞ Zinc. Sulphat.
Potass. Sulphuret.
Sulph. Precipitat. aa grs. xv to ʒi.
Aq. rosæ ʒi.

℥

Apply as often as convenient. It is not necessary to cause dermatitis, only a dryness and desquamation.

Eczema Seborrhoicum—When the scalp alone is affected the following lotion is useful :

℞ Hydrarg. Bichlor. gr. i.
Resorcin, ʒi.
Chloral Hydrat, ʒi.
Ol. Ricini, gtts x.
Spts. Vini, ʒiv.

℥

The purest resorcin must be employed, else it may discolor the hair.

In patchy or general infiltration of the scalp, an ointment is often more useful and the following gives excellent results :

℞ Resorcin, grs. xv—grs. xxv.
Sulph. Sublim. ʒi.
Adipis Benzoat. ʒi.

℥

On the nose and cheeks, employ the white lotion for acne. In lesions on the rest of the body, resorcin, in 1 per cent. to 20 per cent. in ointment is most useful.

DISEASES OF THE EYE, EAR, NOSE, AND THROAT.

Conducted by PERRY G. GOLDSMITH, M.D., Belleville,
Fellow of the British Laryngological Rhinological, and Otolological Society.

REMARKS ON CHOLESTEATOMA OF THE MIDDLE EAR.

DUNDAS GRANT, F.R.C.S., in the *Journal of Laryngology* for October, has a very instructive paper on this topic. He believes the cholesteatoma is formed in the antrum and adjacent cavities, by proliferation of the epithelium on the outer surface of the membrana tympani, over the granulations of the attic and antrum, until they are covered with a cicatrix, which may be a fair substitute for skin. Grant endeavors in his operative work to leave this membrane intact, and finds his cases do much better and get well much more rapidly. Most operators curette the walls, and remove the pearly membrane; but Grant opposes this strongly, as he looks on the cholesteatoma as a "desquamation dermatitis," the stages being the formation of a derma, lining the cavity, then the inflammation of this derma, resulting in desquamation, and the agmination of desquamation products.

A CASE OF REMOVAL OF THE EPIGLOTTIS FOR TUBERCULAR DISEASE.

R. LAKE, F.R.C.S., at the May meeting of the London Laryngological Society, and reported in the *Journal of Laryngology*, cites a very interesting case of a man, aged thirty, suffering from dysphagia. Laryngeal tuberculosis was diagnosed, and slight crepitations were found in one apex. Local treatment was adopted for two weeks, but the patient, getting worse, his epiglottis was removed with a hot snare. Three weeks later, the stump was quite healed and healthy, but the arytænoid regions were still slightly swollen, while his lungs were apparently healthy.

CONTRIBUTIONS TO THE FUNCTIONAL EXAMINATION OF DEAF MUTES IN DENMARK.

PROFESSOR SCHMIEGELOW has examined 185 pupils from deaf mute asylums in Denmark. Of these, 51 (28 per cent.) were found to be absolutely deaf, but 133 (72 per cent.) had more or less tone—
hearing power. These residua were tested by Bezold's continuous series of tones, and an interesting comparison is made between the ranges of

audition (amount of residual scale heard) of those hearing various vowels and those unable to do so. Among the 185 pupils, 19 were found to be suffering from chronic foetid, purulent otorrhoea, depending on median-otitis, with polypi and caries of the ossicles and petrous bone. of the dangers these guardians of the pupils seem to be quite ignorant. Others had occluding masses of cerumen, foreign bodies in the ear, post nasal adenoid vegetations, and various chronic, and acute affections of the nose and naso-pharynx. On the strength of these observations, he insists very strongly on the obvious necessity for the appointment of aural surgeons to all institutions for deaf mutes, and for the inspection of all pupils, or at least once a year. The reviewer of this work for the *Journal of Laryngology* says "that there appears to be a disinclination on the part of teachers of lip-reading, to allow of any interference with the inmates of deaf mute asylums on the part of aural surgeons" Continuing he says, "It is quite possible that, by treatment of the ears, and conscientious cultivation of the residuum of audition by 'Hörübungen,' some of these pupils might be enabled to acquire language through the normal channel. We trust that in time the committees of these schools will take such evidence as that of Professor Schmiegelow to heart, and institute the necessary reforms, even at the risk of breaking down some over-cherished traditions."

ELECTROLYSIS OF THE EUSTACHIAN TUBE.

PIERCE has experimented in the treatment by electrolysis for narrowing of the Eustachian tube and concludes that in otosclerotic disease it is useless, and that in the great majority of catarrhal diseases it has no advantage over other methods of treatment. Only in a few cases where there is probably a soft exudate near the isthmus, may it be regarded as of value.—*Jour. A.M.A.*

GASSERIAN GANGLION IN MIDDLE-EAR SUPPURATION.

HILGERMANN first reviews the anatomical relations and shows the paths which the suppurative inflammation may follow to reach and involve the Gasserian ganglion. Cases where infection has followed the path are rare. He reports one from Von Troeltsch and mentions one from Ostman. He also reports a case of his own observation in which the autopsy showed the Gasserian ganglion bathed in pus after acute mastoid disease, and others where meningitis was transmitted through the cavernous sinus or the cavity of Meckel, though the paths in all could not be so accurately ascertained.—*Jour. A.M.A.*

PROVINCE OF QUEBEC NEWS.

Conducted by MALCOLM MACKAY, B.A., M.D., Montreal.

THE annual meeting of the Montreal Medico-Chirurgical Society for the election of officers was held on December 19th, and the result of the ballot was as follows :

President—Dr. H. S. Birkett.

Vice-President—Dr. John A. Macdonald.

Treasurer—Dr. Alfred T. Bazin.

Secretary—Dr. A. Mackenzie Forbes.

Dr. James A. Jack was elected a Trustee to succeed Dr. G. A. Brown, who has retired.

The main business of the evening was followed by a very enjoyable smoking concert; one of the most successful ever held by the society. The committee in charge selected the best entertainers from the medical profession in the city, and well deserved the vote of thanks tendered them at the end of the programme. Among those who took part were Drs. Drummond, Harvey, Craig, Morphy, and Lauterman.

The first meeting of the new year was held in the Society's rooms on January 2nd, when the retiring officers read the reports. Dr. Armstrong, after congratulating the Society on its choice of Dr. Birkett as president, read a brief *résumé* of the work done during the past year. The members on the roll numbered 199, and the average attendance at the meetings was 45.

Besides the reading of papers, discussions and examination of living cases and pathological specimens, the society had been active in the direction of public hygiene. The milk commission in particular had done good work, and it could be said positively that the milk supply of the city had greatly improved since this work had been commenced. The Civic Hospital muddle had also been partially straightened out by the efforts of the society, and now that the Notre Dame Hospital had accepted the offer of the aldermen, and that as soon as the General Hospital could properly arrange its charter the Protestant Hospital would be provided for, it looked as if the matter would at length be settled.

In concluding he suggested that this year a special effort be made to investigate the water supply of the city. Small towns on the St. Lawrence above the in-tak^e had been growing rapidly, navigation was also

continually on the increase, with consequent increase of contamination, hence it was time that active steps were being taken to see whether the water supply was pure or not, and in case of impurities being found, to take definite action in the matter.

Dr. Bazin then read the financial statement, which showed that the exchequer was in a very flourishing condition.

Dr. Birkett made a short speech, asking for the support of all the members, and stating that he intended to begin the meetings promptly at 8.30, and consequently hoped for a more punctual appearance of those who intended to be present.

In the absence of Dr. C. F. Martin, Dr. Cantlie read a paper on 85 cases of gastric ulcer. A most interesting and complete analysis of the cases was presented, including the main features of the etiology, onset, course and result. Of the whole number, but three were males and the majority of the others were domestic servants. Pain was a very common symptom, but was not localized in more than half of the cases. Pain and haemorrhage occurred in 44 cases, pain without haemorrhage in 30, haemorrhage without pain in 5, vomiting with haemorrhage in 52, vomiting without haemorrhage in 26, haemorrhage without other vomiting in 4. In cases operated on by Dr. Bell, 7 made a good recovery, and in every case there was a general peritonitis from perforation. In the case which died a huge erosion was found in the stomach wall. One other case in the series died, on the medical side, and post mortem multiple minute points of haemorrhage were found all over the stomach wall.

The stomach tube was so seldom used that nothing definite could be said about the stomach contents.

In the discussion which followed, Dr. F. W. Campbell said that a definite diagnosis of gastric ulcer was no easy matter. He cited a case in which Drs. Osler and Geo. Ross had diagnosed gastric ulcer, while Dr. Palmer Howard had diagnosed duodenal ulcer. He himself had agreed with the former. At this time the patient could partake only of the smallest quantity of liquids without being prostrated with intense pain. Not obtaining much relief, he consulted two American specialists, who pronounced the trouble to be due to his liver. Immediately he experienced great relief and partook of hearty meals for several weeks. On returning home, and his doctors persisting in their diagnosis, he had a return of pain and died shortly, of a haemorrhage in the bowel. The post mortem revealed a large ulcer in the duodenum. How such relief from pain could come on as it did, was past his comprehension, and he would be pleased if anyone could explain it. Dr. Finley remarked that the number of males was very small, and he was sure that similar

records from the General Hospital would vary the percentage materially. At the present moment three men were in the wards with gastric ulcer. He had seen many cases in sailors, undoubtedly due to their diet and mode of life. Dr. Stewart agreed with Dr. Campbell when he mentioned the difficulty of the diagnosis, and he advised the physician always to treat the condition as if it were really a gastric ulcer. Dr. Hamilton thought that a great deal of benefit would arise from finding out the subsequent histories of the cases. He personally knew of two of those mentioned as having been operated upon several years ago, who were at present in good health and following their occupation without any discomfort.

Dr. Elder reported a case of perforation in typhoid followed by operation and recovery. The patient gave a history of feeling poorly for about two weeks when he was advised by his physician to go to bed. He had a slight fever and increase in pulse rate, loss of appetite and a few other symptoms pointing towards typhoid fever, but suddenly on the third day after he had taken to bed he was seized with severe abdominal pains, the abdomen became distended and the walls rigid, little change was seen in the pulse and temperature.

He was taken to the hospital and an operation performed. On opening the abdomen a general peritonitis was seen, and a perforation found in the usual site about a foot above the ileo-caecal valve. This was closed with silk sutures and a search was then made for further perforations, none were found, and no other ulcerated spots could be detected. After the customary toilet, drainage tubes were inserted into the abdomen and the wound partially closed. The temperature dropped almost at once and the patient made an uninterrupted recovery, without showing any rose spots or enlarged spleen and without giving the widal reaction.

Dr. Shepherd congratulated Dr. Elder on the recovery, but expressed himself as being sceptical in regard to the diagnosis. Few points went to show that the case was one of typhoid, and several were against it. Dr. Finley also doubted the diagnosis on the same ground as Dr. Shepherd. Dr. Armstrong said that a case of recovery from typhoid perforation was worth recording, the percentage of recoveries was improving and would still improve. The diagnosis was difficult but in case of doubt an operation should be performed for certainly more lives would be saved by early interference than would be lost by mistaken diagnosis, the more so as such a marked mortality was noticed after perforation had existed for more than twelve hours. Dr. Adams supported the diagnosis offered and said that too much dependence was put upon

Widal reaction at the present day, and that it was to be remembered that 5 per cent. of all cases did not give the reaction.

Dr. Elder in reply to those who questioned his diagnosis stated that the ulcer was typically typhoid in position and appearance, there were no signs of chronic inflammation to be seen or felt. He admitted that the diagnosis of typhoid was not confirmed, and expressed himself as willing to accept a better one as soon as it presented itself, but as no suggestion had been offered by anyone present he still held to the one originally made.

At the meeting of the Students Medical Society of McGill University held on January 9th, Dr. Armstrong delivered an address on the History and Origin of Medicine in relation to Students. The lecturer went back to the very beginning of medicine and named the first surgeon and accoucheur—Adam; he then took up the first instrument maker, Tubal-Cain, and proceeded to show that little was known of the medicine of the antedeluvians, but that one thing was certain, medicine became gradually less of an art and more of a science. Practical men gradually became known by their work and people flocked to them according as they showed good results. Teachers of necessity arose, and gathered about them students whose numbers varied as the fame of their instructor. Of these the greatest was Hippocrates who swept away the veil of mysticism and taught his pupils to see things as they were. Pioneers in every department appeared when once this obstacle was removed, and down to the present day there have been men who by single merit and perseverance have made one great leap forward carrying everything with them eventually, such names as Vesalius, Fallopius, Lännee Jenner, Lister and Virchow at once are suggested to our minds. There have also arisen quacks, who have arrived on the scene with many a flourish of trumpets and disappeared quietly without having advanced medicine in any department. In a college career a student is apt to make plans, these he finds must be altered from time to time to meet emergencies, but it is well to have some definite goal and to remember that you can never shoot higher than your aim. A college course is an excellent place to find out what manner of a man you are and how you compare with the majority. Possibly you excel in book learning, in keenness of perception, in original thought. Remember your strong point, make a note of the subject, this is the line in which you may hope to do the best work, make a hobby of it but don't become narrow.

The greater number of students become general practitioners. This is as it should be for this is the end and aim of a medical school. A few may have the faculty of teaching, let not this talent lie in the ground

but use it, a teacher's work is laborious and responsible, but a good teacher is a treasure to any college. If you take up special work of this sort do it well, you may work for years and see nothing ahead, but some day one of the bright lights will go out and the word will not be "who is to fill the place" but "there is the man fitted by years of work for this position." Some of you may have the high faculty of facility in research work. This indeed is a gift to be cultivated. Search out the best in other countries and then come back to work. You will find it a long and severe road with little financial remuneration, but what a field for discovery, for we are only on the boundaries of this unexplored country. We have denuded smallpox and diphtheria of half their terrors, scarletina has been dealt a severe blow, and may we not hope for greater things in the treatment of cancer and tuberculosis?

After some songs and speeches Dr. Armstrong was tendered a hearty vote of thanks and the meeting adjourned.

THE RECENT MEETING OF THE ONTARIO PROVINCIAL BOARD OF HEALTH.

ATENTION was called to the fact that sometimes medical men are required to attend infectious cases among the pauper class. The Health Act provides that payment should be made for such attendance. The local board of health can authorize payment. Steps were taken to issue instructions to barbers, with the view of preventing infectious skin diseases; and for the proper cleansing of towels, brushes, razors, etc. Dr. John A. Amyot has been at work under the Provincial Board of Health doing good service investigating the changes that take place in sewage as the result of bacterial action; and also the effects on sewage of the admixture with it of the products of manufacture and commerce. To further the great advantages to be secured from proper vaccination, the Board contemplates some useful amendments to the present act. We wish the Board every success in its efforts in this matter. Vaccination and re-vaccination is the only safeguard against smallpox.

The Copley medal has been awarded to Lord Lister. It was founded by Sir Godfrey Copley, in 1709. It is given for such research as may be deemed worthy of it.

MARITIME TOPICS AND NEWS.

Conducted by W. D. Forrest, M.D., C.M., B.Sc., M.R.C.S., Eng., Halifax.

A MEETING of the Halifax Branch of the British Medical Association was held at the Nova Scotia Hospital for the Insane, on the evening of December 10th. The members assembled at the ferry wharf, crossed over to Dartmouth and drove down to the hospital in sleighs.

Dr. Hattie and his assistants, Drs. MacKenzie and Lawlor, had a very interesting programme prepared and the meeting proved to be the most instructive so far this season.

Dr. Hattie presented a case of Katatonia. The patient was a young man of some twenty-four years of age and mentally a degenerate. He was subject to periodic states of catalepsy and was in such a state on this occasion. The rigidity of the muscles was most marked and resistance was equally strong for both flexion and extension. When placed in any position the limb remained so for an indefinite period. The muscles relaxed during sleep. The patient's extremities were cyanosed, and his salivary glands were pouring forth an unusual quantity of saliva. He also exhibited "verbigeration"—the repetition of a syllable—while speaking. Dr. Hattie pronounced the prognosis in this case as very unfavorable.

Dr. MacKenzie presented the second case.

The patient, a middle aged man, suffering from general paresis, while out for his afternoon walk, was violently assaulted by another patient, who at the time held a pipe in his right hand. After the assault a piece of the pipe, consisting of the bowl and part of the stem, was picked up—the remainder was missing. The injured man complained of nothing at the time. He had a gash just below the superior internal angle of the orbit from which slight bleeding took place. In the evening he was attacked with vomiting and suffered from intense headache. On further examination it proved that the remainder of the pipe—the mouthpiece and part of the stem—in all about $2\frac{1}{2}$ inches, was imbedded deeply in the orbit. This was with difficulty extracted with forceps. Dr. MacKenzie's opinion was that the stem had coursed along the inner wall of the orbit and had entered the sphenoidal fissure. The optic nerve must have been destroyed for he has since been totally blind in this eye. The muscles of the eye were for a time paralyzed, showing probable pressure on the nerves passing through the fissure. These muscles have since regained their power. The wound healed without suppurating.

Dr. Lawlor then showed a patient who had sustained a fracture of the right malar bone. Beyond some slight flattening there was now nothing to be seen.

The second part of the programme Dr. Hattie happily termed a "symposium" on mental diseases. He himself read a very interesting paper on "Clinical Aspects and Classification of Mental Diseases." Dr. MacKenzie's paper was on the "Therapeutics of Mental Diseases," while Dr. Lawlor discussed the "Pathology of Mental Diseases." The papers were interesting and instructive and gave evidence of careful preparation and thought on the part of the writers.

The third part of the programme was carried out in the dining room of the Hospital, where supper was served to the members. After a vote of thanks was tendered to Dr. Hattie and his colleagues, the meeting adjourned.

PERSONAL.

Dr. S. E. Shaw, of Waterville, N.S., was married on October 23rd to Miss Clara Louise Crispo, of Berwick, but late of Montreal.

The wedding took place on November 5th of Dr. M. D. McKenzie, of Parrsboro, N.S., to Miss Laura Tucker, daughter of M. L. Tucker, Esq

We regret to announce that Dr. D. H. Muir, of Truro, has been seriously ill. Latest reports, however, announce that he is improving.

Dr. M. A. O'Brien, of Noel, N. S., was recently operated upon for a strangulated inguinal hernia at the Victoria General Hospital. We are glad to say that the operation was successful.

Among the members of the recently appointed medical council for the Yukon are two young Nova Scotians, namely, Dr. McLeod, the President, and Dr. Alfred Thompson, one of the Executive.

Dr. Halliday, of Halifax, Provincial Bacteriologist for Nova Scotia, returned home in January, fully restored to health. Dr. Halliday was compelled to leave Halifax some months ago, and we are pleased to learn that the change of climate has had the desired effect. Dr. Halliday's friends in the profession will welcome his return.

We regret to have to report a very serious accident that happened to Dr. S. R. Jenkins, of Charlottetown. While operating on a septic case in the hospital, Dr. Jenkins accidentally introduced some of the material into his eye. The inflammatory process spread with such rapidity that enucleation of the eye was necessitated. We are glad to say, however, that the doctors condition is now most satisfactory, and that the other eye has happily escaped.

MEDICAL SOCIETIES.

TORONTO MEDICAL SOCIETY.

(STATED MEETING DEC. 18th, 1902.)

At the Orthopedic Hospital, the President, Dr. Hay, in the chair.

Dr. Mackenzie showed, first, an x-ray of the foot with injury to the astragalus and loss of its arch. Also a piece of bone blocking the motion of the astragalus. Second, a case of injury to the shoulder, which was more painful and tender after three months with nothing abnormal to be seen. Drs. Silverthorne, Carveth, Bryans and Webster reported similar cases of ankylosis of the shoulder. Dr. Hooper said that Cole of New York held that the pain was due to hyperextension, at the time of injury, and used the thermo-cautery. Dr. Dickson related a case treated with the static spark to develop the muscles. Dr. Price-Brown had treated a case with counter irritation.

In reply, Dr. McKenzie thought that the pseudo-ankylosis was due to spasm of the muscles. He proposed to see if ankylosis was present under an anaesthetic, if so, to break it down. Dr. McKenzie then showed some cases of club-foot. He reported thirty cases, from 16 to 46 years of age, treated without the removal of any bone or open incision. Correction was obtained by degrees and with tenotomies.

Dr. Galloway showed, first, a case of deformity of the leg, age 17 months, born with left foot deformed, and tibia bent outward and forward, also a case of a girl with correction done of both tibiae for bow leg. He said that the proper time to operate was after hope of correction was done from growth of the patient. Second, lemi-hypertrophy of the lower extremity. This case was very interesting. There was an enlargement of the hip, thigh, leg and foot to an enormous extension. In discussion Dr. Beatty said that he had seen a case in London in which the glands of the pelvis were sarcomatous with localized swellings which had been evacuated at intervals. Dr. Hunter asked had any attempt been made to control the blood supply as ligating the artery? Dr. Carveth suggested some central nerve lesion as a cause. Dr. J. McCoullough said there was some suggestion of nerve disturbance. In reply, Dr. Galloway said it is very vascular; the collateral circulation is already established. Third, shortening of the patallar ligament. This was necessary to give the proper strength to the knee joint, as the patella was situate above the joint. A

piece was taken out and kangaroo tendon used for suture. Dr. Beatty asked why the knee was extended rather than on an incline plane, also how could the patella be brought down before operation ?

Dr. Webster showed a case of web-fingers on which he had operated, Dr. Wilson, in discussing the case, said that the trouble was to prevent the growth of cicatrix in the cleft.

(STATED MEETING, JAN. 8TH, 1903.)

The President, Dr. Hay asked Dr. Hunter to take the chair while he showed a case of gun shot wound in the arm. In April last, while dragging a gun, it went off, shattering the arm at the junction of the middle and lower thirds, and injuring the bone. There was now a sinus and some discharge and considerable contracture in the flexed positions of the forearm. Dr. McKenzie said that the contracture was due to cicatricial tissue in the muscles, and the insertion of them, or the tendons, into the provisional callus thrown out. Dr. Webster said that the median nerve was involved, and accounted for some of the atrophy and loss of sensation. Dr. Ferguson said that the biceps had, he thought, taken a new fixture at the point of injury, also the triceps. From the nerve point of view, both the flexors and extensors were involved. The ulnar was partially destroyed, as were also the musculo-spiral and median. Dr. Hunter read his paper on "The Vomiting of Pregnancy". Dr. Bryan related the histories of two cases. He thought that the essayist had waited too long before interfering. Dr. Webster said that a prophylactic measure was the prohibition of the corset. Dr. Ferguson related two cases. One nullipara, the other 6para. As to causes, erosions, flexions, displacements, tubes and ovaries, etc., all failed to explain hyperemesis gravidarum. They might act as exciting causes, but the real causes must be in some excitable condition of the nervous system. The same condition was found in hysteria. The treatment was regiminal, dietetic, medicinal, and surgical, corsets could not cause this condition. Dr. Starr said that he had succeeded in a bad case by the use of 40 gr. chloral, with ʒiii of bromide of potash, given by high enema, repeated in two hours. After a sleep of 9 hours, there was complete recovery. Dr. McPhedran said that the usual dose of strychnine, as given hypodermically, was of very little moment. He had given as high as one-tenth of a grain. As a cardiac stimulant it must be given in large doses. He was quite convinced that there was no greater fallacy than that all their troubles were due to the corset. In reply, Dr. Hunter said this patient was very susceptible to strychnine, tetanic spasms being produced by one-thirtieth of a grain.

Dr. F. N. G. Starr read a paper, "A Plea for the Open Method of Treating Fractures of the Patella". Dr. Ferguson complimented Dr. Starr on his paper. He was glad that Dr. Starr had the courage of his convictions. Mr. Lane and Sir Wm. Bennett had recently been engaged in a discussion of the subject. In fractures of the patella due to tears by muscular force, it was the ideal method; but was not always necessary in those due to blows, because the lateral ligaments of the patella, might not be injured, and there might be but little separation of the fragments. Suture should not be delayed beyond one week. Dr. McKenzie asked to be allowed to digress. He then related a case of fracture of the external condyle of the humerus, with poor result, which had later been cut in upon and wired with good result. Dr. Beatty said one essential point was early treatment.

PNEUMONIA IN CHILDREN.

IN the July issue of the *Post Graduate* Floyd M. Crandall, of New York, has some comments on the above subject. He remarks that the disease in the young is often insidious in its onset, irregular in its development, uncertain in its course, and fatal in its termination. In the adult there is an exudate of red and white corpuscles into the air spaces, but very little inflammation of the bronchial mucous membrane. In the broncho-pneumonia of children there is extensive inflammation of the bronchial mucous membrane and bronchial walls, as well as the alveoli. In the pneumonia of children these differences cause a marked difference in the clinical progress of the disease in the adult and the child. In the latter, there is much risk of connective tissue increase and consolidation even for weeks or months. In some instances the disease lies midway between the two forms, and it is very difficult to recognize which group it properly belongs to. In broncho-pneumonia, or, as it is sometimes called, lobular, there may be so many lobules involved that there is a large area of dulness produced. It is the character of the disease and not the extent of dulness that should be borne in mind. During the first two years of life the disease is usually of the broncho-pneumonic type. Careful examinations can generally detect portions where there are fine rles, and more or less bronchial breathing. Lobar pneumonia in children is not usually fatal, whereas broncho-pneumonia is a disease with a high death rate.

UNIVERSITIES AND COLLEGES.

WESTERN UNIVERSITY MEDICAL DEPARTMENT.

THIS Medical College is now in its 21st session. The tickets for attendance on lectures and the degree in medicine of the Western University are recognized by the several colleges and licensing bodies in Great Britain. Last year a new and commodious building was erected for the Medical Department.

There are at present 25 professors and lecturers in charge of the various classes. From 80 to 90 students are in attendance at the College.

The following fees are charged : Matriculation, \$5 ; Registration, \$5 ; deposit against damage to property, \$5 ; Tuition each year for four years, \$90 ; Annual examinations, \$5 ; Graduation, M.D., \$25 ; Perpetual Hospital Ticket, \$20 ; Six months' Hospital, \$6. A third course is free on any subject, except where material is required, which is charged for. Material for dissection is charged for in addition to the above fees.

Medals, Prizes, and Scholarships are awarded as follows :

A gold and a silver medal will be awarded to the students of the graduating class, ranking first and second on the work of the 2nd, 3rd, and 4th years. The candidates spend one of their sessions at this College, and must obtain an aggregate of 75 per cent. on the above examinations, and must not fall below 50 per cent. on any single subject.

A scholarship of \$25 will be awarded to the student who obtains the highest aggregate marks on the examinations for each of the 1st, 2nd, and 3rd years.

Certificates of honour are awarded to students who obtain 75 per cent. of the marks on the primary and final examinations.

The two students taking first and second place in the 3rd and 4th years' examination will be nominated for hospital assistants.

Clinical instruction is given at the Victoria Hospital of 170 beds ; and the other London charities, as Mount Hope Orphan Asylum, the Protestant Orphan Home, the Convalescent Home, the Aged People's Home, St. Joseph's Hospital. Much attention is given to this aspect of the medical curriculum. Diseases of the mind are practically taught by clinics in the wards of the Asylum. This course is compulsory.

The matriculation in medicine embraces the following subjects : Arithmetic ; algebra, including simple equations ; Latin, translation and

grammar, *Cæsar Billum Gallicum*, Books I, II, or V, VI, *Cicero*, *Pro Lege Manilla*, *Virgil*, *Æneid*, Book I or II; and one of the following: Greek, *Xenophin's Unabasis*, Book I, or First Chapter *St. John's Gospel*; French, *Voltaire*, *Charles XII*, any one book; German, *Schiller's Thirty Year's War*, Book I; *Natural Philosophy*, *Stewart's Physics*.

Graduates in arts of any recognized university in His Majesty's dominions; or those who have passed the matriculation examination of the College of Physicians and Surgeons of Ontario, or Quebec; or who have passed the High School Primary, or Junior, or Senior Leaving with Latin, will be admitted without further examinations.

The medical curriculum calls for compliance with the following regulations: That the candidate has fulfilled the requirements regarding the matriculation; that he has been engaged in the study of medicine for a period of four years, attending lectures during four sessions of six months each, in some university or recognized school of medicine; that he has attended two courses of one hundred lectures on anatomy, practical anatomy, practice of medicine, surgery, theoretical chemistry, midwifery and diseases of women and children, *materia medica* and therapeutics, physiology, clinical medicine, clinical surgery; one course of fifty lectures each in medical jurisprudence, physics and practical chemistry; one course of twenty-five lectures each on toxicology, sanitary science, and surgical anatomy; one course of fifty practical demonstrations on normal and pathological histology; one course of twenty lectures each in botany and zoology, and one course on mental diseases and one on anæsthesia; that he has attended twenty-four months the practice of the Victoria Hospital, or that of a recognized hospital; that he has spent at least six months at a lying-in hospital, and had in charge six cases of labor; that he has attended one session in the College and procured the tickets on the final branches; and that he has been engaged with a practitioner or druggist at least six months, dispensing medicines.

The first year's examination covers anatomy, physiology, chemistry, *materia medica*, practical anatomy, botany, physics, zoology.

The second year, descriptive anatomy, practical anatomy, physiology, histology, general and medical chemistry, *materia medica*.

The third year, medical jurisprudence, surgical anatomy, sanitary science, general pathology, bacteriology, clinical medicine, clinical surgery, toxicology.

The fourth year, theory and practice of medicine, principles and practice of surgery, midwifery and gynæcology, clinical medicine, clinical surgery, diseases of children, therapeutics, diseases of eye, ear and throat.

Candidates must make fifty per cent. of the total marks, and also a minimum of forty per cent. on each subject.

At the end of the course the University confers the degree of M.D.

QUEEN'S UNIVERSITY MEDICAL FACULTY.

THE Medical Faculty is known as the Royal College of Physicians and Surgeons of Kingston. It is now in its 49th session. In charge of its various branches of study there is a staff of some 25 professors. There are in attendance at the College about 185 students.

The certificates of attendance are accepted by the various colleges in great Britain and the degree of M.D. from Queen's University entitles the holder to the privileges accorded to any other Colonial College.

Students receive their clinical instruction in the Kingston General Hospital, the Hotel Dieu, and at the Hospital for the Insane. The Kingston General Hospital has 200 beds.

The fees are: Matriculation, \$5; degree of M.D., \$25; degree of C.M., \$5; Diploma of Royal College of Physicians and Surgeons, \$20; Fellowship of the Royal College of Physicians and Surgeons, \$50; Sessional Fee for each of the first four years, \$100; fifth year, if taken, \$50; Supplemental Examinations each year, \$10; hospital ticket, single session, \$7; ad eundem statum, \$10.

The following prizes are open for competition:

The Dr. Hayunga prize of some standard work on surgery is awarded for the best dissection of an upper extremity.

A prize of \$25 is awarded to the student obtaining the highest marks on second year's examination on anatomy, physiology, and chemistry.

At the end of the second session a standard work on medicine, \$10 for the highest marks on materia medica is awarded by Dr. Hayunga.

At the end of the third session the Dean Fowler Scholarship, \$50 is presented to the student making the highest marks for the year.

The Chancellor's scholarship of \$70 is open to the student who takes the Ontario Medical Council examinations, and is held only if the winner takes a fifth year at Queen's, or in Europe for a like period. The marks for the four years are counted.

A University medal is given at the end of the 4th year for highest standing in medicine, clinical medicine, pathology, bacteriology, sanitary science and jurisprudence.

A medal at end of fourth year is awarded for the highest standing in surgery, clinical surgery, obstetrics, gynaecology, medical and surgical anatomy.

Three house surgeonships for the highest standing in 4th year. All previous examinations must have been passed. These are not open to the one holding the Chancellor's scholarship.

A prize of \$25 given by Dr. Clarke to the student who passes the best examination in mental diseases.

Fifth year students holding the appointments of demonstrators in materia medica and pharmacy, and physiology and histology, will be exempt from the fee of \$50.

The matriculation subjects are: English language, grammar and composition, as required for second class teachers' certificates; Arithmetic, with vulgar and decimal fractions; algebra, including simple equations; geometry, first two books of Euclid; Latin, translations from Cornelius Nepos, Caesar and Virgil, and grammar; natural philosophy, as in Stewart's physics, or Greek, French, or German as optional in place of physics. Graduates and matriculants in Arts from any recognized university, and all who have passed the matriculation examination prescribed by the Medical Council of Ontario, are not required to pass the above matriculation examination. The matriculation must have been passed, before the student will be credited with any of his professional examinations.

The professional curriculum for the degrees of M.D., C.M., or the college diploma, consists of a period of four years' study, which must comprise three winter sessions of at least six months each, and one session of eight months, after having passed the matriculation.

First Year. The subjects of study are Physics, Botany, Animal Biology, Anatomy, Physiology, Histology, Chemistry, Practical Anatomy, and Materia Medica. The subjects of examination are Botany, Animal Biology, Physiology, Theoretical Chemistry, Physics, and Materia Medica.

Second Year. The course of study is Anatomy, Physiology, Materia Medica, Therapeutics, Practical Pharmacy, Theoretical Chemistry, Practical Chemistry, Practical Anatomy, Histology, Embryology. The subjects of examination at the end of session are Anatomy, Physiology, Histology, Materia Medica, Therapeutics and Practical Pharmacy, Theoretical and Analytical Chemistry.

The Third Year studies are Practice of Medicine, Clinical Medicine, Surgery, Clinical Surgery, Obstetrics, Gynaecology and Pediatrics Jurisprudence, Pathology, Medical and Surgical Anatomy, Sanitary Science.

The subjects of examination are Medicine, Surgery, Obstetrics and Gynaecology, Pathology Jurisprudence, Medical and Surgical Anatomy, and Sanitary Science.

The Fourth Year studies are Practice of Medicine, Clinical Medicine, Surgery, Clinical Surgery, Obstetrics and Gynaecology, Medical and Surgical Anatomy, Pathology, Bacteriology, Diseases of Eye, Ear, Nose and Throat, and Mental Diseases. The examinations are on the same, except mental diseases which is optional.

The Fifth Year's course is Operative Surgery on the Cadaver, Sectional Anatomy, Clinical Medicine (including Physical Diagnosis), Ophthalmology, Mental Diseases, Clinical Surgery, Diseases of Women, Diseases of Children, Practical Pathology, and Bacteriology with special attention to the examination of urine, sputum, bile, stomach contents, etc.

All students must present certificates of having compounded medicine for a period of six months in the office of a regularly qualified medical practitioner; of having attended at least six cases of midwifery; of having reported six medical and six surgical cases; of having attended and reported on six post mortem examinations, and of having attended hospital practice for at least twenty-four months.

Graduates in Arts may complete their Medical curriculum in three years.

TORONTO WESTERN HOSPITAL NURSES.

THE following graduates from the training school for nurses of the Toronto Western have been appointed to a number of hospitals as lady superintendents or head nurses: Miss Annie Inch, lady superintendent and head nurse, Stonega Hospital, Stonega, Virginia; Miss Mabel Ireland, head nurse, eye and ear wards, Manhattan Hospital, New York; Miss Pauline Ottaway, head nurse, Aberdeen Hospital, New Glasgow, N.S., Miss Estella Gunn, lady superintendent and head nurse, Royal Alexandra Hospital, Fergus, Ont.; Mrs. Annie Jorke, lady superintendent, Orthopaedic Hospital, Toronto; Miss Vandewater, formerly lady superintendent of the Toronto Western Hospital, lady superintendent Nashville Hospital, Tennessee, and Miss Eva Boggs to be head nurse in the same.

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EDITORIAL.

THE ONTARIO MEDICAL COUNCIL CURRICULUM.

IN our last issue we had something to say on the subject of the entrance standard ; and then took the position that the Council should adopt the pass matriculation with the honor subjects in English and Latin, and suggested that of the present optional subjects, the pass Greek might be made obligatory. It was also stated that the Council could well afford to accept the first year's Arts standing in a recognized university, as this would encourage a still further general education and culture on the part of the students. We now purpose saying a few words on the professional part of the Council curriculum. In doing so, we disclaim any fault-finding spirit. On the contrary, we recognize the great services which the Medical Council has rendered to both medical education and the medical profession. In the first place, the Council holds three examinations. The primary examination is written and oral, and takes place at the end of the second winter session on the following subjects : (a) anatomy ; (b) physiology and histology ; (c) chemistry (theoretical and practical) and, (d) materia medica and pharmacy. Now, we think this is not a good division of the work. To allow the first year to pass without an examination on the work of the session is to encourage a tendency to cram in the second session.

The second examination is called the intermediate, and is held at the end of the fourth session on the following branches :—(a) medical, surgical and topographical anatomy ; (b) principles and practice of medicine ; (c) general pathology and bacteriology ; (d) surgery, other than operative ; (e) surgery, operative ; (f) midwifery, other than operative ; (g) midwifery, operative ; (h) medical jurisprudence, including toxicology and mental diseases ; (i) sanitary science ; (j) diseases of children ; (k) diseases of women ; and, (l) therapeutics. This examination, like the primary, is both written and oral. It is also open to the same criticism of leaving a year, the third session, without an examination, giving rise to careless work on the one hand and to cramming on the other. It is true, the Council requires the students to furnish a certificate of having

passed the examinations of the College they attended at the end of the first and third sessions; but this seems like delegating the Council's functions to other bodies. We are decidedly of the opinion that it would be better if the Council held annual examinations on the actual work of the session.

But there is a much more serious objection to the intermediate examination than either of the above. It embraces too many subjects. To ask a student to pass a written and oral examination upon so many branches of study, is tantamount to inviting failures. It would be much better to have the work divided, and take a certain amount each year. To ask them to carry so much work for two years is neither fair to teachers nor students.

The final examination is held at the end of the fifth session and is both clinical and oral on the following subjects: (*a*) clinical medicine, (*b*) clinical surgery, (*c*) diseases of women, and (*d*) diseases of children, medical and surgical. As things now stand, there are serious defects in this fifth session. It is intended for clinical work, and the student may put in the time at some recognized hospital, or six months with a registered practitioner, and six months at some hospital, dispensary, or laboratory. The difficulty here, however, is that the student has no legal status. He cannot legally act as a resident physician or surgeon in a hospital, nor can he legally assist the practitioner with whom he may be putting in part of the fifth year. If in any of these capacities, he does anything, and trouble arises, the question of his being an unqualified assistant is at once raised. This state of affairs renders it very difficult for the students to find opportunities for usefully putting in the fifth year on clinical work, as demanded by the council.

Now, as to the remedies for these defects. In the first place, we would urge an annual examination. In the first session, a definite amount of anatomy and physiology, and, say, theoretical chemistry, should be prescribed and examined upon. For the second session there should be the remainder of the anatomy, including medical surgical and topographical, of the physiology and histology; the practical chemistry; and the materia medica and pharmacy. By this arrangement, the students have a definite amount of work to do each session; and a definite examination to pass. They are in a better position to keep their work cleaned up as they go along, there is less chance of failure, and duplication of attendance upon the same lectures is avoided.

In the second place, the subjects included in the intermediate examination should be divided into groups for the third and fourth years. For the third session might be assigned (*a*) general pathology and bac-

teriology, (b) medical jurisprudence and toxicology, (c) sanitary science, and (d) therapeutics. For the fourth there could be (a) the principles and practice of medicine, (b) surgery, other than operative, (c) midwifery, other than operative, (d) diseases of children, and (e) diseases of women. Examinations on these subjects at the end of the third and fourth sessions would finish the thoroughly scientific and theoretical branches of the curriculum. For the final examination there would remain (a) operative surgery, (b) operative midwifery, (c) clinical medicine, and mental diseases, (d) clinical surgery, and (e) clinical diseases of women and children.

But to clear up the work of the fifth year, and make it what it was intended to be, a year of clinical study and experience, every student, who is not serving as an interne in some hospital, should be required to spend his fifth session in actual hospital work in the study of cases in the wards, in the writing of clinical histories, in attendance on autopsies, and such like practical work. This change would make the fifth year one of definite work and progress. As it is now, we fear the fifth year is too often largely wasted, and by no fault of the student, but because he has no sure guide to follow.

LORD LISTER.

JOSEPH Lister, who celebrated his jubilee a short time ago, was born on April 5th, 1827, at Upton, Essex. He received his early education at a school kept by a society of friends at Tottenham. He afterwards proceeded to University College, London, and obtained the degree of B.A. in 1874. He then spent five years in the study of medicine at University College and University College Hospital. While here he fell under the teaching and influence of Graham, the chemist, and Sharpey, the physiologist, both great men and destined to give to the world a far greater disciple. These teachers were aided in their efforts by Mr. Lister's father, who did such brilliant and original work in the perfecting of the microscope. On 9th December, 1852, he became a fellow of the Royal College of Surgeons. He served as dresser to Mr. Erichsen afterwards Sir J. E. Erichsen; and was house-surgeon under Mr., now Sir, Henry Thompson. He went to Edinburgh to take six weeks with Professor Syme; but ended by staying there for six years. He became professor of clinical surgery in the University of Glasgow in 1861, a position which he held till 1869. From 1869 to 1877 he filled the chair of clinical surgery in the University of Edinburgh, removing

in the latter year to London, to take the position of clinical surgery in King's College, London.

His great work on coagulation of the blood, on fermentation, and on antiseptics, has made his name familiar to the most obscure scientist and practitioner the world over. Nobly and long he fought on for his views and finally saw them triumph over every obstacle. Learned societies, universities, and crowned heads, have vied with each other in showering honors upon him. But the greatest of all the honors is that which suffering mankind accords, in acclaiming him the greatest of all the followers of the healing art, ancient or modern.

Every department of medicine and surgery has been the gainer, because of Lister's researches. Under his guidance, surgery advanced by leaps and bounds. It is impossible to gild gold; and words in praise of Lister seem like an attempt to burnish the precious metal. Perhaps of no man are the words of Dr. Johnson so true as of Lister: *Nihil erat quod non tetigit; nihil tetigit quod non ornavit.*

EDITORIAL NOTES.

Dr. Perry G. Goldsmith's Appointment.

We learn that Dr. Goldsmith, of Belleville, has been appointed consulting specialist on diseases of the eye, ear, nose and throat to the Deaf and Dumb Institute, Belleville. We congratulate Dr. Goldsmith, and approve of the action of the Ontario Government in this matter.

Gastric Trouble in Spinal Disease.

Sir Frederick Treves in the *Practitioner* (British) for January, has an interesting article on a number of cases in which occurred marked pain and dyspepsia, with some vomiting, resulting from various diseased conditions of the spinal column. In several cases there was Potts' disease of the vertebrae. In one there was an injury from a bullet wound. In another case there was an osteo-sarcoma. These marked conditions irritated the nerves, and set up the trouble in the stomach. The writer remarks "that suspicion may be aroused as to the genuineness of a gastric trouble when pain is the all-predominating symptom, when it is intense and persisting, and when vomiting is at the same time either absent or insignificant."

The Lorenz Sensation.

For several weeks the lay press was flooded with news about the doings and sayings of Dr. Adolph Lorenz. We do not doubt that our Austrian Confère is a skilled orthopaedic surgeon, and his visit to America may stimulate those following this branch of surgery to renewed efforts to perfect their methods, but all this could have been accomplished in a more professional manner. More good would have come of his visit if there had been less of the newspaper pyrotechnical display. A surgeon of such eminence does not stand in need of the lay reporter. The columns of the medical journals, and the medical societies are ample means of securing publicity. It does not sound well for an eminent physician or surgeon to announce to newspaper reporters that any given line of treatment is sure to effect a cure, or that the patient is on the high road to recovery, when, a few days later, another bulletin shows the very reverse to be the case. We hope the next distinguished visitor will adopt quieter methods.

The Care of Inebriates.

It is more than likely that the coming session of the Ontario Legislature will move in the direction of providing some adequate means of treating this class. The matter has been before the profession and the public for some time, and the provisions of the proposed act are pretty well understood, having been endorsed by several medical societies, hospitals, and the prisoners aid association. The main features that have been suggested are that (1) those who are not confirmed drunkards may be fined, that they are allowed out on probation under the charge of a probation officer, and that they may pay off the fine in instalments. (2) When the drunkenness has become a disease, they are to be placed under lengthened treatment, the cost of the same to be repaid after the treatment, and while still on probation. (3) Those who cannot be reformed by these means to be sent to prison on cumulative sentences; or, if feeble and old, to be sent to a poorhouse. (4) A capitation grant to be made to hospitals to aid in the treatment of these cases; and an officer to be appointed to visit hospitals and arrange for them, or to equip cottage hospitals, or provide for proper home treatment. And (5) that three physicians be appointed without salary to act in conjunction with the above medical officer.

To this last proposition we strongly protest. Why should physicians be asked to give their services for nothing for the benefit of this class, and the Province at large? They should be paid a proper per

diem fee when on duty. We hope that when the arrangements are completed, the Act will provide suitable remuneration for the members of this advisory committee. No more responsible task could be assigned to the medical profession than the carrying out of the above provisions. It will pay to secure competent advisors, and it will pay to pay them in proportion to the duties they have to perform.

The Medical Council.

Territorial representatives: J. L. Bray, M.D., Chatham, Ont., Div. No. 1; J. Mearns, M.D., Woodstock, Ont., Div. No. 2; J. Macarthur, M.D., London, Ont., Div. No. 3; J. A. Robertson, M.D., Stratford, Ont., Div. No. 4; L. Brock, M.D., Guelph, Ont., Div. No. 5; J. Henry, M.D., Orangeville, Ont., Div. No. 6; P. Stuart, M.D., Milton, Ont., Div. No. 7; S. H. Glasgow, M.D., Welland, Ont., Div. No. 8; R. Gibson, M.D., Sault Ste Marie, Ont., Div. No. 9; E. E. King, M. D., Toronto, Ont., Div. No. 10; A. A. Macdonald, M.D., Toronto, Ont., Div. No. 11; J. H. Sangster, M.D., Port Perry, Ont., Div. No. 12; S. C. Hillier, M.D., Bowmanville, Ont., Div. No. 13; T. H. Thornton, M.D., Consecon, Ont., Div. No. 14; W. Spankie, M.D., Wolfe Island, Ont., Div. No. 15; J. Lane, M.D., Malorytown, Ont., Div. No. 16; M. O. Klotz, M.D., Ottawa, Ont., Div. No. 17.

Collegiate representatives: W. Britton, M.D., Toronto, Ont., University of Toronto; not yet appointed, University of Victoria College; V. H. Moore, M.D., Brockville, Ont., University of Queen's College; A. J. Johnson, M.D., Toronto, Ont., University of Trinity College; J. Thorburn, M.D., Toronto, Ont., Toronto School of Medicine; M. Sullivan, M.D., Kingston, Ont., Royal College of Physicians and Surgeons, Kingston, J. A. Temple, M.D., Toronto, Ont., Trinity Medical College; not yet appointed, Western University, London.

Homeopathic representatives: E. T. Adams, M.D., Toronto, Ont.; Cl. T. Campbell, M.D., London, Ont.; G. Henderson, M.D., Strathroy, Ont.; L. Luton, M.D., St. Thomas, Ont.; E. A. P. Hardy, M.D., Toronto, Ont.

PERSONAL.

Dr. W. F. McKay has decided to locate at Arnprior.

Dr. and Mrs. E. W. Lambert are spending the winter in California.

Dr. J. C. R. Fitzgerald, has left Woodstock to take up his residence in St. Catharines.

Dr. R. J. Wilson, of Toronto, is recovering from his recent attack of typhoid fever.

Dr. E. J. Sanderson, of Ottawa, was married 29th of December to Miss Alma Gayfer, of Hamilton.

Dr. and Mrs. Clemens, of Toronto, were recently visiting Dr. and Mrs. McArthur, of Ottawa.

Dr. Thos. H. Mott, of Mt. Pleasant, Ont., was recently married to Miss Annie Shoemaker, of Boston.

Dr. Bruce Hewson, of Colborne, has recovered from his attack of pneumonia and is attending to his practice again.

Dr. H. J. Hassard, of Sydney, Man., was recently married to Miss Lena West, a nurse of the Toronto Western Hospital.

Dr. Farrel, of the Provincial Board of Health, recently inspected various lumber camps throughout New Ontario.

Dr. H. Wolferstan Thomas has received a faculty fellowship in pathology in McGill University.

Dr. Malcolm C. Baker, of Montreal, is steadily regaining his health, and hopes are now entertained of his recovery.

The engagement of Dr. George S. MacCarthy to Miss Audrey Blair, daughter of the minister of railways, is announced.

Dr. G. A. Charlton, has been appointed by Dr. Law, medical health officer, house surgeon in the new isolation hospital, at Ottawa.

Dr. Colbeck, of Toronto Junction, and formerly resident physician of the Toronto Western Hospital, has commenced practice in Bracebridge.

Dr. H. Irwin of Warren, Ont., is removing to Pembroke to take up his late brother's practice and expects to be there shortly.

The Board of Governors of Toronto Western Hospital acknowledge recent donations to the amount of \$1,231.

St. Michael's Hospital, Toronto, intends adding a new wing at an early date to its present accommodation.

Dr. Beck was seriously ill a short time ago, suffering from blood poisoning, the result of a slight wound sustained while performing an operation.

Dr. John R. Stone, Superintendent of the Parry Sound Hospital spent about a couple of months taking a post-graduate course, in New York.

Dr. G. N. Smillie, of Montreal, has commenced suit against the estate of the late Henry Hogan of that city for professional services to the amount of \$7,565.

Our readers will be glad to hear that Dr. Jamieson, South Grey's representative in the Ontario Legislature, has recovered from the operation for appendicitis.

Dr. J. A. Macdonald, of Brandon, attended a short time ago the convention of the American Public Health Association. Dr. Macdonald attended in the capacity of a delegate from the Manitoba Provincial Board of Health.

Dr. H. H. Oldright, of St. Catharines, and his father, Dr. William Oldright, of Toronto, spent the Christmas holidays on a short cruise amongst the West India Islands, one of which (St. Kitts) was the birth-place of the last named gentleman.

Dr. Harold L. Hunt, of London, has been appointed by a competitive examination, one of the house surgeons of the New York Polyclinic Hospital for the coming year. Dr. Hunt is a 1902 graduate of the Western Medical College.

The marriage of Dr. F. J. Nicholson, superintendent of the hospital at White Horse, to Miss Huldah Graves, daughter of Howard Graves, of Calgary, and sister-in-law of Mayor Underwood, took place at the Baptist church, Calgary, on Dec 1.

Dr. W. I. Taylor, who obtained the degrees of M. R. C. S. and L. R. C. P., London, Eng., and was subsequently appointed by the Imperial Government to the medical staff in Lagos, West Africa, was home on furlough recently, visiting his parents, Rev. G. I. Taylor and Mrs. Taylor of 269 Gerrard Street.

OBITUARY.

K. McKENZIE, M.D.

Dr. Kenneth McKenzie, of St. Johns, Nfd., died on the 24th December. He was a graduate of Dalhousie College and Edinburgh.

MRS. DR. C. K. CLARKE.

Mrs. Clarke, wife of Dr. Clark, Medical Superintendent of Rockwood Hospital for the Insane, died on Christmas night.

A. C. McDONNELL.

Dr. A. C. McDonnell, one of the leading physicians of Montreal, died recently in his 74th year. He was a graduate of Toronto University, and was for twenty years on the consulting staff of the Hotel Dieu.

C. W. HOPKINS, M.D.

Dr. C. W. Hopkins, Medical Superintendent, Montreal Maternity Hospital, died in the latter part of December of typhoid fever.

W. S. HARDING.

Dr. W. S. Harding dropped dead 12th December, 1902, about six o'clock in the dining room of the house opposite his residence.

W. B. LINDSAY, M.D.

Dr. W. B. Lindsay, L.R.C.P., London, England, died 11th December, 1902, at Strathroy, from apoplexy. Although death came unexpectedly, deceased had been in poor health for some time.

C. A. McPHAIL, M.D.

Dr. C. A. McPhail, of Summerside, P. E. Island, died suddenly on 3rd December, 1902. He retired about eleven o'clock in his usual health and shortly afterwards was stricken with apoplexy, from which he failed to rally. He was forty-two years of age and leaves a widow and two children.

DENNIS NUNAN, M.D.

Dr. Dennis Nunan, of Guelph, died 12th December, 1902. For a year or more the doctor had been in poor health. At times he was confined to his bed and suffered a great deal of pain. On the 11th a sudden change for the worse took place and the stricken gentleman was removed to the hospital. It was realized, however, that the end was near. He sank into unconsciousness and passed peacefully away. The immediate cause of his death was Bright's disease. He was 47.

A. S. FRASER, M.D.

Anson S. Fraser, M.D., one of Sarnia's most prominent citizens, died 31st December, after a lingering illness of many months. Deceased was born at London, in 1846, and was a graduate of Queen's University, Kingston. He commenced practice in Sarnia in partnership with the late Dr. Bucke, afterwards superintendent of the London Asylum for the Insane. For several years he was examiner in physiology for the Medical Council of Ontario. He was largely instrumental in the establishment of the Sarnia General Hospital in 1896, and was president of the

Hospital Board from its organization until last November, when his illness compelled his resignation. He held appointment as town physician and physician to the Sarnia Indian Reservation, and for many years was surgeon to the 27th Regiment.

A. Y. SCOTT, B. A., M. D., C. M.

Dr. Scott died at his residence, 2 Lamport Avenue, Toronto, on the morning of 3rd January, 1903. He was in his 42nd year, and was born in Stratford, Ont. At one time he was a master in Upper Canada College. Since 1890, he occupied the position of professor of botany at the Ontario College of Pharmacy. He was well and favorably known in military circles. He served with C School in the North-West Rebellion. He was Major of No. 4 Field Hospital Company of the Army Service Corps. Deceased leaves a widow and two sons, one 12 and the other 10 years of age.

It was our good fortune to have known the late Dr. Scott for many years, being fellow students together at the High School in Clinton, Huron County, Ont. From an acquaintanceship extending over twenty-seven years, we can speak in the highest terms of Dr. Scott's many qualities of head and heart. He lived up to the axiom of Ruskin that "It is better to be nobly remembered than nobly born"; and in doing so, in the words of Emerson, "He builded better than he knew; the conscious stone to beauty grew." What Stedman said of Penn can be said of Dr. Scott: "Worth, courage, honour, these indeed his sustenance and birthright were." His early death, in the full tide of usefulness, reminds us all of the lines of Anna Green:—

" Full many a vessel threads the gates of morn
 " With spreading sails and gold upon its prow,
 " That ere the eve will bend beneath the storm."

We cannot do better than close our remarks with the eulogy of Byron on the death of Lord Howe:—

" A truer, nobler, trustier heart,
 " More loving, or more loyal, never beat
 " Within a human breast."

BOOK REVIEWS.

A REFERENCE HANDBOOK.

A Reference Handbook of the Medical Science embracing the entire range of Scientific and Practical Medicine and Allied Science. By Various Writers. A new edition completely Revised and Rewritten. Edited by Albert H. Buck, M.D.; New York City. Vol. II. Illustrated by numerous Chromolithographs and seven hundred and sixty-five half-tone and wood engravings. New York, William Wood Co., 1901.

OVER eighty writers of high standing take part in the preparation of the second volume of the Reference Handbook of the Medical Science. The volume runs from "Blastoderm" to "Chloraloximes." We have taken special pains to examine this volume with very great care. The result of this perusal is to convince us that the articles have been prepared with the utmost regard to accuracy of statement, clearness of expression, and arrangement as to length. Each subject is handled by a specialist on that subject. Thus, one can turn to any article and feel confident that he will find the latest and the best teachings in it.

The illustrations are not only numerous, but they are of an altogether superior character. The engravings cover every possible object taken up in the volume, such as instruments, plants, parasites, morbid specimens, diseases, anatomy, histology, etc. The plates are object lessons in art.

The paper is of high quality, the printing clear and the binding substantial. We have no hesitation in recommending the Reference Handbook as one that will give perfect satisfaction.

THE A B C OF PHOTO-MICROGRAPHY.

A Practical Handbook for Beginners. By W. H. Walmsley. 155 Pages, 5x7, with 29 Photo Micrography by The Author. Cloth, \$1.25 Net. Tennant and Ward, New York.

THE lack of any American book dealing with this fascinating branch of photographic work, and the great need of an elementary introduction to photo-micrography, has led Mr. W. H. Walmsley to prepare this excellent manual. Mr. Walmsley is a recognized authority in the photo-micrographic world, and has had a more varied and longer experience in the field than most of his co-workers. He deals with his subject in a plain but comprehensive way, and the beginner who will study the A B C should find his difficulties vanish. The illustrations add largely to the practical value of the book and are, in themselves most interesting.

PROGRESSIVE MEDICINE.

A Quarterly Digest of Advances, Discoveries, and Improvements in the Medical and Surgical Science. Edited by H. A. Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia, etc. Assisted by H. R. M. Landis, M.D., Assistant Physician to the Out-patient Medical Department of the Jefferson Medical College Hospital. Vol. IV. December, 1902. Lea Brothers & Co., Philadelphia and New York. 1902. Price \$10.00 per annum or \$2.50 per volume.

THE contributors to this volume are Drs. W. T. Belfield, J. C. Bloodgood, John Rose Bradford, Albert P. Brubaker, Max Einhorn, Charles Harrington and E. G. Thornton. The names are sufficient guarantees of the merit of the volume. This volume takes up diseases of the digestive tract and allied organs, (the liver, pancreas and peritoneum), anaesthetics, fractures, dislocations, amputations, surgery of the extremities, orthopaedics, genito-urinary diseases, diseases of the kidneys, physiology, hygiene, and practical therapeutic referendums.

The volume is well illustrated, and, like its predecessors in the series, is handsomely bound and printed. This volume is an excellent summary of medical and surgical progress for the quarter. The entire series constitute a magnificent reference library. We can recommend this series to our readers with the utmost confidence.

THE PRINCIPLES AND PRACTICE OF GYNAECOLOGY, FOR STUDENTS AND PRACTITIONERS.

By E. C. Dudley, A.M., M.D., Professor of Gynaecology, Northwestern University Medical School; Gynaecologist to St. Luke's and Wesley Hospitals; Fellow of the American Gynaecological Association; Corresponding Member of the Societe Obstetricale et Gynecologique de Paris; Fellow of the British Gynaecological Society, Ex-President of the Chicago Gynaecological Society. Third Edition, Revised and Enlarged, with 474 Illustrations, of which 60 are in colors and 22 full-page plates in colors. Lea Brothers & Co., Philadelphia and New York, 1902. Cloth, \$5; Leather, \$6; Morocco, \$6.50 net.

IT is just four years since the first edition of this work appeared. During this period the book has been improved in many ways. It then contained 637 pages, whereas it now contains 760. The illustrations have also increased in numbers.

The main aim of the author is the elucidation of the best methods of treatment. While etiology, pathology, and diagnosis receive such attention as makes clear their importance, the larger share of the space at the author's disposal is given to the question of treatment. It is, therefore, essentially a practical work. It is announced as being designed for students and practitioners. This is no easy task to carry out satisfactorily. The text-book for the student is apt to be rather encumbered with minor detail, whereas that for the practitioner is likely to be

loaded with too many technicalities and operative procedures for the average student. In the present instance, the author has avoided both these difficulties with much skill.

That Dr. Dudley's work has found a place for itself is abundantly proven by the fact that three editions have appeared in a little less than four years. The reasons are the excellence of the illustrations and the clearness of the descriptions of various diseases and operations.

The general division of subjects is into General Principles; Infectious Inflammations and Allied Disorders; Tumors, Tubal Pregnancy, and Malformations; Traumatism; Displacements of the Uterus and other Pelvic Organs; Disorders of Menstruation and Sterility.

As it would be impossible to do more than refer to a few points the following are singled out for mention. The author prefers catgut to silk for buried sutures, and regards it as perfectly safe when properly prepared. His method is to wind the gut tightly round a glass tube, it is soaked in ether for 12 hours, it is then soaked for 24 hours in a 5 per cent. solution of formaldehyde, the tubes are placed under running water for 24 hours, they are then boiled for twenty minutes in water.

Wounds are closed by subcutaneous continuous suture of catgut. The wound is dusted with nosophen, and a layer of gauze placed over it. The edges of the gauze are fastened with collodion, but this is not applied over the wound. A quantity of absorbent cotton is put on the gauze, and this is covered by another layer of gauze, and the edges fastened by the collodion. The entire dressing is secured by strips of perforated adhesive plaster. This takes the place of the abdominal binder, frequently employed.

On the management of the peritoneal cavity in abdominal operations the author makes some valuable observations. With regard to washing out the peritoneal cavity, he states that pouring the fluid in from a pitcher is not reliable. The fluid should be carried into the remote parts of the abdominal cavity by means of a canula. Normal salt solution is the fluid best adopted for such a flushing of the cavity. With regard to drainage, he contends that it is contra-indicated in all clean operations that have not hitherto been infected. As to septic cases the author remarks that the results in a large number of drained pus-cases and an equal number of like cases not drained uniformly show a strong preponderance of recoveries in the non-drainage series. If, during the operation, pus escapes into the peritoneal cavity it should be removed at once by sponges. If the pus is sterile this is sufficient. Where there is reason to fear that the pus is virulent, the peritoneal cavity should be thoroughly flushed out with normal saline solution, leaving a consider-

able amount of the fluid in the cavity to dilute the pus, and favor its ready absorption and removal by the absorbent channels.

Where drainage must be had recourse to, he lays down the following indications for its employment: 1. General septic peritonitis. 2. The presence of a nidus of infection whence septic matter must continue to be propagated, as by an open intestine, an abscess, a cyst, an infected hæmatocele, a large amount of necrotic tissue. 3. Hæmorrhage which cannot be controlled by suture, ligature, temporary pressure, or hot sponges.

On the treatment of tubal pregnancy the author lays down the following rules: 1. The treatment before rupture or abortion occurs is that the tube and its contents should at once be removed. 2. When rupture has taken place the general rule is to operate at once, as it may be unwise to wait for reaction from the shock and hæmorrhage. 3. If rupture or abortion has occurred, and the patient has recovered from its immediate effects, and gestation has ceased with the death of the fœtus, there may be spontaneous cure, with absorption and disappearance of the products of conception. Under these favorable conditions, especially if there be continuous gradual improvement in the symptoms, one may adopt the plan of watchful expectancy. 4. If gestation has advanced beyond the fourth or fifth month, and the child is living, the removal of the fœtus, together with the placenta and gestation-sac, is practicable in only a small minority of cases, where there is a pedicle to the gestation-sac. In the vast majority of cases, beyond the fourth or fifth month, the operator must be content to incise the sac, remove the fœtus, stitch the sac to the abdominal wound, and leave the placenta, establishing drainage by gauze or tube. In two or three weeks the wound may be opened, and the placenta removed. The general plan, however, is to let the placenta disintegrate and drain away as debris.

It would be impossible to review all the chapters; but will only refer to the author's operation for anteversion and anteflexion of the uterus. The cervix is divided with scissors backward in the median line past the utero-vaginal attachment nearly to the utero-peritoneal fold in the pouch of Douglas. The incision is deepened in the uterine wall next the cervical canal, and a small angle cut out on each side to permit the walls of the wound to fold upon themselves. The cut surface on each side is now folded on itself by a single silkwormgut suture, which passes through the lower and upper ends of the cut surface. This suture is fortified by others. The cut surface is thus folded upon itself in a direction at right angles to the cervical canal. When the anterior lip is too long a considerable portion of the redundant tissue is removed, and

the wound closed by sutures that run across the direction of the cervix, so that when these sutures are tied, the line of the united wound extends from the os upwards along the anterior aspect of the cervix.

The whole work is of a most practical and helpful character. It is particularly valuable as a guide to the best methods of treatment, medical and surgical. We have no words but those of commendation for the present edition of Dr. Dudley's *Principles and Practice of Gynaecology*.

THE DISEASES OF THE NOSE, THROAT AND EAR.

By Charles Prevost Grayson, A.M., M.D., lecturer on Laryngology and Rhinology in the Medical Department of the University of Pennsylvania. Laryngologist and Otologist to the Philadelphia Hospital. Illustrated with 129 engravings and 8 plates. Colors and monochrome. Lea Bros. & Co., Philadelphia and New York. Cloth, \$3.50 net.

NOWADAYS one can scarcely take up a medical journal without finding in it something new either in treatment or in instrumental means to manage the various pathological conditions found in the upper respiratory tract. Many of these articles are written while the procedures are yet in the experimental stage while not a few would never have been written had the authors waited a little to know for themselves more of the measures they advocate. In this volume of 534 pages the author has carefully eliminated things that are too new and do not bear the stamp of experience. The book is quite conservative in its nature and of more value we think because of this. The author insists that these regions should be treated as parts of the entire system and not as structures independent of the rest of the body, thus making his therapeutics something more than an unvarying local routine of sprays, powders and pigments. The intimate association of various changes in the mucous membranes with the digestive and circulatory systems is plainly and fully shown. He asserts that a very large proportion of the affections of the nose and throat that are brought to us for treatment are associated with subacute or chronic gastro-intestinal disturbances and with the autotoxaemic state that proceeds from them. And the specialist who limits his study and practice to the boundaries of some petty gland or cavity limits also his usefulness and discredits his profession. Many practical points are brought out in the chapter on semeiology and therapeutics on the use and abuse of the various appliances ordered for the patient to use. The remarks on the galvano-cautery are particularly apt and very forcibly given. The abuse and mutilation that has been caused by the indiscriminate use of the galvano-cautery is none too plainly set forth. Regarding the frequency of its use he says, "Every practi-

oner who chose, whether he had any special knowledge of the nose and its important functions or not, provided himself with a cautery battery and considered himself amply equipped to conquer every known nasal malady. Batteries are luxuries, not necessities, and the longer one pursues his work without them the more likely and more able will he be to dispense with them entirely." The author condemns we think unnecessarily those who use solutions of cocaine in operation work in strengths of 10 or 20 per cent. Rather than employ a solution stronger than 6 or 8 per cent. he would use a general anaesthetic. Either he must use general narcosis quite frequently or his patients are particularly adept at controlling their feelings. In connection with acute rhinitis he takes the decided stand that 99 per cent. of such patients have what is called lithaemia and it is from the presence of uric acid in excess that their symptoms appear. Coryzas in those patients are therefore to be regarded as neither more or less than nasal signals of systemic poisoning. Treatment is directed to eliminate the poison and he places much more value in an hours sharp exercise than all the quinine, Dover's powder and Turkish baths that were ever prescribed.

Purulent rhinitis in children, the author says, often leads to the atrophic form of catarrh. The pathology of atrophic rhinitis is not sufficiently understood as yet to warrant such a statement. In connection with this form of rhinitis mention should be made that nasopharyngeal adenoids, foreign bodies, and even antral mischief may be the cause. The chapter on hypertrophic rhinitis is the best we think that has appeared in any of the most recent works. The intimate association of this disease with the general health is clearly shown. The connection of all vices tending to keep up the trouble and the use of various cleansing and stimulating remedies is advised before resorting to any cauterizing agent. Iodine, followed if ineffectual, by chromic acid used as a "stimulant" is given preference to the cautery. It is difficult to understand how a bead of chromic acid applied to the mucous membrane of the inferior turbinated body could be anything but a caustic yet the author uses it as a stimulant in one case and later prefers it as a cauterant to the galvano-cautery. In removing posterior turbinal hypertrophies, the author says, with a snare 20 or 30 minutes is not too long a time to allow for this purpose. Without general narcosis it will be a very well trained patient that will submit to such a long sitting. Thoroughness is the key note in the treatment of atrophic rhinitis and after reading this chapter one cannot but have a more hopeful view of this very troublesome disease. The author believes uric acid is in excess in cases of hay fever, and he begins his treatment by measures calculated to eliminate the

toxaemia. During the acute stage he strongly advises the use of a small speck of chromic acid applied to the turbinated body. This pin point application he says is of immense value and as it occasions no loss of tissue may be repeated with advantage at intervals of a few days. One is almost stunned on reading this and were the author not writing on conservative lines we would feel like thinking him a faddist on this point. Specks are of various sizes and we feel sure the author means the most infinitesimal. A nasal lesion the author says is always present though difficult to detect.

In speaking of the recurrence of polypi no mention is made of the probability of accessory sinus disease the cure of which must precede the cure of the polypi. The chapter on affections of the septum is very well written. The author states that *the past decade has witnessed a great excess of nasal surgery. The exercise in the present of a little common sense will do much to restrict it.* He is not carried away by the multitude of instruments used in septal operations preferring to be familiar with a few *useful* ones rather than knowing a little about many.

The chapter on diseases of the accessory sinuses of the nose is entirely too short. In connection with maxillary antral disease he says it is only in exceptional cases that we are compelled to resort to transillumination and perhaps to tapping in order to confirm our suspicions. To this we must take exception. If the author can satisfactorily diagnose his cases of antral disease without these means he has reached a point in diagnostic ability which we envy very much. True, in very typical cases the diagnosis may be easy, yet in a large number a *positive* diagnosis is only made by SEEING the pus come out of the natural or artificial opening. He first treats these cases through the natural opening. We think few cases are adapted to this form of treatment. No mention is made of the fact that the maxillary antrum may act as a reservoir for the frontal or ethmoidal sinus, or that ethmoidal suppuration may be kept up by other sinus mischief. The ease with which the author reaches the sphenoidal sinus and irrigates it makes us think his cases have been particularly favorable ones for this performance. The cuts of the various cavities leading into the nose are excellent. Following the removal of adenoids no mention is made of what is of very great importance from a respiratory point of view, viz: teaching the patient how to breathe through the nose. Those who have never had nasal respiration must be taught it. Frequently this is secured by supporting the chin at nights by a bandage or holding the mouth shut and forcing the child to inhale through the nose may be the only means of showing him he can. The best performed adenoid operation may be a failure by disregarding this feature of the after treat-

ment. Intra tracheal medication in disease of the larynx is very highly spoken of. A more hopeful view is taken of tubercular laryngitis than is usual by writers on this disease. In paralysis of the vocal cord from aneurism of the arch of the aorta no mention is made of the value of x-rays assisting the diagnosis. Diseases of the ear occupy 200 pages while at the end of the book are found a number of formulæ with full directions for their use. The book is one we have had great pleasure in reading and one that presents the diseases of the nose, throat and ear in a very attractive and up-to-date manner. The publishers have succeeded in getting up a handsome volume.

SAUNDERS' MEDICAL HAND-ATLASES. ATLAS AND EPI- TOME OF TRAUMATIC FRACTURES AND DISLOCATIONS.

By Professor Dr. H. Helferich, Professor of Surgery at the Royal University, Greifswald, Prussia. Edited, with additions, by Joseph C. Bloodgood, M. D., Associate in Surgery, Johns Hopkins University, Baltimore. From the fifth revised and enlarged German edition. With 216 colored illustrations on 64 lithographic plates, 190 text-cuts, and 353 pages of text. Philadelphia and London: W. B. Saunders & Co., 1902. Cloth \$3.00 net Toronto: J. A. Carveth & Co.

THIS worthy addition to Saunders' Series of Hand Atlases will be found of inestimable value in facilitating the student's introduction to the important department of fractures and dislocations, and as a ready reference book for the use of physicians in general practice. This department of medicine is one in which, from lack of practical knowledge, much harm can be done, and one which in recent years has obtained great importance. A book, accurately portraying the anatomic relations of the fractured parts, together with the diagnosis and treatment of the conditions, became an absolute necessity. The work before us fully meets all requirements. As complete a view as possible of each case has been presented, thus equipping the physician for the manifold appearances that he will meet with in practice.

The author has brought together in this work a collection of illustrations unrivalled for accuracy and clearness of portrayal of the conditions represented, showing the visible external deformity, the x-ray shadow, the anatomic preparation and the method of treatment. We have no doubt that the book will be received with the favor it demands, filling as it does so admirably, a want long felt. A perusal of this volume convinces one of the great importance of the graphic method of teaching a subject. It is both pleasant and profitable to examine these beautiful plates.

SURGICAL PRINCIPLES AND DISEASES OF THE FACE, MOUTH, AND JAWS.

A text-Book of the Surgical Principles and Surgical Diseases of the Face, Mouth, and Jaws for Dental Students. By H. Horace Grant, A. M., M. D., Professor of Surgery and of Clinical Surgery. Hospital College of Medicine; Professor of Oral Surgery, Louisville College of Dentistry, Louisville. Octavo volume of 231 pages, with 68 illustrations. Philadelphia and London: W. B. Saunders & Co., 1902. Cloth \$2.50 net. Toronto: J. A. Carveth & Co.

THIS text-book, designed for the student of dentistry, succinctly explains the principles of dental surgery applicable to all operative procedures, and also discusses such surgical lesions as are likely to require diagnosis and perhaps treatment by the dentist.

The arrangement and subject matter covers the needs of the dental student without encumbering him with any details foreign to the course of instruction usually followed in dental colleges at the present time. The work includes, moreover, such emergency procedures as not alone the dentist and physician, but also the laymen, may be called upon to perform. These, like the other subjects in the book, have been described in clear, concise language, admitting of no unequivocalness. Whenever necessary, for the better elucidation of the text, well selected illustrations have been employed. For the dental student the work will be found an invaluable text-book; and indeed, the medical beginner, also, will find its perusal of more than passing benefit.

The paper, type, and binding are a credit to the well known publisher. The work should obtain a wide sale.

A MANUAL OF BACTERIOLOGY CLINICAL AND APPLIED WITH AN APPENDIX ON BACTERIAL REMEDIES &c.

By Richard T. Hewlett, M. D., M. R. C. P., D. P. H., (Lond). Professor of General Pathology and Bacteriology, King's College London; Physician to the Seamen's Hospital, Greenwich; Lecturer on Bacteriology, London School of Tropical Medicine; formerly Bacteriologist to the Jenner Institute of Preventive Medicine, London. Second Editor. London, J. and A. Churchill, 7 Great Marlborough Street. Post 8 vo, price 12s and 6d. 1902.

THE first edition of this work appeared in 1898. Since that date, the science of bacteriology has made much progress; and we note with pleasure that the author has kept his book well up to date on all points. The unicellular organisms, known as bacteria are immortal, for the protoplasm of the parent cell divides into two daughter organisms and so on. It is on this quality that Weisman basis his theory of heredity. With-

out the presence of germs, there could be no decay, or putrefaction, and the dead remains of animal and vegetable life would encumber the earth, which would become sterile, for want of the organic matter originally derived from it. Commercially micro-organisms are of the utmost importance, as without them there would be no fermentation and the wine, beer, and indigo industries, the ripening of cheese and tobacco, and many like processes would be non-existent. In a financial aspect they play an important rôle, as many diseases of man, animals, and vegetables, are due to them. It has now been settled that without micro-organisms there can be no putrefaction.

A large portion of the work is taken up with the discussion of the various organisms which cause disease, and of the diseases that are regarded as of bacterial origin, though no organisms have as yet been discovered. The author closes the work with a very careful and instructive chapter on the bacterial remedies, the anti-toxins and the antisera, such as those for diphtheria, tuberculosis, glanders, cholera, typhoid fever, Coley's fluid, and vaccination.

The book is excellently got up. The binding, paper, press work, and illustrations are all that could be desired.

No practitioner can afford to be without a work on bacteriology, and Dr. Hewlett's is all that could be desired. We can very confidently recommend the book.

THE NURSE'S GUIDE FOR THE OPERATING ROOM.

By Nicholas Senn, M.D., Ph. D., L.L.D., C.M. Professor of Surgery, Rush Medical College, etc., etc. Published under the Direction of the Sisters of Charity, St. Joseph's Hospital, 360 Garfield Ave., Chicago. W. T. Keener & Co., Chicago, Ill. 97 Wabash Ave., Price, \$1.50.

THIS book is got up in a very attractive manner. The press-work, the illustrations, the paper, and the binding are of the very best in the book-making line. The information in the book is of the most useful kind. Full directions are laid down on the preparation of operating rooms, instruments, supplies, and sterilization. A complete inventory of the instruments, required for the principal operations, is given. A glance through the book convinces one that it ought to be in the hands of all trained nurses, especially surgical nurses. It might be read to advantage by many medical men who propose to do surgical work. It should be in the library of every training school for nurses.

MISCELLANEOUS.

"THE DOCUMENTS IN THE CASE."

WE hope that every physician who receives the somewhat graphic description of the case of Mrs. S., and notices the marked and rapid improvement in her condition as evidenced by the differential blood counts, may apply to the Palisade Manufacturing Co. for information in regard to the treatment which proved so distinctly successful in this marked case of chloro-anemia. Those who have not as yet received this unique portfolio of legal-looking documents should apply for copy at once before the supply is exhausted.

PRACTICAL IDEAS ON THE TREATMENT OF PNEUMONIA, PERICARDITIS AND TUBERCULAR PLEURISY.

EDMOND J. Melville, M.D., C.M., Bakersfield, Vt., in the *Southern Practitioner*, writes as follows: About a year and a half ago my attention was called to a new form of applying moist heat by means of a preparation called Antiphlogistine. I had discarded the poultice years before, not, however, without being aware of its therapeutical value in certain affections. Though skeptical I was desirous of finding something possessing the virtues of the poultice, minus its vices, and made a trial of Antiphlogistine in a series of cases with favorable results. After an experience of eighteen months with the product I have come to the following conclusions:

1. When a coating is applied over an inflamed area, or the skin area covering an inflammation in an internal organ, an afflux of blood takes place, thereby diminishing the pressure and arterial tension in the internal organ.
2. The tissues are relaxed and the removal of the pressure from the sensory nerve filaments relieves pain at the periphery and very often the impression is conveyed to internal organs far removed and having no anatomical connection with the part where the Antiphlogistine is applied.
3. Again, I have found that in tense, indurated swellings, one or repeated warm applications of Antiphlogistine will soften the tissues and relieve the stasis, consequently tension of the inflamed part is lessened and resolution favored or the inflammation aborted. Even in cases where the stage of suppuration has been reached, as in suppurating boils and felons, I have seen the migration and multiplication of white blood corpuscles promoted and extrusion of the purulent contents hastened.

CASE 1.—FIBRINOUS PLEURISY. Miss C. N., aged 46 ; feeble health always. Family history of rheumatism and tuberculosis. Called January 8, 1900. Patient suffering from severe chill, lancinating pain in region of right nipple extending over a surface as large as the hand. Dry cough, scant expectoration streaked with blood, dry rales, temp. following chill, 103 deg. F., pulse 120, resp. 50. Patient propped up in chair to relieve tension on pleura. Bronchial breathing ; friction rub present ; no exudate discernible. Diagnosis acute fibrinous pleurisy. Gave epsom salts, one ounce, to insure free purgation. Applied warm Antiphlogistine over the entire thoracic walls front and back. At 10 p.m. I found that the patient had had a copious evacuation. Removed Antiphlogistine and applied a fresh coat. Pain and dyspnoea were greatly relieved, temp. 101, pulse 95, and patient was able to resume the recumbent position. January 9th (9 a.m.), patient was free from pain, temp. 99, pulse 84, resp. 22. She was very comfortable. No untoward pleural symptoms. Applied Antiphlogistine daily for three days when recovery had so far progressed that further attendance was deemed unnecessary.

CASE 2.—PNEUMONIA AND PERICARDITIS. H. D., aged 60, hotel keeper, heavy eater and drinker. Contracted a well defined attack of unilateral pneumonia of left lower lobe, May 5th, 1900, severe chill, lasted over an hour. Temp. 105, pulse 104, resp. 38 ; tongue coated, foul-smelling breath, consolidation over posterior portion of left lobe. May 7th, cough and rusty sputum ; other symptoms practically unchanged. Ordered rest, liquid diet, and in short, gave usual treatment for pneumonia. May 8th (5 a.m.), patient had another severe chill and pericarditis with effusion supervened with severe pain in left axillary region. Temp. 105, pulse 140, weak and intermittent. Dislocation of heart beat to right of sternum. Dyspnoea out of all proportion to extent of effusion. Patient delirious and tossing about in great mental and physical distress. Enveloped area, well over and around the site of pain and effusion with a coating an inch thick of warm Antiphlogistine. Placed patient on as dry diet as possible and gave a capsule containing strychn. 1-20, glonoin 1-50, pilocarpine 1-10, every three hours. Changed Antiphlogistine every 8 hours for the first 48 hours, then every 24 hours for three days following. Watched symptoms closely, and under this line of treatment patient showed immediate and continuous improvement. May 10th, the symptoms had become so favourable that I considered the danger over. Pain was pretty well under control before second application began to dry. Pulse beats became slower, less intermittent and increased in volume. Temp. dropped 3 deg. in as many

days and the effusion began to disappear. Lastly and most marked of all, the dyspnoea was relieved. The epsom salts produced copious liquid discharges, the glonoin and pilocarpine produced free diuresis and diaphoresis and thus aided materially in absorbing the liquid from the lymph spaces in the pericardium. May 12th (11 a.m.), patient sat up in bed. Temp., pulse, and resp. were normal. Lungs and heart acting well. In three weeks patient was practically as well as ever.

CASE 3.—TUBERCULAR PLEURISY. Mr. R. S., aged 65. Contracted tuberculosis in spring of 1900. Saw him in June of 1900, when he was suffering with an agonizing pain in right axillary region from an aggravating pleurisy of six weeks' duration. Opiates had been given without avail and blistering, cupping and strapping gave only temporary relief. Excessive doses of morphine only partially relieved pain. Applied coating of warm Antiphlogistine to affected part and next day found patient had rested well, notwithstanding the fact no opiate had been given. Each application was peeled off at the end of 24 hours and a fresh coat applied.

The disease steadily progressed, however, and the patient succumbed in October to general tuberculosis. I report this case merely to show that Antiphlogistine's remedial value is of much consequence, even in hopeless cases, where our patients' dying hours may be soothed without blunting their reasoning faculties.

While I would not wish to say, as yet, that Antiphlogistine used often and early will abort pneumonia, pleuritis and pericarditis, I can safely say that it is the most valuable agent I have yet used to shorten these diseases.

ANAESTHESIA OF THE DRUM MEMBER.

DR. G. B. McAULIFFE, in the November, 1902, number of the *New England Medical Monthly*, recommends hydrozone for cleaning the ear and drum prior to the application of the cocain. The conditions favoring this application of cocain are: (1) The removal of foreign substances and loose scales from the drum membrane and canal. (2) Dehydration of the outer layers of the membrane—a dessication which causes molecular contraction and interstices through which the anæsthetic can reach the deeper parts and nerve terminations. (3) The induction of endosmosis. The first condition is met by the use of hydrozone which is stronger and better than any other kind of H_2O_2 preparation in softening and boiling out the debris of the canal and in lessening the resistance of the dermal layer. The hydrozone is subsequently mopped out by

cotton applicators or syringed from the canal. The second and third conditions are met by the use of alcohol and aniline oil. The latter is absorbed more slowly and its effects last longer than the former. The solutions used are 5 to 20₀/° of cocaine in equal parts of absolute alcohol and aniline oil. Anæsthesia is gained in 10-15 minutes. The disadvantage of the solution is that the aniline oil is toxic and obscures the field. The external canal is generally filled to ensure osmotic instability and certainty of penetration. The toxicity can in a great measure be prevented by not filling the canal but by applying to the drum membrane a small wad saturated with the solution and by making only one application. The obscuration of the field by the dark oil will then be less and the solution can be more easily mopped away.

LAXATIVE ANTIKAMNIA AND QUININE TABLETS.

APPRECIATING the importance of the command, "Keep the Bowels Open," The Antikamnia Chemical Company offers Laxative Antikamnia & Quinine Tablets, the laxative dose of which is one or two tablets, every two or three hours as indicated. When a cathartic is desired, administer the Laxative & Quinine Tablets as directed and follow with a saline draught the next morning, before breakfast. This will hasten peristaltic action and assist in removing, at once, the accumulated fecal matter.

GLYCO-HEROIN.

GLYCO-HEROIN (Smith) is a glycerine solution of heroin. It contains one sixteenth grain heroin to each teaspoonful, along with white pine bark, ammonium hypophosphites, balsam tolu, etc. The dose is one teaspoonful every two hours, or longer intervals, for adults. It is a valuable expectorant.

LITHIA TABLETS.

The salts of lithia have been highly esteemed by many in conditions of a gouty, lithæmic, and rheumatic character, and in cases of imperfect metabolism, where the kidneys suffer as a consequence. These waste products often give rise to serious renal trouble. The lithia water tablets prepared by Wm. R. Warner & Co., are an excellent and convenient form for administration.