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Original Communications

DIRECTIONS FOR NURSE AND HOUSE PHYSICIAN, BURNSIDE LYING-IN HOSPITAL, TORONTO.

DIRECTIONS FOR NURSE.

PATIENT ON ADMISSION.

Have the patient undressed at once, and her cast-off clothing placed in a receptacle, from which it is to be taken for fumigation.

Let her then take a warm tub-bath, after which she is to be dressed in hospital clothing.

Then make a record of her pulse, temperature, and respiration.

Take pulse and temperature morning and evening while "waiting," and record everything abnormal.

PREPARATION AFTER ONSET OF LABOR.

Give soapsuds enema.

Give warm bath.

Let patient then put on a nightgown and remain in bed until examined.

Prepare delivery room and table.

Have at hand sterile towels, gauze sponges, absorbent cotton balls, thread for cord, three basins for solutions of sterile water, mercury bichloride, and lysol or cresoline, scissors, and two clamps.

Place small portable table near bed and operator.

FURTHER PREPARATION OF EXTERNAL GENITALIA.

After patient is placed on operating table:

Put Kelly's pad under buttocks.

Cut short all hair at sides of vulva, and all hairs above long enough to reach the vulva.

Give a vaginal douche of green soapsuds at about 110 degs. F.

Scrub the lower abdomen, pubes, vulva, perineum, buttocks and thighs, using green soap; then wash with warm sterile water, then with bichloride solution.

During the scrubbing process, wash from before backwards, *i.e.*, towards the anus.

Then place a bichloride guard over the vulva.

If labor is advancing too rapidly to allow all these procedures, omit the douche, but, if possible, cut short the hairs at side of vulva, and wash vulva and adjacent parts.

Then remove the Kelly pad, and place under back, buttocks, and thighs a fresh sterilized draw-sheet, and an absorbent gauze pad under the buttocks.

In prolonged labor give a second rectal enema in twelve hours after the first.

If there is any operative interference, wash the external genitalia again, and put on the Snively stocking-drawers.

The patient's legs are then to be held or fastened with leg-straps, as directed by the operator.

Catheterize only when directed by the obstetrician, the house physician, or head nurse.

MANAGEMENT OF PATIENT AFTER LABOR.

Wash the external parts first with warm sterile water, then with bichloride solution, then cover with bichloride pad retained in place by T-bandage, or fastened to binder when applied.

Change vulvar pad as often as necessary, *i.e.*, before it becomes saturated with blood, sometimes every hour, for a few hours; after one day, every four to eight hours for a week.

When changing pads, wash the parts with a bichloride solution for seven days, and with soap-water after seven days.

Give a cathartic on the evening of the day after labor.

Note the height of the fundus uteri, and keep the daily involution line.

Prop up on pillows the head and shoulders for a few minutes, twelve hours after labor, and afterwards three times a day for seven days. Allow patient to sit up and void urine on and after second day, if she desires, unless there has been a perineorrhaphy, in which case the nurse will be instructed by the attending obstetrician. Allow her to sit up in bed on and after the fifth day, if she desires. Do not allow her to get out of bed earlier than the tenth day, and not then if the fundus is still above the pubes, unless by order of attending obstetrician.

ECLAMPSIA BEFORE, DURING, OR AFTER LABOR.

Remove false teeth, if present.

Prevent patient from injuring herself; use several pillows as buffers.

Prevent her from biting her tongue, by covering an ordinary clothes-pin or large spoon handle with gauze, and holding it between the teeth during convulsion.

Darken room if possible, and keep the patient very quiet.

If there is much blood or mucus in mouth and throat, turn patient on her side, with head in a position to allow liquids to run out of the mouth.

HEMORRHAGE BEFORE OR DURING LABOR.

Keep patient absolutely quiet; elevate the foot of the bed.

THE NEW-BORN BABE.

Weigh the baby at once, anoint with albolene, examine the cord for bleeding, the head for meningocele, etc., the back for spina bifida, etc., the limbs for talipes and other deformities, the whole body for birth-marks, etc.; notice if babe turns blue, and examine for imperforate anus.

Bathe the babe as soon as convenient, and thereafter every day; apply dry dressing with boric acid over cord, remove this dressing and apply a new one after each bath.

If babe weighs less than five pounds, anoint with albolene and wrap in flannel or cotton wool, or both, taking care to keep it very warm until ordered by the attending obstetrician to wash and dress it.

Let babe nurse every six hours during first day, every four hours during second day, and every two hours for twenty minutes during third day and thereafter, except at night, when he should nurse at half-past ten, half-past four, and in morning, half-past eight.

Take the temperature twice every day.

Weigh baby before each daily bath.

DIRECTIONS FOR HOUSE PHYSICIAN.

Examine each patient on day of admission, especially as to condition of heart, lungs, and kidneys, and also general health, and record.

If there is any nasal or vaginal discharge, have a bacteriological examination made, and record the results.

Examine by abdominal palpation for position and presenta-

tion; also make external measurements by pelvimeter; record results as to both palpation and pelvimetry.

Examine specimen of urine furnished by nurse on day after admission, and every seventh day thereafter up to time of labor, and daily if there is headache, nausea, anasarca, or any other abnormal condition.

PREPARATION OF ATTENDING OBSTETRICIAN AND RESIDENT
PHYSICIAN.

Cut the nails short; wash hands and arms in hot water, using green soap and nail-brush; cleanse well under and around nails; rinse in sterile water and then in a one-per-cent. solution of lysol or cresoline. Keep one of these solutions in a sterile basin on the small table beside the operator, and rinse hands from time to time. Put on operating-gown. The attending obstetrician may, and the intern must, wear rubber gloves in making vaginal examinations, which shall be as few as possible.

MANAGEMENT OF PATIENT IN LATTER-PART OF LABOR.

Let the patient lie on her left side during the last expulsive pains, and let her turn on her back while the child is being expelled, or immediately after its delivery.

Keep one hand on fundus, press gently or irritate slightly with finger-tips, without using force.

After separation and passage into vagina, or after thirty minutes, endeavor to express placenta by pressure on fundus.

If placenta is retained, send for attending obstetrician, but in case of emergency, such as serious hemorrhage, introduce gloved hand and extract.

In all other cases of retained placenta, place a bichloride guard over vulva, and wait until an attending obstetrician arrives, but at the same time watch for hemorrhage.

Tie cord after pulsation has nearly ceased, or in five minutes.

Examine placenta carefully, measure, and weigh.

Report all injuries and tears of the soft parts to an attending obstetrician, who shall treat or instruct as to treatment.

MANAGEMENT OF PATIENT AFTER LABOR.

See that directions for the nurses are properly carried out.

See that patient gets a cathartic on the evening of the day after labor.

Watch carefully the uterus for involution.

Keep patient in bed not less than nine full days.

DIRECTION FOR CASES OF EMERGENCY.

Eclampsia.

Use mouth-wedge at once.

Give hypodermic of morphine at once, half-grain, also another hypodermic, quarter-grain, in half an hour, and a third hypodermic in one hour if convulsions are not controlled in the meantime.

See that patient is kept very quiet, and protected from cold and drafts.

If the patient becomes conscious, give calomel, 3 grains, as soon as possible, and magnesium sulphate, 2 drachms, every half-hour.

If not effectual within two hours, order, 1, 2, 3 enema (Epsom salts 1 ounce, glycerine 2 ounces, water 3 ounces), and also continue salts by the mouth until bowels are well moved.

After bowels are evacuated, administer high enema of salt solution, one pint every hour until three pints are injected, or use colon irrigation, if directed by attending obstetrician.

Apply hot packs on kidneys.

HEMORRHAGE BEFORE OR DURING LABOR.

Keep patient absolutely quiet.

Elevate foot of bed.

Give hypodermic of morphine, quarter-grain.

Repeat hypodermic of morphine, quarter-grain, in fifteen to thirty minutes if necessary.

Give adrenalin 1-1000 solution, M. 10 by mouth or M. 5 hypodermically. If serious bleeding continues, and membranes are unruptured, plug the vagina, keep pressure over fundus uteri, and give three salt solution enemata, one pint each, at intervals of one hour.

HEMORRHAGE AFTER LABOR.

Massage fundus uteri so as to express clots.

If uterus cannot be well contracted, and hemorrhage is alarming, introduce the gloved hand into uterus, clear out clots, and irritate uterine walls with finger-tips, and massage externally.

If the uterus is well contracted, and serious hemorrhage continues, look for bleeding-points in lacerations of perineum, vulva, pelvic floor, other parts of vagina, and cervix

USE OF FORCEPS.

No house physician shall use the forceps without the permission of an attending obstetrician.

Do not apply the forceps until the cervix, vagina, vulva, and perineum are dilated and softened.

After dilatation, apply the forceps within three hours in primiparae, and within two hours in multiparae, if nature has not completed delivery.

In using traction on handle attached to traction-rods, pull intermittently, and if considerable force is required, occupy not less than twenty to thirty minutes in delivering the head, taking the time from a watch or clock.

As soon as the head commences to press on the pelvic floor, remove leg-holder and allow extension of the thighs, etc., allow legs and thighs to hang over the end of the labor-table.

THE USE OF ANESTHETICS.

No house physician shall administer an anesthetic without the permission of an attending obstetrician.

In all serious operations, and in all operations on patients in a serious condition from disease or other cause, an official anesthetist shall administer the anesthetic.

The term "attending obstetrician" refers to the individual members of the visiting Burnside staff, and to all physicians who have charge of patients in the private wards.

All obstetricians in charge of private patients are requested to observe these rules.

Examine every male child on the seventh day after birth, to ascertain the condition of the prepuce. If found adherent, "strip" the glands, and secure, if possible, a prepuce freely movable. If this cannot be done after using the prepuce-forceps, and a probe or director, report to an attending obstetrician, who shall see that circumcision is done if required.

During labor and the puerperium, record, or let nurse record, as far as possible, the following: Length of first stage, length of second stage, length of time before expulsive pressure is used over the fundus of the uterus, length of time of such pressure, total length of third stage, time of washing of vulva, time of application of abdominal binder, time of putting patient in bed, time of first weighing baby, time of first washing baby.

In forceps delivery, record when forceps are applied, when head is extracted, when body is expelled or extracted.

In all other operative procedures record length of time of operation.

REMARKS.

When Solon gave laws to the Athenians, he was asked, "Are these the best laws you can frame?" He answered, "No; but they are the best laws that the Athenians can keep."

We have endeavored to profit by Solon's wisdom, and have tried not to frame rules that are too elaborate. The tenure of office of our nurses and house physicians is very short, and the frequent changes make the training of the staff somewhat difficult. We find that a printed set of rules, which are to a large extent similar to those used in other maternities, especially in the United States, is very serviceable in many respects. We have made our rules simple, and we hope they will prove useful for our young graduates.

We have considered for several years that it is difficult or impossible to keep the Kelly pad perfectly sterile, and we use it only to a limited extent. We therefore remove the Kelly pad after preparing the patient for labor, and place under the patient a clean draw-sheet and an absorbent gauze pad.

For many years we used no vaginal douche before or after labor in normal cases. Recently, however, we commenced the administration of the antepartal douche, as was the custom years ago in the Burnside. We do not use a douche of any kind after labor, unless there is some special indication for it.

Our rule as to the vulvar pad after labor is to change it as *often as necessary*, instead of every four or six hours, as was once our custom. Our aim is to change the pad before it has become saturated with blood, *i.e.*, before the bed-clothing has become soiled. Frequently changes, sometimes every hour, are generally required during the first twenty-four hours after the completion of labor.

We administer a cathartic earlier than we did a few years ago, with benefit, we think, to our patients. The height of the fundus is noted daily, and the involution line has been carefully kept on our ordinary charts for the last six years, according to the custom of Queen Charlotte's Hospital, London, England. The head and shoulders are propped up on pillows for a few minutes three times a day, to favor free vaginal drainage.

In cleansing the hands of the obstetrician, and the genitalia and adjacent parts of the patient, we have discarded alcohol, for two reasons. Its use involves considerable expense and some inconvenience, especially for the general practitioner who does not, as a rule, carry alcohol in his obstetrical satchel. So far as our observations show, we get along as well without it.

As to antiseptics, we still use the bichloride of mercury to

a large extent. We have used lysol for some years, and are now using cresoline to a limited extent. Professor Amyot, of Toronto University, conducted a series of experiments for us last winter, and found that the germicidal powers of lysol and cresoline were strong. They are both commercial preparations, somewhat similar in nature, being saponified cresol mixtures.

In fixing a time limit after the Dublin fashion, we do not mean that in all cases the operator should wait for two or three hours after complete dilatation before applying the forceps, but we do mean that he should never wait longer.

Our chief aim in making rules as to certain time records is to secure uniformity in methods of procedure. For instance, we don't want a muscular and strenuous house physician to pull the head over the pelvic floor and through the vulva in five minutes. We don't want him to guess as to time, but use his watch, or the clock on the wall beside him, so as to know what progress he is making in a given time.—*A. H. W.*

REPORT OF A CASE OF PRIMARY CARCINOMA OF THE LIVER.

By JOHN GERALD FITZGERALD M.B. (Tor.)
The Sheppard and Enoch Pratt Hospital, Baltimore, Md.

The history of this case is rather interesting, illustrating as it does how much progress an incurable disease process may have made without exhibiting any subjective signs and, in patients of the insane class, with very little subjective feeling of discomfort.

The patient, R. R., was admitted some ten years before her death, age 45; her family history being negative, no heredity, alcohol or syphilis. Personal history: Patient has been a seamstress, always worked hard and had constantly complained of various somatic disorders, but except for a condition of chronic constipation, she was really in fair physical health. Her hypochondriacal condition, with slight affect depression, necessitated her being committed to the Buffalo State Hospital, where she remained until the time of her death. Her mental condition slowly grew worse and she finally demented.

During the entire time of her residence in the hospital she continued to complain of various ills, but careful physical examinations failed to discover any cause for her subjective expression of malaise. She ate and slept well, adapted herself to the hospital routine and led an automatic, almost vegetative, existence. In November she complained of feeling very weak and she was ordered to bed, and on examination it was noticed that she was anaemic. A few days later she became markedly jaundiced. The skin of her face became quite yellow as did also the conjunctivæ. Constipation, which had been present for some time, became more marked, and when the patient had a stool it was of a very light clay color and bile was also demonstrated in the urine. Patient later complained of pain in the right epigastric and hypochondriac regions, the abdomen became distended and there was some dullness in the flanks.

The liver did not appear to be enlarged, the edge was distinctly palpable and no nodules could be felt. There was no enlargement of the spleen. A provisional diagnosis of hepatic cancer was made at this time.

About two weeks later patient developed a pneumonia on the right side which was only discovered when there was increased rapidity of respiration and pulse rate—there was no pyrexia and only slight coughing, no complaint of any feeling of distress in the chest. Patient died two days later.

The autopsy report is as follows: Body is well nourished—markedly jaundiced throughout. Rigor mortis not well marked—no post-mortem discolorations. Right lung pleura adherent

everywhere. Pneumonia—lobar in type, of the entire lung, with the exception of a small portion at the base. Left lung—a few pleural adhesions, lung normal otherwise. Heart—muscle soft and friable, the edges of the mitral orifice slightly thickened but competent, other orifices and valves normal. Aorta normal. The abdominal cavity contained a large quantity of bile-stained fluid. Spleen pushed back out of place by the apparently enlarged left lobe of the liver. Normal on section. Stomach dilated, pylorus free, no cancer nodules anywhere. Duodenum absolutely free, no signs of carcinomatous process, remaining portions of the gut also normal. Pancreas indurated but not carcinomatous. Uterus and ovaries normal. Kidneys somewhat swollen—capsules adherent, more on the right than the left. Markings indistinct.

Liver perhaps slightly enlarged, weight $51\frac{1}{2}$ ozs., studded everywhere with yellowish, hard nodules which do not project above the surface of the organ, are about the size of an almond, have undergone no degenerative changes and merge into normal liver tissue. Anatomical diagnosis—lobar pneumonia, carcinoma of the liver (primary). Chronic interstitial nephritis.

The microscopic examination showed a thickening of the capsule and diffuse infiltration of the liver tissue by small round cells, the cancer cells were imbedded in strands of fibrous tissue, this connective tissue stroma being an accompaniment of the new growth.

The liver cells themselves showed many interesting changes—fatty degeneration, vacuolation, etc., others progressive changes, cells in various stages of mitosis. The cancer cells had invaded liver lobules in certain areas, the outline of the cells in places was very irregular owing to their being crowded aside by the neoplasm. Some liver cells contained large vacuoles, the nuclei also showed changes—a considerable number of giant forms with large masses of chromatin. The nuclei in other places were also undergoing mitosis. The increase in the amount of chromatin was also very conspicuous. The blood vessels showed very little change, some slight increase in fibroblastic tissue (this was inconspicuous)—newly formed fibroblasts and fibroblasts in various stages of mitosis being seen, but chiefly where the cancerous tissue was most in evidence.

An examination of the spleen and other organs failed to reveal any signs of a cancer growth, so by a careful process of exclusion we decided the growth was primary in the liver.

I have to thank Doctor Arthur Hurd, of the Buffalo State Hospital, for the privilege of reporting the case, and I am indebted to Dr. Joseph B. Betts for his kindness in assisting in the preparation of the material.

MEDICAL THOUGHTS, FACTS AND FANCIES.

By JAMES S. SPRAGUE, M.D., STERLING, ONTARIO.

Author of Medical Ethics, (Etc.)

“ Read not to criticize, but to accept, to consider or reject.”

I think it was Epictetus, who flourished during the first half century, A.D., who told us in good Latin the fact: “ That appearances to the mind are of four kinds. Things either are what they appear to be; or, they neither are, nor appear to be; or, they are, and do not appear to be; or, they are not, and yet appear to be. Rightly to aim in all these cases is the wise man’s task.” Dear brother, write in large letters and not to be effaced these lines on the tablets of memory, for not only will they be monitors, but will remind you of perilous and unworthy motives which, if carried to the full fruition, grief and disappointment would have marked the issue. In no other learned profession do things appear in so manifold colorings, not that we are especially susceptible to well unfounded impressions and deductions, for we have been termed, and very wisely so, *easy marks* in business relations, and if applicable, certainly thus in other and many considerations that are not necessary to name.

Complicated, yet simple, as are the lines of the great Roman, whose life is guided, yet thinks it guided, scrupulously directed by his words. Different interpretations and even contrary reasonings will arise to many who may read these words of a philosopher, and in making this assertion I do not forget that Montaigne has told us “ There is more ado in interpreting interpretations than in interpreting things, and more books upon books than upon all other subjects; we do nothing but comment one upon another.” Self-study and the study of life’s apparent riddles will help us to balance things. Observation is not all, but to experience,—and it alone to a great extent as the unerring guide, we look for the unfolding and clarifying of the mysterious, wilful, yet apparent contrarities of life’s devious courses.

Yes, appearances are deceptive at this date as when Hippocrates made the assertion. Things are not what they seem, and our regrets are, and they, no doubt, are yours, that they blur our remembrances when we reflect how easy marks we have been, and continually are, we studying the subject of things that are and then do not seem to be—really will-o’-the-wisp hunters—Meleagers, in fact—blind plodders, too often, for things which appear to be, yet are not—too many pipe-dreamers—too much evidence that the great “ prerogative of mind ” is abused and

we think, yet do not, if so, in a visionary manner and not as philosophers or careful thinkers, and too often are we influenced even, thoughtfully directed, in our insouciance in seeking the agenda et corrigenda.

Can each of us say, with Harvey: "My trust is in my love of truth and the candour of cultivated minds"? If so, do we observe these admonitions in our daily studies, when we accept as the classics the praises of a patented dope by an arch-enemy of medicine—even by one who treacherously states he is one of our flock, and his article appears in our journals?

This very day, even in five medical journals, I behold an attempt, an article, with carefully arranged words, entitled: "Another Phase of the Proprietary Question." Brother, if the four or five hundred medical journals of the United States and Canada were before you, you can read it, for it is evident the proprietary medicine companies' organization had the contract in its widespread publication. Read the article carefully, re-read it. It is needless to tell you that things in it are not as they seem, or really not as stated. Brother, such is the literature too often presented, and it is so seductive that, if you do not think, it catches you very badly and your pocket-book too, and, to give you fully the truth, we are evidently *easy marks* for the proprietary companies, and especially marked as such by druggists who chance to see our weakness in pharmacy. To be convinced, ask your druggist in reference to the last-named statements; ask him to give you his candid views, and if you are not too stubborn he will free your mind "from many silly notions," and you will regret you do not know pharmacy, for, if you did, few patent dopes would you prescribe, if not abandon. Read carefully the lines of Epectetus to confirm the worth, if worth there is, in this article, for these lines are *apologia mea*—the incentive. However, brother, if you are trying to enrich the proprietaries—who are no friends to honest medicine—you I have offended, and although demanding and wishing to extend all charity, and requesting the same in return, it is well, even advisable, for you to write in large letters the words of the old Roman, Epectetus, on the tablets of your memory, for "Rightly to aim in all these cases is the wise man's task" most assuredly.

"Prudens advertit ad gressus suos stultas divertit ad dolor."

With papers before me that announce the names of candidates for position as members of the Senate of Toronto University, I, only an adopted son, and really the possessor of no parchments to prove the fact of my enrollment among its lists of graduates, most painfully notice that of the fifty-two candidates only seventeen live outside the city of Toronto. It is gratifying, probably,

to the few, to notice that of the eight candidates in Medicine, only two are Extra Mural. The Victoria Alumni in Arts have one candidate, resident extra muros, the remaining candidates, nine in number, claim the metropolis as their address. I mention these interests as they are present and are in keeping with my text and illustrate that it *appears* as if Toronto University *was made* for Toronto, and its resident graduates, and the word *Provincial* not in evidence. However, things are not in this case what they appear to be, and it is time we, who unfortunately are not residents of Toronto, should realize that we M.D.'s, M.A.'s, etc., have rights that *are* and do not seem to be, and are entitled to the honors in the Senate of our Province's university. Who among us doubts these facts, even if careless or indifferent?

DIONIN IN DISEASES OF THE EYE.

BY R. W. RUTHERFORD, M.B. (TOR.), CHATHAM, ONTARIO, CANADA.

Dionin or Ethyl.—Morphin hydrochloride since its introduction a few years ago by Darier, of Paris, has become an important part of the oculists' armentarium. It is a powerful lymphagogue, producing marked chemosis of the ocular conjunctiva, and to this property its usefulness is due.

I have used it in my private practice for the past eighteen months and have obtained very excellent results. I will now record some eye conditions that are amendable to its therapeutic action.

Pain.—Every practitioner is well aware of the severity of the pain met with in some cases of iritis, irido-cyclitis, corneitis and glaucoma; and before dionin was heard of, I may venture to say that many of them have found it necessary to give morphine hypodermically to allow the patient a good night's rest. Not so much now. I am of the opinion that dionin in 2 to 5 per cent. solution, or as an ointment of the same strength, if used properly and at close enough intervals, will relieve the severest of eye pain. Some may think that cocain is just as effective, but it is not. Furthermore, it dilates the pupil and increases the intra-ocular tension, and is thus contra-indicated in acute glaucoma. The relief afforded the patient by dionin is also longer in duration than that got from other ocular analgesics, such as cocain and holocain.

Corneitis or Ulcer.—In this condition, by means of its powerful lymphagogic properties, dionin combined with atropine

relieves pain and hastens the absorption of the corneal infiltrate. After the ulcer is entirely healed, I have the patient insert into the lower conjunctival cul de sac a little dionin ointment, and then have him close his eyelids and massage the cornea by means of his fingers. I employ at the start, ointment 2 per cent., and gradually work up to 5 per cent. Let me emphasize here that the more recent the opacity the better the result.

Iritis and Irido-cyclitis.—In the acute form of these diseases dionin combined with atropine, besides relieving the pain, assists the latter drug in its dilatation of the pupil; a feature most desirable. In old cases of iritis, where posterior synechiæ are present, and there is also a plastic exudate over the pupillary area, there is no adjuvant to atropine like dionin. It is also very useful in post operative iritis and irido-cyclitis.

Acute Glaucoma.—Dionin is said to lessen the intra-ocular tension of the acute glaucoma. My experience in cases of acute primary glaucoma has been very limited, but combined with atropine, I have used it with splendid results in cases of secondary glaucoma due to synechiæ.

In conclusion, from my experience, on account of its usefulness in iritis, irido-cyclitis, corneitis and opacities of the cornea, I think that dionin has already come to stay as one of our most valuable and useful ocular therapies.

Selected Articles

FACTS AND FIGURES OF END-RESULTS IN ONE HUNDRED CASES OF CONSERVATIVE OPERATIONS ON THE UTERINE APPENDAGES*

BY W. P. MANTON, M.D., DETROIT.

One's point of view regarding any surgical procedure must be largely based on personal experience. A method which proves disastrous in the hands of one man and leads to its denunciation, may, under a more careful selection of cases, a keener perception of conditions present, and a more finished technique, give rise to brilliant results and unstinted praise.

The conception of the term "conservative," as applied to the conditions under discussion, may also vary with different operators and thus give rise to confusion. The definition accepted by the writer includes in its meaning all of those procedures directed to the ovaries and tubes in which the morbid process alone is removed, or so modified as to put these organs in the way of renewed physiologic health. This includes puncture and resection, but does not comprehend the breaking up of adhesions and the liberating of organs bound down by adventitious products.

From the above it is plainly evident that the question of benefits to be derived from conservative operations on the uterine appendages presents a problem difficult of solution, which can really be answered only to individual satisfaction.

If it is admitted that the ovaries have their place in the economy, not only as the source of ovulation for procreant purposes, but as purveyors of an internal secretion which is essential to the wellbeing of woman during the active period of life, then there can be no question as to the desirability and importance of preserving the whole or a part of these structures whenever the involving morbid process renders this possible. On the other hand, if it is assumed that beyond supplying the elements for the perpetuation of the race, the ovaries have no other function, their total ablation when diseased is clearly indicated. In the majority of cases of pelvic disease demanding operative intervention, the carrying out of conservative measures cannot be considered, the condition having either existed too long or being of such a nature as to prohibit the saving of even a fractional part of the organ

*From the Transactions of the American Gynecological Society, 1906.

558 OPERATIONS ON THE UTERINE APPENDAGES.

involved. There remains, however, a fair percentage of cases in which the disease is limited, and in which the removal of the pathological process is possible without the destruction or ablation of the entire organ.

Whatever the attitude of mind regarding these matters may be, however, the ultimate results, whether the radical or the conservative operation be undertaken, are alone of value in determining the worth of either procedure.

In order to ascertain my own experience along conservative lines, I have taken one hundred cases from my note-books, the facts and figures from which I herewith submit.

Of the one hundred women there were:—

Single	30
Married	64
Not noted	6
	100

The following operations were done:—

ON THE OVARIES.

Resection.

Both ovaries in	17 cases.
Right ovary in	26 cases.
Left ovary in	13 cases.
	56

Puncture.

Both ovaries in	22 cases.
Right ovary in	8 cases.
Left ovary in	14 cases.
	44

In 19 women the ovary of one side was found to be so largely involved as to require removal; the right in 6 instances, the left in 13.

ON THE TUBES.

Resection.

Both tubes in	13 cases.
Right tube in	4 cases.
Left tube in	7 cases.
	24

It was found necessary to remove 1 tube in 10 of the patients: the right in 4 and the left in 6 cases. The opposite side was left untouched or resected.

Results.—In the one hundred women the immediate results

were entirely satisfactory; that is, all the patients recovered from operation and were relieved from the sufferings of which they formerly complained.

The mortality was therefore nil, and the results temporarily perfect. The majority of these patients remained under observation for at least three months. Following this quarter-year, 61 are known to be well at the present time; 31 have been lost sight of; 5 are doubtful, complaining of pelvic pain, referable to the resected ovary, but in which no change can be detected on examination; and 3 have required a second operation for the removal of the conserved organ, which had undergone, in each instance, further cystic degeneration. Of the 64 married women, 5, or 85 per cent., and of the 30 single women, 23, or 75 per cent., were well a year following operation.

Of 64 patients of whom knowledge was had a year or more following operation, 41 are married. Of this number, 6 (14 per cent.) subsequently became pregnant; 4 of these were delivered at term, 1 aborted at the third month, and 1 is still eniente.

From this limited number of cases it appears that the conservative operations performed on the uterine adnexa have been followed with satisfactory and permanent results in more than 60 per cent. of those patients still alive and traceable. It is quite possible that among the thirty-one lost sight of some may have relapsed and undergone operation at the hands of others. It is also equally possible that the majority have remained well and that some have borne children.

The results just noted demonstrate that the conservative surgery of the appendages, where it can be properly undertaken, is better surgery than total obliteration, since it not only relieves from the suffering for which operation is undertaken, and restores the patient to her wonted health, but it maintains intact womanhood, which, in the single who may contemplate marriage, is a matter of no little comfort and importance, and renders in all the possibility of future pregnancy. From the foregoing I maintain that my own statistics and those of others show that the conservative surgery of the ovaries and tubes, having passed the experimental stage, has established itself as a legitimate and successful operation in all the conditions to which it may be properly applied, and that it should be the operation of choice in all instances during the child-bearing age where the diseased state of the organs admits of its employment.—*Surgery, Gynecology and Obstetrics.*

PATHOLOGY AND THERAPY OF LEPROSY.

BY P. G. UNNA, M.D., OF HAMBURG.

Fortunately, the time has passed when leprosy was considered an incurable disease. Owing to the efforts of a few physicians, who were not satisfied to accept the verdict, a marked change has followed in the view taken of this affliction. At first, attention was directed only to the occurrence of spontaneous remissions in the course of leprosy, and the so-called cures were attributed merely to spontaneous improvements. Every physician who has made a study of leprosy knows, however, that these slight periodic remissions, seen for instance, with change of climate or after hospital treatment, are really retrogression. An energetic and successful treatment, on the other hand, results in a rapid and pronounced improvement, which can often be predicted in advance. The true value of the therapeutic methods at our command will never be underrated by him who has actually witnessed the sudden, beneficial effect.

Much has been accomplished for the better understanding of the disease, by its study in foreign countries. Thus, Ehlers and Cahnheim examined the lepers of Creta and found cured cases among them. Of greater importance still are the observations of Tonkin, who encountered many cured lepers in Sudon. He states that the incurability of leprosy has been proclaimed without sufficient investigation.

In the meantime, the reports of improvements and cures of leprosy in civilized countries have so multiplied that they can no longer be overlooked. Remarkable improvement or a cure after the use of chaulmoogra oil has been reported by many reliable authors throughout the world. Many cures have also been reliably reported to follow the use of balsam of Gurjun, mercurial preparations, strychnine, arsenic, salicylic acid preparations, ichthyol, airol, and chinisol.

Most authors agree upon the value of hot baths.

The external treatment introduced by Unna has been used successfully by others.

Even Armauer Hansen agrees that Danielssen has discharged many lepers cured from the Lungegaard Hospital in Bergen. The latter ascribes the cure in part to drugs, such as the salicylate of soda, in part to the good care possible in the hospital. Hansen himself, however, believes that we can do nothing to bring about a cure, and that the disease has healed spontaneously in the cured cases he has seen. This opinion is in marked contrast to the views of such excellent clinicians as Kaposi and Vidal.

Unna has treated sixty lepers in twenty-two years and has followed these cases from two months to twelve years. The lesions varied from the mildest form of nerve leprosy, free from bacilli and recognizable only to the expert, to most pronounced, universal nodes in the cutis and subcutis. Common complications were paresthesia, circumscribed muscular atrophies, affection of the nasal mucous membrane, and leprosy eye diseases. Since all the cases exhibited skin lesions, the treatment was chiefly dermatological.

Every physician must confess that in treating leprosy he has a very difficult problem before him. Unlike syphilis, we do not possess a ready specific which will dissipate the lesions. Yet even with regard to syphilis, many cases might be cited where the constitutional treatment has little or no effect, unless preceded by an energetic external application. Some individual or local resistance is probably offered, possibly by the encapsulation of the virus or by a mixed infection, which prevents the action of mercury and the iodides. The leprosy lesions closely resemble these torpid syphilides, and a number of factors are present which will explain their obstinate character. The invasion of the bacillus of leprosy does not give rise to symptoms of an acute inflammation, but, instead, there is a tendency to encapsulation, with simple hypertrophy of the fibres and part of the cells of the connective tissue. The lymph-spaces will become obstructed, so that drugs penetrate only very slowly. The bacilli themselves elaborate a fatty substance and are surrounded by a mucinous material (zooglea), containing some solid fat. This substance represents the dead and swollen germs. By means of a special staining method (Victoria blue and safranin), the living bacilli will appear blue-black, the zooglea mass golden-yellow. Some of the germs, however, also show a marked affinity for the yellow constituent of the stain, and therefore are most likely dead, even though they still retain their original shape. Probably a large percentage of the bacilli cast off by the patients belong to this class.

It follows from what has just been said, that our first attempts must be directed toward removing the mechanical obstacles present. The simplest way to attack the solid fat present in the bacilli and in the mucinous material, is by means of heat. Hot baths, particularly sulphur baths, have claimed popularity for ages. In certain natural springs of Japan and Roumania, strong acids (sulphuric acid) and iron compounds play an active part. Hot alkaline baths probably possess a better penetrating power, but the patients soon complain of heart weakness and general languor, and cannot stay in the water suffi-

ciently long. Moderately acid and ferruginous baths, on the other hand, are better tolerated. After many experiments, Unna now resorts to "ink-baths," extemporized by means of sulphate of iron and tannin. The initial temperature is 30 degrees C., and is gradually increased by the addition of hot water. The patients stay in the water one-quarter to one hour, according to the reaction. These baths are indicated in the intervals between inunctions, during conditions of weakness, with extensive paresthesia and vasomotor disturbances, particularly of hands and feet; in complicating joint affections, and lastly with desquamative anomalies (eczema, psoriasis, pityriasis). Hot douches or local baths may, under certain conditions, be substituted for the general baths.

Another way of applying heat is by means of the smoothing iron. This is especially indicated in discrete nodes, where inunction of the entire skin is not desired. Several layers of flannel are placed upon the skin and the iron is then firmly pressed upon the desired spot, as long as the heat is tolerated. Discrete embolic foci, which only give rise to a moderate reddening and increased resistance of the skin, will not yield so readily to any other simple method. In the presence of anesthesia, a burn may result, but this will heal rapidly after the application of camphor-gynocard, guttaplast.

The most intense application of heat, such as is possible by means of the Paquelin, has only rarely been employed by Unna during recent years, since the removal of tuberosities by means of a sharp razor, down to the level of the skin, gives better scars and does not spoil the pathological material. The parts are first rendered anesthetic with ethyl chloride, and the bleeding is controlled with styptic powder and lecoplast. The dressing is removed the following day, the wound again sprayed, and then thoroughly cauterized. The frequent use of this method will shorten the disease and improve the cosmetic result; it is especially indicated in tuberosities of the face and hands. The fact that we possess an efficient application for the cure of spontaneous and artificial leprosy wounds in the gynocard-camphor guttaplast, should popularize this method.

The stoppage of the lymph-spaces and lymph-vessels by means of mucoid masses of bacteria is a serious obstacle for the penetration of our remedies. The simplest way of overcoming this condition is by means of pressure and massage. Massage by means of disinfecting oils is frequently practiced. Recent nodes will often disappear very rapidly after the application of a firm bandage, but one disadvantage of this method lies in the fact that the bacilli are often forced into the lymph-nodes and into

the blood. Invasion of the lymph-nodes is easily combated by injection of carbolic acid or by extirpation, and the inundation of the blood is often marked by a febrile reaction which probably destroys many germs. A certain number, however, will gain a foothold in the capillaries and thus give rise to new embolic foci which develop later into new nodes. It follows that the pressure should never be excessive and should preferably be combined with other antibacillary methods. The simplest is the pressure of the hot flat iron, mentioned above. The use of plasters containing strongly reducing drugs (pyrogallie acid, chrysarobin), or a gentle massage, can also be recommended.

Next to physical methods, the application of chemicals for the local treatment of leprosy is of importance. Owing to the fatty nature of the leprosy bacilli, it is but natural that alkalies should play an important role. The simplest way of using alkalies is in the form of the caustic paste, which is applied pure and then covered with zinc-oxide guttaplast. In large areas, as in leontiasis of the forehead, it is better to use a vaselin ointment containing 1 to 5 per cent. of the paste, and then to apply some pure paste in addition upon the raised areas. The cauterized skin will heal best with zinc guttaplast, until the secretion ceases, when camphor-gynocard; guttaplast should be substituted. The paste is also excellent for lesions of the mucous membranes.

The tendency to form keloids, seen so often after the use of alkalies, may be avoided by cauterizing with alkalies only the first time, and substituting carbolic or hydrochloric acid for the later applications; or else injections of thiosinamine may be given, or thiosinamine be employed locally in the form of soap or plaster. Thiosinamine is also indicated where the nodes are exceptionally hard and are imbedded in sclerotic portions of the skin or where the usual methods no longer affect the process, probably owing to encapsulation of the bacilli in hypertrophic connective tissue.

The most commonly employed external remedies which are supposed to have a specific effect upon the protoplasm of the bacilli after the removal of the fatty and mucinous zooglea, are pyrogallie and carbolic acids, resorcin, chrysarobin, sulphur, and ichthyol. Unna's own experience is most extensive with pyrogallie acid, a drug which is certainly not indifferent but the toxic properties of which can be accurately neutralized by giving dilute hydrochloric acid in doses dictated by the degree of darkening exhibited by the urine.

The ointment commonly employed for general inunctions contains 5 per cent. pyrogallie acid, 5 per cent. ichthyol, and

2 per cent. salicylic acid. For a more local action, the pyrogallie and salicylic acids may be increased to 10 per cent. Instead of pyrogallie acid, the oxidation product, pyraloxin, may be employed. This has a similar elective, but somewhat weaker, action. Or an ointment may be used containing 5 per cent. pyrogallie acid and 5 per cent. green soap. Part of the acid will be converted into pyraloxin and the green soap will take the place of the salicylic acid. For circumscribed nodes the pyrogallol gutta-plast may be substituted.

Resorcin is considerably milder than pyrogallol, and is especially indicated for women, children, and individuals with soft skin and with mild eruptions. It is chiefly employed upon the face in the form of the *Pasta lepismatica*, which is rubbed into the skin twice daily for one to two weeks. Since the resulting resorcin crust will exercise quite some pressure upon the skin, this treatment is hardly in place where the subcutaneous fat of the face still contains many bacilli. Here the bacilli should first be destroyed by means of pyrogallie acid. If it is desired to use resorcin also upon the rest of the body, about one-third of the surface is treated like the face; in the meantime the rest of the skin is prepared by daily washings with green soap or pèrnatrol soap, which softens the superficial layers. The original surface is then covered with zinc glue, so as to exclude it from further treatment. General intoxication has never been observed, but still, hydrochloric acid should be given internally.

Concentrated carbolic acid is an excellent, almost painless, caustic for superficial nodes. For deeper nodes and recent, embolic foci, the daily injection of a 2-per-cent. solution is preferable. If this treatment lasts weeks or months, hydrochloric acid should be given internally to counteract any intoxication.

Chrysarobin does not play the same role in leprosy that it does in psoriasis, as its action is more superficial. It is therefore indicated only in the mild erythematous and pigmented, flat, and tuberosus neuroleprides. Since conjunctival irritation must be carefully avoided, it is best applied only to the lower extremities.

Sulphur, in the form of the zinc-sulphur paste, is an excellent remedy to hasten the cure of skin lesions induced by the stronger reducing agents.

Ichthyol is indicated in the following condition:

(1) Pure, with or without hydropathic applications, in the common edema and stasis of the extremities, in painful swellings of the joints, and in all vasomotor disturbances.

(2) As a mitigating agent in all ointments containing strong reducing drugs, such as pyrogallol, chrysarobin, and resorein; as a mild, universal inunction, with salicyelic acid, in weakened individuals, and to remove pigment.

(3) As 5 per-cent. ichthyol-vaselin with or without zinc ointment or zinc sulphur paste, upon the mucous membrane of the nose.

(4) As 10-per-cent. ichthyol-collodion upon swollen glands and recent embolic nodes, together with carbolic injections.

(5) As ichthyol guttaplast upon painful joints and upon painful ulcers, either spontaneous or resulting from cauterization.

Internally, ichthyol is an excellent tonic in weak or emaciated patients. The daily dose is 1 to 2 Gm. (15-30 min.) in drops, pills, or capsules.

Another excellent tonic is camphor. Unna generally injects a syringe-ful of oleum camphoratum forte daily into the gluteal region. It improves the general condition and diminishes the tendency to form new emboli.

Camphor is used externally in the form of (1) camphor-gynocard. ointment in ulcers upon the nasal mucous membrane and upon the leg; (2) camphor-gynocard. guttaplast, as a general curative plaster in all wounds induced by other treatment.

The nearest approach to an internal specific is found in chaulmoogra oil (Gynocardia oil). It is better absorbed and causes less gastric disturbance if the saponified oil is used in the form of keratin-coated pills. Each pill contains 0.15 Gm. (2½ grn.) of oil, and the patients take 32 pills daily, so that they receive about 5 Gm. (75 grn.) of oil. If intestinal disturbances follow, a small amount of anesthesin and menthol may be added. (Pil. gynocard. mitig.) Some authors recommend subcutaneous injections of the oil, but these are generally painful and cause indurations and inflammations. A good method is to give fewer pills and to add some of the oil to the daily camphor injections. The oil may also be given in the form of clysmata with milk; 5 Gm. (75 grn.) are thus introduced into the rectum every evening after an irrigation. In bad cases, two enemata may be given a day.

Salol or aspirin often does good service in painful conditions, such as neuralgias and joint affections.

Of the four internal remedies mentioned, chaulmoogra oil probably possesses a specific action upon the protoplasm of

the bacilli, while ichthyol and camphor act as tonics. Unna's experience is not sufficiently large to form an opinion of the action of the salicylic acid preparations, gurgun balsam, arsenic, the mercurials, chinisol, airol, etc. Strychnine, however, is excellent in extensive anesthesia and involvement of the nerves.

Other accessory remedies are the salicyl-cannabis and salicyl-creosote guttuplast, where there is a much thickened horny layer over the nodes, and to remove the callous edges of indolent ulcers. Applications of Merck's 30 per cent. hydrogen peroxide (perhydrol) or washings with pernatrol soap (2 to 25 per cent.) have the same action and also destroy pigment. The pigment is also affected by the ungt. bismuthi oxychlorati, and where it is desired to remove erythematous patches, 2 to 5 per cent. of fluid extract of rhubarb may be added.

Marked cyanosis of hands and feet calls for the use of local hot baths containing mustard flour or of poultices made of it.

The destruction of bacilli by the various caustics can be followed on pathological preparations by means of the Victoria blue-safranin stain. In parts cauterized with the caustic paste or with potash, almost all the bacilli, except in the deeper tissues and laterally, are yellow. The same may be found in areas treated with carbolic acid and heat. After the use of strong mineral acids, on the other hand, the greater number of bacilli are still blue, showing that they still retain the substance which has an affinity for the Victoria blue, even though they need not necessarily be alive.

Cures by the external treatment have been doubted, as the leprosy nodes in the internal organs are not taken into consideration. Unna had occasion to examine the lymph-nodes of two cases which had been actively treated, and to his astonishment could not detect any bacilli, even though the nodes were swollen. No doubt the same thing may occur in liver, spleen, and testes, for the external remedies employed are not limited in their action to the skin, but also enter the system. His cure is therefore not a strictly external one, but is both external and internal. The rapid general improvement certainly speaks in favor of this view. It has also been stated that the use of such drugs as pyrogallie acid is liable to set up serious renal disturbances, particularly since, according to Lie, 40 per cent. of all lepers already show traces of albumin in the urine. In reply to this, Unna states that he has had occasion to examine histologically seven kidneys from patients who had died of leprosy. They were not only free from bacilli, but actually showed no lesions whatever.

General Rules for Treatment.—

1. Treat locally and generally every day. No intervals should be permitted.
2. A change in the general plan of treatment is therefore only indicated when the improvement does not continue.
3. The external treatment should never be discontinued as long as there are still lesions of the skin or mucous membranes present.
4. The internal treatment should be continued for years after the external symptoms have disappeared.
5. A short, energetic treatment, even if accompanied by visible effect, is of no value.—*Merck's Archives.*

Editorials.

AMERICAN ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS.

The Nineteenth Annual Meeting of the American Association of Obstetricians and Gynaecologists was held at the Hotel Havlin, Cincinnati, September 20, 21 and 22, 1906.

There are certain incidents in connection with the organization and subsequent history of this admirable association which are sufficiently interesting to be worthy of regard at the present time. In the year 1886 it was decided to form a Congress of representative physicians and surgeons of the United States. Preliminary invitations were sent to the various special societies asking for co-operation. The American Gynaecological Society was the only one which refused to co-operate. In the official report of the Society for 1887 we find the following words: "The proposition to become part of the American Congress of Physicians and Surgeons was not adopted." The promoters of the proposed confederation were naturally disappointed because they desired a representation of the important subjects of Obstetrics and Gynaecology. As a consequence of this disappointment there was a conference of some friends of the Congress. As the result of such conference the American Association of Obstetrics and Gynaecologists was organized, not in opposition to any other society, but rather in the interest of the new Congress. After the organization was fairly completed a formal application for admission was sent to the Congress. In the meantime, however, a change had come over the society which had formerly opposed the proposed Congress. We were not told whether this marvellous change was brought about in consequence of the organization of the new society; but it was certainly a singular coincidence that the applications from the old Gynaecological Society and the new association of Obstetricians and Gynaecologists for admission to the Congress were practically made at the same time. After some deliberation by the executive authorities of the Congress it was decided that the society which had shown pronounced hostility to the Congress up to the time of its sudden conversion should be received, and that the

new organization which had been formed to assist the confederation in a serious emergency should be put on trial for a couple of years. In accordance with this remarkable decision the following resolution was passed: "Resolved that it is the sense of this Executive Committee that they will not consider the application of any society which has not held at least two annual meetings."

The new association entered into its period of probation with feelings of both surprise and disappointment, but with hopes that its work would be judged on its merits, and duly recognized at the proper time. After the second annual meeting the volumes of the transactions for two years were duly filed. After the third meeting, which was held in Philadelphia, twelve copies of each volume of transactions were asked for. This meeting was so successful from every point of view that it was supposed the perusal of the transactions would strengthen any favorable impressions which had been created by the former two. The delay was to some extent embarrassing because the association was unable to announce definitely the time and place of the fourth meeting. The third volume was completed as soon as possible, and the thirty-six books were forwarded to the Committee of the Congress. When all the evidence was received the committee did not arrive at a conclusion suddenly or rashly; they took ample time for deliberation, and while they were deliberating the new Association was waiting.

After about seven months the Executive Committee of the Congress of American Physicians and Surgeons was held in Philadelphia, and shortly afterwards sent an official intimation to the new society, stating that it would not be admitted to the Congress.

This is a brief but plain statement of one of the most extraordinary transactions known to medical history in North America. Why was the new association accorded such treatment? This question was asked by the president of this association fifteen years ago, and has not yet been answered. There was at that time a rumor in the air that the general argument used against the new association was that it really represented

nothing more than a duplication of the work of other sections, and for that reason should not be admitted.

This statement of the position is taken from the address of the president of 1891. With reference to the "duplication of the work of other sections," the president spoke as follows: "I have nothing to do with such an argument, and care not whether it be considered good, bad or indifferent. I shall remove the necessity of using it by saying that we concede that the Congress has a perfect right to refuse to admit us if its members thought fit. We insist, however, that it had no right to subject us to humiliation such as this. It had no right to place us on probation for an extended period, and then absolutely ignore the essence of the implied contract between them and us. The resolution of the Congress required certain things from us. We have fulfilled those requirements in every part. We actually came into existence in the interests of the Congress. We have supported it loyally in every particular. We have shown no particle of antagonism to any of its sections; we have patiently submitted to much inconvenience through the delay in sending its singular ultimatum. Is it possible that the majority of the members of that great organization will feel proud of the actions of their Executive? I have considered the matter in all its aspects, and I cannot conceive how the members of the Congress can reasonably defend the methods of their committee."

The president then spoke as follows respecting the future prospects of the association: "Well, gentlemen, what are we to do now? It gives me unbounded pleasure to assure you that our Executive Council holds no divided opinions. The necessities of the case compel us to bid the Congress a sad farewell, but in doing so we indulge in the hope that we may be permitted to continue our existence, which we have found exceedingly pleasant, as well as extremely profitable. Our association is alive to-day, it is going to live, it is going to thrive, it is going to do a great work on this vast continent. I say this in no boasting spirit. I desire to assume no air of bravado. I feel fully impressed with the responsibility I assume when I say that we have a grand future before us. I, who have done so little for you, can express myself with greater freedom than can others

who have borne so nobly the burden of organizing this magnificent society. I have witnessed the efforts of our founders with profound admiration. I have watched their zeal, their devotion, their untiring energy, with a feeling of wonder. I have viewed their boundless enthusiasm, their wondrous capacities for work, and their unselfish devotion to each other and our common cause with perfect delight. In addition it gives me great pleasure to refer to the dignified bearing of our councillors under somewhat trying circumstances. I know of no act on our part that will ever bring a blush of shame to any of our members. It appears to me that our prospects were never brighter than they are to-day. The object of our association, "the cultivation and promotion of knowledge in whatever relates to abdominal surgery, obstetrics and gynecology," is ever kept in view by one and all, and the results in three short years, the evidence of which may be found in the three volumes of our transactions, will inspire us with confidence and fill us with hope in the future.

"Let it be our duty as well as our pleasure to worthily continue the work which has been so auspiciously begun. Let envy, hatred and all uncharitableness toward other societies be ever kept far from us. Let us forget the indignities which have been heaped upon us. Let our memories of the past pertaining to our own work ever remain as pleasant as they are to-day."

Has the society realized the somewhat lofty expectations thus expressed? It would seem not unprofitable to consider some of the features of the meeting held at Cincinnati. One noticed very soon that the "old guard," the founders, are still on deck and ever ready for action. Among the founders present were Potter, Price, Carstens, Hill, McMurtry, Reed, Taylor and others. The able and active secretary has a genius for organization and executive work, and looks quite as young as he did fifteen years ago. McMurtry, Reed, Price, and Carstens show no signs of getting old, they are as vigorous, keen and alert in debate as ever. Among others present were a number who joined shortly after the organization of the society and are still active members, such as Ross, Hall, Longyear, Murphy, Morris, Ricketts, Zinke, Hayd, etc.

We learn that others of the founders and members had

expected to be present, but were prevented by unforeseen circumstances. There is also much new and young blood. To one attending the session of the first forenoon there appeared in the chair a boyish looking fellow with a clean-cut man's face. Who is that? He is the president, John Young Brown, a Kentucky boy, born in Louisville, a son of one of Kentucky's ablest Governors, now one of the leading surgeons of St. Louis. After a time a well groomed boy with an intelligent man's face takes the chair. Who is that? He is another Kentucky boy, now in New York, one of the vice-presidents. These men presided with a grace and dignity that was altogether admirable.

The association has shown much wisdom in holding out the glad hand to bright young surgeons and obstetricians, and bringing them into the fold.

The meeting lasted three days of two sessions each, morning and afternoon. The attendance was large, the room being filled most of the time. It is impossible to give a condensed report in the space at our disposal which would give any adequate conception of the character of the papers and the discussions. Some of the papers were far above the average, and some of the discussions were extremely good, and were listened to with breathless interest by those present. There was a general consensus of opinion that the meeting was one of the best that the association has ever known. One may go, perhaps, a little further, and say, without any fear of contradiction on the part of those in attendance, that it was one of the best medical meetings ever held in North America.

One cannot speak too highly of the work done by the Committee of Arrangements, of which Dr. Bonifield was chairman and Dr. Tate was secretary. One can also positively state that the unbounded and generous hospitality of the resident fellows will ever be remembered by those who had the privilege of attending this great meeting in Cincinnati.

In conclusion I may answer the question as to "lofty expectations" by saying that, although I feared that the enthusiasm of the president of fifteen years ago was causing him to soar a little too high, I now think, after attending this meeting, that the

results have fully justified his statement: "The association is alive to-day, it is going to live, it is going to thrive, it is going to do great work on this continent."—*Adam H. Wright.*

INTERNATIONAL TUBERCULOSIS CONGRESS

The next International Tuberculosis Congress will be held at Washington in 1908, that is about two years from the present time.

We understand that the American National Association for the Study and Prevention of Tuberculosis has already outlined a general plan for the arrangements of the meeting. In the first place, it assumed the task of collecting \$100,000 towards the expenses. It started with the rule that the minimum subscription was to be \$5,000, acting on the belief that it would be an easy matter to find twenty citizens of the United States who would be willing to subscribe such an amount. We believe that this amount has been practically collected now.

It is hoped that the committee will thus be enabled not only to pay the ordinary expenses of the Congress, but will also be able to award substantial prizes to the authors of the best papers on certain selected subjects, such as Sanitoriums, Treatment, Municipal Control, etc.

It is also proposed that the Congress shall officially last three weeks. This arrangement will be made chiefly in the interests of those who come from the Eastern Continent. It is expected, however, that only the middle week will be devoted to scientific meetings and discussions, and that the first week will be spent by the visitors in exploring some of the greater cities north of Washington, and that the third week will be spent in visiting certain cities south of Washington. Arrangements will probably be made in all these cities for a formal reception to the visitors.

The great desire of the people of the United States is to show both public and private hospitalities to all the visitors. In making such arrangements they think that there may be many visitors who can reach Washington before the date of the scien-

tific meetings and would have to leave immediately on their termination, while others might have considerable time to spare for such visits during the week after the close of the scientific meetings.

NEW PROVINCIAL BOARD OF HEALTH.

The Board of Health for Ontario, which simply takes the place of the old Board, which went out of office last month on account of expiration of time, is composed as follows:

Dr. Chas. Sheard, of Toronto; Dr. Milton I. Beeman, of Newburg; Dr. Jno. W. S. McCullough, of Alliston; Dr. Chas. B. Coughlin, of Peterboro'; Dr. W. J. Robinson, of Guelph; Dr. W. R. Hall, of Chatham.

Dr. Sheard has been Medical Health Officer of Toronto for several years, and is also Professor of Preventive Medicine in the Medical Faculty of the University of Toronto. He graduated from Trinity University in 1878. Dr. McCullough graduated from Trinity in 1890, and since that time has been in active practice in Alliston. He is at present a member of the Board of Examiners of the Ontario Medical Council. Dr. Beeman graduated from the University of Toronto in 1873, and has taken an active interest in matters pertaining to public health for many years, and has been for some time Medical Health Officer of his district. Dr. Coughlin graduated from Trinity in 1890, and after practicing for a short time in Ayr went to the city of Peterboro'. Dr. Robinson graduated from the University of Toronto in 1883, and has been Medical Health Officer of Guelph for some years. Dr. W. R. Hall graduated from Detroit Medical College in 1878, and became a member of the College of Physicians and Surgeons in 1884. He has been Medical Health Officer at Chatham for a number of years. Dr. C. E. Hodgetts, of Toronto, is the permanent Secretary of the Board.

We have reason to believe that the personnel of the Board will give general satisfaction to the profession of Ontario, although many of us would have preferred to see two or three members of the former Board reappointed.

THE BRITISH MEDICAL ASSOCIATION.

The British Medical Journal expresses its pleasure concerning the large attendance of Canadian physicians at the Toronto meeting, and hopes that the membership of the Association may be permanently increased in the Dominion. As a result of the large attendance of Canadians at Toronto the membership is for a time being increased by several hundreds. We are told that a similar increase occurred as a result of the Montreal meeting in 1897. Increased membership at that time was not maintained in anything like its entirety, and we fear that it is not likely to be this year. At the same time we hope that the increase in membership will be fairly substantial.

The Journal thinks it would be very much to the advantage of the association if its organization in Canada could be placed on a solid and permanent basis. The relationship between Canada and Great Britain as to this great association has been discussed many times in various parts of the Dominion. It was hoped by some that the Province of Ontario would take an important step in the way of bringing us closer to Great Britain by making the Ontario Medical Association a branch of the British Medical Association. Our provincial society showed by its action at the annual meeting of 1905 that it is not disposed to take this important step at the present time.

It seems to us, however, that there is reason to hope and believe that the permanent increase in membership will take place from one decade to another, and the officers of the association should not be discouraged in this regard when a number of new members drop out, as they certainly will, at the end of this year.

NOTES.

Toronto General Hospital House Physicians.

There was a very interesting reunion of the Hospital Staff of the Toronto General Hospital Monday afternoon, August 20th, when over one hundred ex-members and members of the Resident Staff from different parts of Canada and the United States met on the Hospital Grounds.

There were only two House Physicians in 1872, while there

are sixteen now. During the thirty-four years of the existence of the Hospital there have been 156 Resident Physicians, of whom sixteen are dead.

The following had charge of the preparations in connection with the reunion: Executive Committee—Dr. R. B. Nevitt, president; Drs. W. P. Caven, of Toronto; J. McAlpine, Lindsay; James Third, Kingston; A. E. Ardagh, Orillia; R. Hillary, Aurora; T. Middlebro, Owen Sound; J. H. Mullin, Hamilton; George Atebison, Galt; D. Armour, London, Eng.; L. Barker, Baltimore, vice-presidents; Drs. J. F. W. Ross, H. A. Bruce, P. E. Doolittle, W. B. Hendry and W. N. Barnhardt, all of Toronto, councillors; Dr. J. N. E. Brown, secretary-treasurer.

On the evening of the same day the members held a banquet in the building of the Royal Canadian Yacht Club, Toronto Island.

Interesting Bowling Match.

Among the most interesting of the games played during the recent visit to the bowlers from Scotland, England and Ireland was that known as the Veterans' Match, between four from the Old Country and four residents of Toronto.

The visitors were driven to the Victoria Rink, Toronto, on the morning of August 1st and were introduced to the Veterans of Toronto. Mr. Campbell, of Scotland, and Dr. Jas. H. Richardson, of Toronto, being each 83 years of age, were requested to settle between themselves which of them was entitled to be called the oldest active bowler in the world. The request was soon decided by Dr. Campbell gracefully withdrawing his claim in favor of Dr. Richardson. This means, then, that our dear old friend, Dr. Richardson, is the oldest active lawn bowler in the world.

The following will show the names, aggregate ages of the bowlers, and the result of the game:

TORONTO.	OLD COUNTRY.
Dr. Richardson,	William Kerr,
Jas. Spooner,	Peter Campbell,
John Bain,	D. Willox,
J. S. Russell, skip 17	Adam Lilly, skip 27

Aggregate ages—British, 283; Toronto, 324.

Personals.

Dr. Franklin Dawson, of Toronto, has removed to 633 1-2 Spadina Avenue.

Dr. Brefney O'Reilly has returned to Toronto and commenced practice at 52 College Street.

Dr. W. A. Mearns, of Hanover, was married September 26th, to Miss M. R. Whyte, of Nottawa.

Dr. Chas. R. Dickson, of Toronto, returned from a trip to New York and Philadelphia, September 28th.

Dr. W. F. Mayburry, of Ottawa, was married September 25th to Miss Florence Graham, daughter of Dr. C. E. Graham, of Hull, Que.

Dr. Arthur Jukes Johnson, who went out to the Pacific Coast with certain members of the B. M. A., returned to Toronto, September 29th.

Dr. Frank Beemer, of the Hamilton Asylum, had charge of the Asylum for the Insane, Penetanguishene, during the absence of Dr. Spohn in September.

Mr. D. R. Wilkie, president of the Imperial Bank, has been appointed a member of the Toronto General Hospital Board, in the place of Mr. W. F. Maclean, resigned.

Dr. Herbert P. H. Galloway, who removed from Toronto to Winnipeg last year, has been appointed lecturer in Orthopedic Surgery in the Manitoba Medical College.

Dr. Perry G. Goldsmith, of Belleville, who has been for many years medical attendant at the Deaf and Dumb Institute of that city, has been dismissed.

Dr. Walter W. Boyce has been appointed to the position in the place of Dr. Goldsmith. The salary is \$600 a year. We are told that Dr. Boyce had been an active Conservative worker. We hope this does not imply that a good medical attendant has been dismissed and another good physician has been appointed in his place simply for political purposes.

Dr. Alex. Hugh Ferguson, of Chicago, has been rewarded for eminent services to surgery a Commandership in the Order of Christ of Portugal. It is said to be the highest decoration the King of that country can bestow on anyone outside of royalty.

Dr. Ferguson is a native of Canada and received his medical education in Trinity Medical College, Toronto. He first commenced practise at Buffalo, but in a short time moved to Winnipeg, where he practiced until 1894, when he went to Chicago, where he has practiced during the last twelve years, devoting himself exclusively to surgery, with distinguished success.

Dr. Albert A. Macdonald, of Toronto, has left his former residence on Simcoe Street, and is now living at the house of his brother-in-law, Mr. Alf. Beardmore, St. George Street, where he will remain until his new house at the corner of Bedford Road and Prince Arthur Avenue is completed and furnished.

Dr. T. K. Holmes, of Chatham, had a narrow escape from death on the evening of September 26th. On returning from the north side of the river in the darkness he made a mistake as to the position of the bridge and fell into the water. He was able to swim to the pier and remained there until rescued.

Drs. Jas. F. W. Ross and Adam H. Wright, of Toronto, attended the meeting of the American Association of Obstetricians and Gynecologists at Cincinnati, September 20, 21 and 22. At the close of the meeting they went to Louisville, Ky., where they remained for three days, Dr. Ross being the guest of Dr. L. S. McMurtry, and Dr. Wright the guest of Dr. Horace Grant.

Obituary.

JOHN MATTHEW LEFEVRE, M.D., M.R.C.S. Eng.

Dr. J. M. Lefevre, a graduate of McGill University, and one of the most prominent medical practitioners in Vancouver, B.C., died September 15th, 1906, aged 53.

W. FRANKLIN EASTWOOD, M.B.

Dr. W. F. Eastwood, of Claremont, Ont., died September 17th, aged 46. He received his medical education in the Toronto School of Medicine, and graduated M.B. from the University of Toronto in 1882.

MINERVA M. GRENAWAY, M.D. C.M.

Dr. Grenaway, of 563 Church Street, Toronto, died at St. Michael's Hospital, Sept. 27th, after a short illness from a virulent form of typhoid fever.

She was educated in the Women's Medical College of Toronto, and graduated from Trinity University in 1899. She then took a post-graduate course in the Western Hospital, Philadelphia, and began to practice in Toronto in 1904. She had a very good knowledge of her profession, and was much beloved by her many friends.

Ralph Oliver Morris, aged six months, second son of Dr. E. Ralph Hooper, died at his father's residence, 415 Bloor Street West, Toronto, September 29th.

Book Reviews.

Surgical Suggestions. Practical Brevities in Surgical Diagnosis and Treatment. By WALTER M. BRICKNER, M.D., Chief of Surgical Department, Mount Sinai Hospital Dispensary, New York; Editor, *American Journal of Surgery*, and ELI MOSCUCOWITZ, M.D., Assistant Physician, Mount Sinai Hospital Dispensary, New York; Editorial Associate, *American Journal of Surgery*. Duodecimo; 60 pages. New York: SURGEON PUBLISHING Co., 1906. Cloth, 50 cents.

This little book contains 250 suggestions grouped under proper headings and its contents is carefully indexed. While some of the items are familiar to the practical surgeon, they are presented in a manner that will impress them on the reader's memory. It will be much appreciated by the general practitioner, not alone on account of the value of its contents, but as an artistic bit of book-making.

Practice of Pediatrics, in original contributions by American and English Authors. Edited by WALTER LESTER CAER, A.M., M.D. 199 Engravings and 32 full page plates. LEA BROS. & Co., Philadelphia and New York, 1906.

This is one of three volumes covering respectively Gynecology, Obstetrics and Pediatrics, of the Practitioner's Library. It is difficult to speak too highly of the work, which fills a long-felt want in this department, and gives to the physician a short though comprehensive article on almost any subject he may require. In other words, it is a system of pediatrics in one volume of 1,000 pages. Nor are the wants of the student forgotten, for technic and method are constantly emphasized. The only fault to be found is that in the attempt to make the work complete, many pages are added on blood-counting, bacteriology, etc., which might with advantage be left to other text-books. The two English contributors, Drs. F. J. Poynton and Cline Riviere, write the sections on Circulatory and Respiratory Diseases respectively.

The Diseases of the Nose and its Accessory Sinuses. By H. LAMBERT LACK, M.D. (Lond.), F.R.C.S., Surgeon to the Throat Dept. of London Hospital and Lecturer on Diseases of the Throat to its Medical College (University of London), Surgeon to the Throat Hospital, Golden Square, etc. 124 illustrations. Longmans, Green & Co., Paternoster Row, London, New York and Bombay. 1906.

Although there are already many text-books on this subject, it is most refreshing to meet with one which leaves the beaten track of compilation and includes some original observations. It is interesting, too, to find a surgeon who gives his whole attention to one department of medicine, and yet who does not get the mental strabismus which comes from looking at that one thing too closely. Dr. Lack is eminently fair in stating the case of nasal trouble in relation to disease in other parts of the

body, and his views will be most acceptable to the general practitioner.

The crowning glory of the rhinologist is the diagnosis and treatment of sinus disease. It is safe to say that the chapter on this subject is not surpassed in the English language, and is perhaps the most masterly in the whole book. The section on Atrophic Rhinitis, which contains a description of a new and satisfactory treatment, is also worthy of commendation.

Although the book is quite complete, it makes interesting reading for those who are not devoting themselves entirely to rhinology, while to the specialist it is simply invaluable.

The Examination of the Function of the Intestines by means of the Test-Diet. Its Application in Medical Practice and its Diagnostic and Therapeutic Value. By PROF. DR. ADOLF SCHMIDT, Physician-in-Chief of the City Hospital, Friedrichstadt in Dresden. Authorized Translation from the latest German Edition. By CHARLES D. AARON, M.D., Professor of Diseases of the Stomach and Intestines in the Detroit Post-Graduate School of Medicine; Clinical Professor of Gastro-enterology in the Detroit College of Medicine; Consulting Gastro-enterologist to Harper Hospital, etc. With a frontispiece Plate in Colors. Crown Octavo, 91 pages, Extra Cloth. Price \$1.00, net. F.A. DAVIS COMPANY, Publishers, 1914-16 Cherry Street, Philadelphia.

The author's aim in this little monograph of about ninety pages is to bring before us a practical method for use in the examination of the intestinal functions. Schmidt devotes a chapter to the test diet which he and Strasburger used and found satisfactory, and then proceeds to the detailed examination of the faeces, with special stress on abnormal constituents and their relation to disease. The remainder of the work is devoted to an analysis of intestinal disturbances under headings of Gastro-, Hepato- and Pancreatogenic disease as well as those due to local and functional causes. The book is of especial value to the student of internal medicine and is somewhat unique. Schmidt has also throughout taken up therapeutic indications in a practical manner which adds greatly to its value.

A Short Practice of Medicine. By ROBERT A. FLEMING, M.A., M.D., F.R.C.S., F.R.S.E. Lecturer on Practice of Medicine School of the Royal Colleges, Edinburgh; Assistant Physician, Royal Infirmary, Edinburgh. J. & A. Churchill, 7 Great Marlborough Street. 1906.

The author explains the reason for the appearance of this volume of 750 pages as due to the fact that though there are many excellent text-books there are few small-sized manuals, particularly for the medical student. It is consequently intended to be a time-saver, and "the student burdened with innumerable classes demands some guide as to what is necessary for the all-important examinations which lie before him, and such a guide is offered in the following pages."

"No attempt has been made to group together clinical features in tabulated form, because such tables are more useful

if drawn up by the reader himself, but a definite method has been followed where possible so as to aid the student's memory in mastering the clinical features of each disease."

Take it all in all, this text-book is really very fair, and no doubt as accurate in scientific detail as is possible in a volume of this size.

The author is a pronounced believer in the use of alcohol in many of the acute infectious and wasting diseases.

This manual might answer very nicely for a third-year student in a Canadian medical college, but those in the fourth year require a work much more comprehensive.

The Ear and its Diseases. A Text-Book for Students and Physicians. By S T H SC R R BISHOP, B.S., M.D., LL.D. Honary President of the Faculty and Professor in the Post-Graduate School and Hospital of Chicago; Surgeon to the Post-Graduate Hospital and to the Illinois Hospital, etc. Illustrated with 27 colored Lithographs and 200 Additional Illustrations. Royal Octavo, 440 pages. Bound in Extra Cloth. Price, \$4.00, net. F. A. Davis Company, Publishers, 1914-16 Cherry Street, Philadelphia, Pa.

The above is a profusely illustrated volume of about 400 pages, treating the subject in a plain and concise manner. A considerable section is devoted to the Anatomy; numbers of original sections and preparations are presented. The remainder of the book is a treatise on the various diseases encountered, special stress being laid on Mastoiditis; a chapter is devoted to the use of compressed air in treatment, the various operations are also fully described. The relation of the ear to general diseases, and Life Insurance receive due consideration.

Green's Encyclopedia and Dictionary of Medicine and Surgery. Vol. I. (Aachen to Brain). William Green & Sons., Edinburgh and London, Publishers. 1906."

The various articles are contributed by a large number of authorities, such well-known names as Lander Brunton, Risier Russell, Dudley Buxton, Rolleston, Ashley and many others of equal prominence are noted. The author, J. W. Ballantyne, M.D., F.R.C.P.E., has written the whole of the dictionarial and most of the minor articles.

The book is the first of a series containing in alphabetical order an elaborate and exhaustive repertory of information of all the branches of medical science, from simple definitions to extensive treatises; a few of the latter, such as those on anæsthetics and the brain, being especially noted.

The system of cross-references used greatly adds to the value—it is simple and yet complete; one can also see at a glance at the commencement of the article a summary of the matter to be dealt with, a point of great importance to a busy practitioner; and it is intended to be to him a colleague, assistant and consultant so far as these parts can be played by a book.

Selections.

Generalized Blastomycosis.

C. Christensen, La Crosse, Wis., and L. Hektoen, Chicago (*Journal A. M. A.*, July 28), give detailed histories of two cases of disseminated blastomycosis. In both the onset was sudden and without the presence of any chronic external lesion that might be regarded as the primary localization. In the first case, the cutaneous and subcutaneous lesions developed simultaneously after an acute febrile attack, and suggest the lungs as the portal of entry of the infection. In the second case, the localization of the infection seems to have been in the deeper tissues before the subcutaneous invasion. The authors suggest the advisability of experiments to determine whether the organisms are easily conveyed by air currents when dry, whether they retain their vitality and infectiousness after drying and whether or not they are carried in minute droplets of sputum. The peculiar predilection for the skin possibly indicates an important avenue of escape of the germs, it may be to new hosts. The authors also suggest the possibility of infection of skin lesions by way of the blood current and not always, as seems to have been supposed, by direct implantation from without. No effective treatment has yet been devised. In these cases the authors tried a sterile vaccine prepared from the blastomycetic organism, with the idea of stimulating opsonic action according to the method of Dr. A. E. Wright. Unfortunately, the patients passed out from under their observation, leaving the hospital before any definite conclusion of value could be drawn as to the result of this treatment. Work is now being done to develop certain methods by which the effect of the blastomycetic vaccines can be tested *in vitro*, so as to furnish some guidance in the treatment of the disease.

Treatment of Loosened Teeth.

M. L. Rhein, New York City (*Journal A. M. A.*, July 28), distinguishes two classes of loosened teeth: 1. Those cases due to infection which has caused the spreading of pus so as to interfere with the pericemental attachment of the root to the alveolus. In these the more or less speedy removal of the infecting focus will usually restore the solidity of the tooth. Infection from dying pulp, difficult eruption, ligatures around the neck of the tooth, ill-advised separation of the teeth and other injudicious dental procedures are the most common cause in this class, and the

condition can therefore be considered a strictly localized disease readily cured by the removal of its cause. 2. Cases in which necrotic conditions prevail and the tooth becomes gradually loosened in its socket as it loses more and more of its periodontal attachment. The condition here is the result of some form of malnutrition and is less amenable to treatment. The importance of ascertaining the cause in each case, therefore, is plain. Gingival pockets should be looked for and their extent ascertained. If they extend all round the apex of the root the pulp is probably dead and should be removed. If of slight extent, the question is more difficult and the pulp condition must be tested in various ways. The condition of the occlusion of the tooth must also be considered. Rhein speaks highly of the value of the X-ray in the diagnosis, but points out the need of care in the interpretation of the radiographs. In the second class of cases the general opinion is that the pulp has lost its physiologic characteristics, and its thorough removal when feasible is a well-recognized and satisfactory treatment. The X-ray has been suggested in these cases as a therapeutic method, but its real value is yet undetermined. The high frequency current in its various forms has also been used, and has, at least, the advantage of apparently lacking the dangerous qualities of the X-ray. In the treatment of these cases every possible pus focus must be removed, and one that frequently escapes observation is a root of multirooted tooth that has lost its entire attachment and remains as a necrotic appendage. Such a root must be removed without fail, and the best results can only be obtained by replacing it with a porcelain substitute, the technic of which Rhein has elsewhere described. About 85 per cent. of his cases thus treated have resulted favorably. When all other means have failed there remains the last resource of uniting loosened teeth together, or to healthy teeth. In all cases of loosened teeth of the second class, after the mouth has been brought into a comfortable condition this can only be maintained if it is followed once every month by careful prophylactic treatment by the dentist and dental nurse.

Opium in the Laryngeal Stenosis of Diphtheria (Therap. Monats.

Rudolph observes in the treatment of severe cases of laryngeal stenosis in diphtheria by serum that the addition of opium is of benefit. Tracheotomy and intubation are often performed which might have been obviated. He quotes three cases in support of his contention. First, he was called to a child two years old after the usual medical attendant had advised that tracheotomy

be performed in a hospital, which the parents refused to have done, even though so advised by Rudolph. He therefore injected Behring's No. 2 Serum, and prescribed 2 minims "tinct. opi." four times a day, or oftener if required. On the child waking from sleep it was given food, and although only four hours may have elapsed since previous dose, another dose was given if it did not quickly go to sleep again. After twenty-four hours the effects of the serum was shown by the membrane on the tonsil becoming loosened. The laryngeal stenosis became more noticeable, the breathing noisier, the indrawing of the sternum more apparent, especially when the child was not under the narcotic. Possibly the serum beginning to take effect gave rise to mechanical obstruction of the larynx. After about twenty-four hours there was no stridor; general improvement began, with speedy recovery. The other two cases were very similar. In one, where the patient's brother had died a few days previous after tracheotomy had been performed, symptoms of laryngeal stenosis commenced two days prior to his being called. Despite this, the treatment was quite successful. The author claims these cases prove his contention that the serum gave excellent results; but before any appreciable result was obtained, the patient's suffering was made bearable and the breathing easier by means of opium. The dose should be 1 drop for each year of the child's age.—*Treatment.*

Lumbar Puncture.

Lumbar puncture as a therapeutic and diagnostic procedure has come to stay. At present there is some retrocession from the enthusiasm which characterized its first introduction, and some contraindications have been formulated, notably those cases of long-continued increase in intracranial pressure such as occurs in cerebral tumor. In such cases where the communication between the cerebral and the spinal fluids is obstructed or obliterated the sudden relief of pressure may result in forcibly driving the medulla into the posterior fossa with a prompt fatal termination. In ordinary infections, hemorrhages and similar conditions, lumbar puncture is devoid of danger providing it is carefully performed. Hackenbruch (*Centralbl. für Chir.*) has carefully formulated the steps in this procedure. Ordinarily puncture has been made between the third and fourth lumbar vertebrae, though it may be one vertebra higher or lower. He points out that it is simpler and easier if a short skin incision is made, and there is less danger of infection from organisms which are commonly present in the skin. The same care should be exercised in making a lumbar puncture that is followed in any ordin-

any surgical procedure. The skin should be carefully cleansed and shaved over the site of operation, and the skin should be anesthetized by some of the infiltration methods. The opening in the skin need not be more than one-sixth of an inch. There is then introduced into the wound a needle furnished with a mandrel, which is removed after the needle enters the spinal canal, permitting the spinal fluid to flow out. The same precaution should be employed in spinal anesthesia. This latter procedure has deservedly fallen into some disuse since it was first advocated, but it still has its indications.—*Medicine*.

Local Analgesia In Ocular Therapeutics.

In lecturing on the old and the new in ocular therapeutics, A. Maitland Ramsay, surgeon to the Glasgow Ophthalmic Institution, mentions only dionin under the head of local analgesics. He says: Dionin is a derivative of morphine and in five-per-cent. solution is one of the most valuable agents which we possess for the relief of deep-seated pain—*e.g.*, in glaucoma, iritis, scleritis, etc. When dropped into the eye it causes at first a smarting and burning sensation, accompanied by chemosis of the conjunctiva and swelling of the lids. These symptoms are sometimes very pronounced and may alarm the patient greatly if he has not been forewarned of the probability of their occurrence and told that they speedily pass off. This lymphagogue property of dionin is intimately associated with its power as an analgesic, because only after a good reaction is there much relief of the pain. This property also explains its power in promoting absorption of inflammatory deposits in the cornea. Its action in this way, very satisfactory in itself, is greatly increased if it be used along with collargol. In the author's experience the best results are obtained when a five-per-cent. solution of dionin is instilled in the morning and a disk of ten-per-cent. collargol gelatin is placed in the conjunctival sac in the evening. He is satisfied that this method of treatment hastens the clearing of the cornea after an attack of ulceration or of interstitial keratitis.—*The Lancet*.

Diet in Renal Disease.

Bradford says that a rigid system of dieting is suitable neither for all kidney diseases nor for all stages of the same disease, and attention in determining the diet should not be directed exclusively to the condition of the urine, but other factors, such as the general nutrition of the patient, the presence or absence of dropsy, the degree of cardiovascular degeneration present, and the presence or absence of uremia, are all factors

that should be taken into consideration. In cases of true acute nephritis associated with considerable suppression of the urine, and in which the eliminating functions of the kidney are most seriously compromised, the diet should be reduced to the greatest extent possible, and in some cases of very acute nephritis it may be advisable to withhold all food for a few days. In most cases such starvation treatment is not necessary, but it is still essential to give as little food as possible, and it may be as well to restrict this to one or one and a half pints of milk, moderately diluted, in the twenty-four hours.

All meat extracts and soups should be avoided throughout the illness, as their nutritive value is low, and they contain numerous extractives and salts which can only act as irritants to the kidney. The amount of fluid given to these patients should also be strictly limited, especially if there is any tendency to dropsy or to the development of hydremic plethora, and the use of dilutents as diuretics should be restricted to the later stage of the malady, where, no doubt, much good may be derived by the administration of moderate quantities of fluid in order to promote the removal of debris from the renal tubules. In chronic renal disease, if complications such as uremia and dropsy are present, the dietetic treatment must be somewhat similar to that applicable to cases of acute nephritis, but owing to the long-continued character of the disease, restrictions cannot be carried to the same length as those suitable to the treatment of the acute malady. In chronic renal disease associated with dropsy, and particularly with increasing dropsy, a milk diet is also advisable, but in very chronic cases, in which the dropsy is moderate in amount and persistent for weeks or for months, a pure milk diet for prolonged periods. Such patients may be put on a milk diet of some three pints per diem, and if improvement sets in such a diet may be continued for three weeks, but it is probable that no useful purpose is served by maintaining such a diet for months, and a more solid diet with a minimum of common salt may often produce more beneficial results.

The improvement under a milk diet in chronic renal disease is often more spurious than real, the quantity of urine is seen to be increased, and the albuminuria to be apparently diminished; these are looked on as signs of improvement, when really all that has happened is that the diuretic action of the milk has led to an increase in the flow of urine, and thus the loss of albumin, although really the same, has undergone a percentage reduction. Attention should never be directed solely to the state of the urine, the general appearance of the patient and the body weight should be carefully observed. An increase

in dropsy frequently shows itself by a rapid increase in the body weight. The milk diet is not recommended as a routine measure for long-continued periods in chronic renal disease.—*Practitioner and J. A. M. A.*

Uric Acid Solvents.

If we analyze the various remedies that are recommended as uric acid eliminators or solvents, we find that nearly all of them contain two chief ingredients—*i.e.*, alkali and water; the idea being presumably to alkalinize the blood-stream, thereby rendering the uric acid more soluble and hence promoting its excretion. This in itself is not a bad idea, although it is an exceedingly difficult matter more than temporarily to change the reaction of the blood by the administration of alkalis by mouth, because the kidneys at once eliminate any excess of alkali. The idea, however, that alkalis given by mouth can in any way aid in dissolving uric acid concretions after they have once formed is, of course, preposterous. One might as well give ether to dissolve the fat of the body in obesity or acids to dissolve the calcium out of osteophytes, on the ground that ether or acids can dissolve fat or calcium salts in the test-tube; in other words, the fact that alkalis are a uric acid solvent *in vitro* does not mean that they can accomplish the same *in vivo*. The amount of ingested alkali that could reach uric acid deposits in the circulation would be so infinitesimally small that a solvent effect could not possibly be accomplished.

This criticism applies with particular emphasis to lithium preparations that are so popular in the treatment of uric acid diseases. In the first place so-called lithia waters contain only a few decigrammes of lithium carbonate to the liter; as they always also contain large quantities of other alkalis, only a very minimal amount of uric acid (according to Berthollet's law) would combine with the lithia, the bulk with the sodium and potassium salts, while at the same time most of the lithium would be promptly excreted as chloride, phosphate, and sulphate. Finally, lithium carbonate, which actually does readily dissolve uric acid in the test-tube, is immediately converted in the stomach into lithium chloride, a salt that possesses only slight uric acid dissolving properties.

Whatever virtues, therefore, the innumerable uric acid remedies and lithia waters may possess they owe to the alkali that they contain, but this alkali acts only mildly as a uric acid eliminator and not at all as a solvent of urate concretions; it acts chiefly as an antacid in acidosis, and possibly as a stimulant to the liver function. The water is probably the most

efficacious ingredient of these uric acid remedies, because abundant water-drinking combined with a rational diet, the details of which cannot be enumerated here, undoubtedly acts beneficially in most disorders in which metabolism is retarded and in which incompletely oxidized waste products accumulate.

Until we understand the real cause of gout and allied conditions, until we know which produces the symptoms that are popularly considered to be manifestations of a hypothetical uric acid diathesis, we can do no better than to treat the gastrointestinal tract and the liver, to promote elimination, and give the patient the benefit of certain symptomatic and local treatment.

If alkali and water are to be used, and we know empirically that they are of some benefit, why not order our patients to drink a few quarts of water a day, to which may be advantageously added a teaspoonful or so of baking soda and a pinch or two of precipitated chalk? This would accomplish all that can possibly be claimed for their goods by promoters of a host of expensive mineral waters and the manufacturers of most of our well-advertised so-called uric acid remedies.—*Journal of the American Medical Association.*

Bacteriuria.

Bacteriuria, understanding by the term the presence of bacteria in the urinary tract above the compressor urethrae musele, is, according to G. P. La Roque, a much more common condition than is generally supposed. Unless associated with suppuration it produces none of the symptoms of true inflammation in a healthy person, but such may follow in conditions of lessened vital resistance. Local symptoms, when present, are: Slight increased frequency of micturition, mild ardor urinae, occasionally incontinence, and in children there may be nervous disturbances. If no abrasions exist, toxins are not absorbed. In many cases there are no subjective symptoms. The most common infecting organism is the *Bacillus coli*, and it is present in nearly all cases, often in pure culture. In some cases of typhoid bacteriuria it is absent. Alkalinity of the urine means the presence of the staphylococcus or *Bacillus proteus vulgaris*; all other organisms, these being absent, produce an acid urine. When the bacteria come by way of the kidneys, as in typhoid septicemia or scarlatina, there is always a positive albuminuria. When they enter from the genitalia or the lower intestinal tract, the presence of albuminuria is dependent on the previous condition of the kidneys. The history will probably suggest the causative germ. In treating the condition, urinary and intestinal

antiseptics, urotropin (hexamethylenamina), salol, boric acid, and large draughts of water are advised. Vesical instrumentation and irrigations are to be avoided so far as possible. In spinal disease with paralysis of the compressor muscle, bacteriuria is a constant attendant affection, and when the urine becomes ammoniacal, cystitis is inevitable. The danger to life in these cases from ascending urinary affection makes bacteriuria a serious matter, and everyone recognizes the value of thorough, gentle, aseptic bladder drainage in their treatment. In cases, as in the aged, dependent on colitis and constipation, free purgation, regulated diet and intestinal antiseptics are essential. Colonic lavage for two or three months is practiced by Janet. A case of very marked bacteriuria following dysentery is reported.—*Jour. A. M. A.*

Ichthyol in the Treatment of Angio-Neurotic Edema.

Angio-neurotic edema, designated by Schlessinger hydrops hypostrophos, is a serious disease, writes Frederick C. Forster, of West Southbourne, Bournemouth, because it may attack mucous membranes as well as skin, and sudden edema of the larynx may, therefore, occur and prove rapidly fatal, as in a case recorded by Morris. Tracheotomy was performed on three separate occasions for asphyxia due to edema, but the patient succumbed one night from a fourth attack before medical assistance could arrive.

Other cases have from time to time been recorded, notably one complicating enteric fever, reported by Drs. Martin and Gillies. The surgical importance of its visceral crises has been demonstrated by Professor Osler, and instances given in which laparotomy was performed for angio-neurotic edema of the intestine, the symptoms closely simulating an acute abdominal lesion.

A nervous, unmarried lady, aged thirty-seven, sought advice with an eight years' history of evanescent swellings, neither inflammatory nor dependent on any injury. They usually occurred at fortnightly intervals on the face, chest, and upper arms, lasting about two or three days, and then disappearing. They occasioned no pain, but only a sensation of tingling and slight soreness. No therapeutic measures tried had either ameliorated the attacks or lengthened the intervals between them. He ordered ichthyol, grn. iij, in pill form, to be taken thrice daily. This she continued for two months, then twice a day for another month, and at present she is taking one each day. She writes that for the past three months she has had no recurrence.

The author is not aware that ichthyol has been tried for this disease, but was led to prescribe it because of its efficacy in controlling the "flushings," "vasomotor neuroses," and allied phenomena which are common at the menopause, when the vasomotor system appears to be the escape valve for pent-up nerve storms.

Though there was no evidence of any climacteric change in the patient, ichthyol proved beneficial. The author says it is too early to claim that the trouble is more than checked. He considers ichthyol worthy of a continued trial. Where angioneurotic edema is accompanied by gastro-intestinal disturbance, ichthalbin (an albuminate of ichthyol) may be more easily tolerated.—*British Med. Jour.*

Typhoid Diagnostic of Ficker.

In all cases in which typhoid fever is suspected, M. Meyerhoff removes blood from a vein at the bend of the elbow and performs the Widal test with Ficker's typhoid diagnostic and the various pipettes recommended by him. The fact that in each one of nineteen cases the test was eventually positive, speaks well for the value of the method. In one case, the symptoms were typically typhoidal, yet daily tests never showed any agglutination; as soon as the paratyphoid-B diagnostic was employed, agglutination was strongly positive and the real nature of the disease was beyond doubt. The test is generally positive by the end of the second week, sometimes not before the twenty-first day. Agglutination was never obtained in cases other than typhoid, unless typhoid existed previously, as in one instance where the patient had been ill six years before. The reaction with the diagnostic is therefore in every way as good as that with the living bacilli, except that it does not enable diagnosis in the earliest stages of the disease.—*Berl. klin. Woch., in Merck's Archives.*

The After-care of the Consumptive.

In the antituberculosis crusade attention has been devoted to the means of preventing infection, the discussion of laws relating to notification and also to treatment of the tuberculous, particularly the establishment of sanatoria both public and private. There can be no doubt of the value of this movement and of the amount of good which it has already accomplished. There is another feature which has been given comparatively little attention, and that is the after-care of the tuberculous. In those who are well-to-do this problem is not difficult, but for the working man, and particularly for the working woman, the

problem of how to live after the disease has been arrested is one of paramount importance. Already the public is becoming fairly well educated on the main topics relating to tuberculosis, and the one that has sunk the deepest in the public mind is the feeling that tuberculosis is contagious; hence in the narrower field that is open to the employment of women, which is largely in a sedentary way and in comparatively close contact with others, the problem of occupation is all-important. For working-men there is a much wider range of choice. The man who has been employed within doors can obtain work on the farm or in various out-of-door occupations, but the number of places open to women in out-of-door work is very limited. To return to the same surroundings under which the disease was contracted is almost certain to mean a recurrence. Discussing this one feature of the antituberculosis crusade shows how the problem of tuberculosis is essentially a sociologic and economic one. With the disease arrested it is highly important to discuss the question of after-care.—*Medicine*.

Recognition of Albumin Bodies in Urine.

T. W. Hastings, in *The Medical Record* (July 7, 1906), refers to the fact that the term albuminuria is loosely used to designate the presence of any albumin body in the urine which responds to the tests for albuminous material. It is possible to have in the urine several kinds of albumin bodies. The ordinary tests such as nitric acid, or this acid plus heat, may throw out nucleo-albumin. In order to test the presence of serum albumin, which is alone an evidence of pathological states, the best test is the use of a saturated solution of sodium chloride acidulated with 5 to 10 drops of 50-per-cent. acetic acid. Mix the urine with such a solution and boil the upper one-third of the urine. Any pathologic albumin will be precipitated. If this test is carried out in a routine way much more satisfactory and reliable results are reached than by the older methods of testing for albumin. It is important to examine the urine within six hours after it is gathered, otherwise the products of bacterial disintegration may interfere with moderate reactions for albumin.—*Medicine*.

Paget's Disease.

Hartzell (*Journal of Cutaneous Diseases*) describes two cases of Paget's disease treated by the X-ray. The first healed entirely, but this healing was followed by the development of a breast tumor a year after complete cure of the skin lesion. The second case ran an identical course, excepting the mammary carcinoma had not reached the same stage at the time of report.

Hartzell from a study of the current literature notes that excellent results seem to follow the use of the X-rays in Paget's disease. He personally believes that the careful, systematic and prolonged use of the ray may permanently cure disease of the areola and nipple, but that this agent has very little effect upon the epithelial proliferation in the ducts and in the alveoli of the mammary gland. He notes that the ducts become involved only after some considerable time; that if the X-ray is applied early and persistently there is some prospect of a complete and lasting cure. This when the ducts and glands are involved can only be accomplished by surgical operation.

Ravogli regards Paget's disease as a precancerous disease developing as an epithelioma and gradually involving the deeper layers of the skin.—*Therapeutic Gazette*.

Advice for Tuberculous Patients.

The following is from the recommendations of the Bellevue Hospital of New York:

Bathe regularly. Sponge your chest with cold water every morning.

Rest. Avoid all unnecessary exertion. Do not walk more than you are allowed. Sleep at least eight hours every night, and go to bed early. Never run; never get out of breath. Never lift heavy weights; never get tired. If you have to work, take every chance to rest that you can. Go slow.

Food. Eat plenty of good, wholesome food. Drink at least one quart of milk a day. Eat from three to six eggs a day, and take them raw if you possibly can. Eat slowly; avoid anything which causes indigestion. Keep your bowels regular. Do not drink liquor, wine, or beer. Do not smoke.

Medicine. Take no medicine without your physician's advice. Stop any medicine which upsets the stomach. Report regularly to your physician. Report immediately if you have indigestion, diarrhea, constipation, pain, increased cough, or hemorrhage.

Follow instructions carefully and exactly, and your chances of getting well will be increased ten times.—*Therapeutic Gazette*.

Infantile Scurvy.

Still is convinced of the superior potency of potato as an antiscorbutic, although it is not so suitable for prophylaxis as it is for treatment. It is usually tolerated well for a few weeks during the treatment, but it is more apt to cause digestive disturbance than is fruit juice, and therefore is less suitable for prolonged use as a regular addition to the diet. The potato is

prepared by boiling or steaming in the ordinary way with care to obtain a floury potato: the outer floury portion is then scraped off and beaten up thoroughly with enough milk to make a smooth cream, sufficiently thick to pour out of a jug rather heavily—potato 2 heaped teaspoonfuls (with average 2 dram teaspoon) to 1 ounce of milk: $1\frac{1}{2}$ to 2 teaspoonfuls of this potato-cream are given three or four times daily; after two or three weeks the dose of this should be gradually reduced, and omitted altogether within four weeks from the commencement of treatment. The mode of giving the potato-cream is of some importance: most infants take it best mixed up with the ordinary food, but if this is done it should be mixed with a portion only of the food to ensure all of the potato-cream being taken, otherwise if part of the food is left the child does not get the full dose of potato. Occasionally it is taken more readily given separately: in either case it is often disliked at first, but Still has rarely had any serious difficulty in getting a child to take it. In addition, two teaspoonfuls of raw-meat juice may be given three or four times in the twenty-four hours, and sometimes one-half teaspoonful of orange juice two or three times a day, but any looseness of the bowels should make the physician cautious in adding this to the potato-cream, for diarrhea in infantile scurvy is a serious complication, as Glisson seems to have observed. At the same time, the child is placed on a diet of milk which has been heated just short of boiling point and diluted with water; the scurvy-producing "food" is, of course, stopped.—*B. M. J. and J. A. M. A.*

The Coated Tongue.

L. Kast (*Berl. Klin. Wochenschr.*)—The examination of the coated tongue as an index to gastric disorders, upon which formerly so much stress was laid, has now generally fallen into disrepute. This is probably chiefly due to the lack of evidence that the condition of the stomach can affect that of the tongue either by the direct ascent into the mouth of stomach contents to swallow capsules containing lycopodium powder. The mouth was rinsed with water that same evening and again the next morning. In over half the cases the mouth was found to be (in the absence of regurgitation, eructation or vomiting) or otherwise. Kast, however, has shown that such a process actually does take place. A number of patients, all of whom were free from regurgitation, eructation and the like, were made free from lycopodium in the evening but to contain it next morning. The conclusion may fairly be drawn, that in some cases stomach contents may gradually wander up the esophagus

into the mouth and form a coating on the tongue. In these cases the condition of the tongue may fairly be assumed to represent that of the gastric mucosa.—*Interstate Medical Journal*.

The Early Diagnosis of Gastric Carcinoma.

D. Maragliano (*Rif. Med.*) returns once more to the early diagnosis of gastric carcinoma by means of the method of precipitins. In view of further experiments and greater experience the method is becoming more clearly defined. One of the difficulties has been the variety of precipitates which may be obtained, and hence the necessity of fractional precipitation by which the non-specific and non-essential precipitins are excluded. In the first place, it is essential that the gastric juice should be rendered neutral; if it is acid, precipitation occurs readily. Broadly speaking, the various precipitates likely to occur when an immunized serum is added to the gastric fluid may be divided into four chief groups: (*a*) Albuminoids common to the organism as a whole, and corresponding to those contained in the blood; (*b*) albuminoids coming from the secretion of a wound, no matter of what nature; (*c*) albuminoids peculiar to the stomach, and due to epithelial desquamation or to inflammation; (*d*) the specific albuminoids of cancerous tissue. Obviously, therefore, the aim is to get rid of the groups (*a*), (*b*), and (*c*) by means of fractional precipitation and deal with group (*d*), which alone is of value in the diagnosis of cancer. The author then goes into details as to the exact method of preparing the immunized serum (goats are better for this purpose than rabbits), and the precautions to be observed in applying it for diagnostic purposes. Clinically the test has proved useful, and only requires wider application and further experience to estimate its proper value. The author believes that it is as likely to be useful as the Widal reaction in typhoid, and will give positive results long before the cancer could be certainly detected by the means at present at our disposal.—*British Medical Journal*.

Abscess of the Kidney in Convalescence from Typhoid Fever.

F. Stinelli (*Gazzetta degli Ospedali*).—A man had typical typhoid fever. While delirious he fell out of bed and struck the ground on his right loin without injuring the skin. When convalescent, about the twentieth day of apyrexia, he began to feel a little pain in this spot. High fever followed and lasted two days. The fever recurred five days later and took a remittent form, rising to 104 degrees in the evening, with chills, and followed in the night by sweating. Two weeks after the onset

of the fever a painful non-movable swelling was found in the right lumbar region. The urine did not contain pus or albumin. An incision was made from the twelfth rib to the ilium and a perirenal abscess, and an abscess between the kidney and its capsule were found and evacuated. The fever at once disappeared and recovery was complete in a month. The pus contained the typhoid bacillus.—*Medical Review.*

Thephorin.

T. A. Mass (*Therap. Monats.*) has made experimental investigations as to the value of the new diuretic agent thephorin. Thephorin is a double salt of theobromine and formic acid, and has a composition analogous to that of diuretin, but that in thephorin formic acid takes the place of the salicylic acid in diuretin. The drug was supplied to the author in the form of tablets, each containing 0.5 gram of thephorin, and also as a powder. It is easily soluble in water, especially in warm water, and forms a clear weakly alkaline solution, which becomes turbid with long keeping. The author has not tried the effect of thephorin upon human subjects, but he has injected it into rabbits and guinea-pigs, both when the animals were apparently healthy and also when nephritis with oedema had been artificially produced, in order to determine its general action, its toxic effects, the fatal dose as compared with that of diuretin, and its effect upon diuresis. The following are the conclusions arrived at: (1) Thephorin is relatively only slightly poisonous; the fatal dose lies between 0.8 gram and 0.9 gram per kilogram for the guinea-pig; the theobromine would seem to be the poisonous element, because the amount of it contained in the above dose is almost the same as that contained in the fatal dose of diuretin; (2) given in small doses, the action is a slightly irritant one, in larger and fatal doses there is general paralysis ending in death; (3) thephorin lowers the blood pressure, and at the same time increases the frequency of the pulse; (4) in sound animals diuresis is temporarily greatly increased, but the effect so quickly disappears that the whole quantity of urine passed in twenty-four hours is not increased; (5) in animals suffering from dropsy, the result of toxic nephritis, thephorin is extraordinarily effective in combating the symptom; for example, in one of the animals treated by thephorin the free fluid in the pleural and peritoneal cavities after death was only 48 c.cm., as compared with 90 c.cm. in the control animal; in another case the amount for the animal treated was 4 c.cm., as compared with 60 c.cm. in the control animal; (6) the dose of thephorin which is effective clinically is far smaller than the toxic dose;

over-dosing is to be avoided because it leads to inhibition of the action of the drug; the dose for clinical purposes should be the same as that of diuretin; (7) the coagulability of the blood is diminished by thephorin. It is thus seen that in thephorin we have a new preparation which, from its composition and from the result of experiments on animals, would appear to be well suited for clinical purposes, but how far it will replace older diuretics can only be judged from clinical observation.—*British Medical Journal*.

Oesophageal Symptoms in Aortic Aneurysm. E. HIRTZ and H. LEMAIRE (Bulletins de la Soc. Med. des Hospitaux.)

and H. Lemaire (Bulletins de la Soc. Med. des Hospitaux.)

A man, aged 55, was admitted into hospital on March 3, 1905. For four months he had been losing health and strength. For two months vomiting had followed nearly every meal. At first the vomiting occurred about an hour after meals, then it occurred earlier, and finally it took the form of regurgitation. After taking a few mouthfuls of food the patient had to get up in order to reject what he had swallowed. This always occurred in the case of liquids, but solids were often retained. Deglutition was not painful and did not appear to be difficult. The patient had not been obliged to diminish the size of the mouthfuls.

He looked cachectic and the conjunctivæ and face had a subicteric tinge. There was myosis without inequality of pupils. In the upper part of the epigastrium some deep and painful lumps were felt. On taking a glass of milk the patient vomited it after some seconds and in the meantime abundant salivation occurred. The urine was increased in quantity and contained a trace of albumin. The area of cardiac dulness was increased, especially to the left. The apex beat was in the fifth space outside the nipple line. There were a "bruit de galop" on the left side and a resounding second sound at the base. The arteries were atheromatous; the radial and femoral pulses were equal. Abundant salivation always followed the taking of food, but occurred at no other time. The patient complained of great thirst which he could not quench. The existence of painless œsophageal vomiting with abundant salivation caused stricture of the œsophagus to be diagnosed. The lump felt in the epigastrium seemed to point to malignant disease of the cardia. But the facts that the regurgitation followed closer and closer upon deglutition, and that the patient was not compelled to diminish more and more the size of the bolus, and that the regurgitation was almost selective for liquids, were not in accord with the existence of a progressive malignant stricture of the lower end

of the œsophagus. The hypothesis of pressure on the œsophagus by a mediastinal tumour was also entertained. On March 8, there was a severe attack of hæmatemesis; bright red blood was rejected without any effort of vomiting. Syncope followed and about an hour later a stool consisting of block clot was passed. Next day a similar attack of hæmatemesis proved fatal.

Necropsy.—The heart was greatly enlarged and the aortic valves were indurated. The thoracic aorta was uniformly dilated to a diameter of more than 5 cm. At the diaphragm was a spherical aneurysm of the size of the fist and intimately adherent to the œsophagus into which it had perforated. The lumen of the œsophagus was but little contracted by the aneurysm. The left pneumogastric nerve was involved in the adhesions between the œsophagus and the aneurysm, and was exposed in the communication between them. The walls of the aorta were thickened and of calcareous consistence. The stomach contained an enormous clot. The kidneys were slightly atrophied and the capsules were adherent. The abdominal aorta and the iliac arteries were a little sclerotic.

The case presents several points of interest. The patient complained only of digestive symptoms, œsophageal vomiting (regurgitation) and brief, but abundant, salivation after taking food. The latter appears to be an œsophago-salivary reflex. M. Antony has pointed out the existence of this reflex in cancer of the œsophagus. There were no signs of aneurysm. The survival of the patient after the first attack of hæmatemesis did not seem compatible with the hypothesis of rupture of an aneurysm into the œsophagus. But cases of survival after such hæmatemesis for days, weeks, and even for two months after more than a litre of blood has been lost, have been recorded. [See "Non-fatal Rupture of Aortic Aneurysm," "REVIEW," 1904, p. 703, and "Recurrent Copious Hæmoptysis" from an Aortic Aneurysm," "REVIEW," 1905, p. 367.] Rupture of an aortic aneurysm into the œsophagus is even compatible with a return to activity of the patient. The arrest of the hemorrhage has been explained as due to plugging of the opening with clot. Dysphagia is rare in aortic aneurysm. In this case there was no mechanical obstacle to deglutition. The selective character of the vomiting for liquids points to the absence of such obstruction and to spasm of the œsophagus as the cause. Evidently both the salivation and the vomiting were due to irritation of the exposed pneumogastric nerve during deglutition.

Rupture of an aortic aneurysm into the digestive tract is rare. In a period of seventy-two years 142 cases of ruptured aneurysm were reported to the Societe Anatomique of Paris. In

79 rupture occurred into the air passages and in only 6 into the digestive tract, once into the duodenum, once into the stomach, and four times into the œsophagus.—*Medical Review*.

Prolonged Lochia.

Whenever the vaginal discharge continues into the third week after delivery, either there is retained debris with subinvolution or an unhealed laceration of the cervix. It is perhaps not best to make a perfect examination at this stage since intrauterine manipulation might result in serious pelvic infection. Rather it is better to use boric acid or carbolic injections followed by antiseptic suppositories and internally 5 grn. of quinine thrice daily—a drug which contracts the uterine fibres and thus promotes involution. If bloody discharge continues into the fourth week the uterus must be carefully scraped out and perhaps touched with iodine and carbolic. Internally ergotin, quinine, and strychnine are now indicated, and in two weeks more the uterus will generally be found of normal size unless serious infection has occurred at time of labor.—*Amer. Jour. Clin. Med.*

Koplik's Spots.

Burg has recently called attention to the positive value of Koplik's spots in the diagnosis of measles. These spots, which appear on the mucous membrane of the inside of the cheeks, have a rose-colored periphery with a bluish-white centre. He has not found them in any patient except one who was developing measles. Their diagnostic value lies mainly in their early appearance, nearly two-thirds of their appearances being on the second or third day preceding the eruption of the disease. Some few cases show the spots the day before the eruption appears, and they are very rarely observed to develop coincidentally with the eruption. Their absence, however, does not exclude measles, as they may not appear during the entire course of the disease.

The diagnostic importance of these spots should always be remembered in instances of delayed eruption, especially when such cases occur during the occurrence of scarlatina.—*The Clinical Review*.

Telephone Advice.

The use of the telephone by patients who wish to secure medical advice for which they do not expect to pay is the source of considerable annoyance to most practitioners. In order to put an end to all doubts as to the lawfulness of charging for tele-

phone consultations a Viennese physician recently brought a case into court, in which a patient who had on several occasions, even in the night-time, asked for professional advice and had refused to pay a fee for the service. The judge decided that advice must be paid for whether given in the consulting-room, by a letter or telephone, or at the bedside. It is the duty of a practitioner to decide whether the case is such that he may safely give instructions by telephone after he has seen the patient on a previous occasion. If physicians would render bills for telephone consultations at the same rate they charge for office consultations they would soon cease to be annoyed in this manner.—*Medical Age*.

Routine Urine Examinations.

M. H. Fussell, Philadelphia (*Journal A. M. A.*, July 28), insists on the value of the routine examination of the urine. Even though albumin and casts do not always mean nephritis, their presence in the urine indicates that a vital organ is at fault, and that this fault must be duly considered in the diagnosis, prognosis and treatment. There are other conditions also to be made note of, which are of the greatest importance, such as the presence of glucose, of pus, of blood and persistent or intermittent excessive amount, all of which are to be taken note of in the routine examination. He gives, as illustrating his view, his own experience for the past eighteen months, in which he has examined the urine of 763 patients, and found abnormalities in 15 per cent. He gives abstracts of the case histories of a few of these which proves, he thinks, that it is only by a routine examination that we can make more than a tentative diagnosis only when symptoms point to a genitourinary disease is to miss the diagnosis in many important cases in time to be able to give them benefit by treatment.

Earache. A. BARDES (*Medical Record*, January, 20, 1906).

The writer advises that as soon as earache begins the patient should be kept quiet, put to bed, and placed on a fluid diet, and in other ways treated as one would treat a patient with a high fever. The bowels should be kept open, and a single dose of morphine may be given to insure rest and comfort. Dry heat or else an ice-bag can be applied to the ear. The former is the more acceptable to most patients. Every three the ear should be gently irrigated with a hot solution of bichloride 1 to 5,000, after which a few drops of a 12 per cent. solution of carbo-glycerine may be instilled. Under no

consideration should a person be allowed to suffer pain longer than twenty-four hours. If the pain continues and the drum-head is inflamed and distended, palliative measures are worse than useless, and any attempt to abort the inflammation by means other than surgical is dangerous, and valuable time is lost in so doing. A bulging drumhead should be treated in the same way as a septic formation in any other place. It should be freely incised, rather than simply punctured or allowed to break.—*Monthly Cyclopedia of Practical Medicine. cine.*

Perinephritic Abscess. RAMON GUITERAS (*New York Medical Journal*, January 27, 1906).

The author believes that many more cases of perinephritic abscess are due to suppurative renal disease than is generally supposed, a fact which will be proved with the rapid strides that are now being made in renal surgery. Traumatism, exposure, and similar influences to which primary perinephritis is attributed, are not so important as many observers have claimed. They are often vaguely given as causes, when they are simply coincidences, or the active causes of rupture of already existing abscesses in the kidney or neighboring structures.

It is important, though difficult, to determine the source and course of the pus. Therefore, before the operation, pus should be looked for in the common urine and the separate urine by the ureteral catheter. During the operation the surgeon should try to determine whether the kidney is the source, and if not, what tissue or organ is. It is equally as important to discover the road taken by the pus, as it indicates where a counter-opening should be made, and the further treatment of the case for complications.

The elements of success in operations for perinephritic abscess may be summed up as follows: Early incision and evacuation before the pus has had time to burrow extensively. Thorough exploration, without timidity, opening the kidney and exploring the ureter if need be. Thorough drainage down to the deepest part of the sac by means of large, soft rubber drains or gauze, the drain being kept in place until a well-formed sinus exists down to the deepest part of the cavity. Nephrotomy, nephrostomy, or nephrectomy should be performed if indicated at the time of the operation or later.—*Monthly Cyclopedia of Practical Medicine.*

British Medical Association.

It would be unpardonable not to take special notice here of the above mentioned *Handbook and Souvenir of Canada*. This handsome and artistic volume, in very truth an *edition de luxe*, by "Polymetis," is at once a history, a guide book, an illustrated album, and a bibliography of the sturdy and vigorous Dominion. It treats of the physical conditions of the various sections of this great Dominion of 3,575,000 square miles, an area "somewhat larger than the United States (including Alaska, but not Hawaii and the Philippines), and not quite as large as Europe;" of Nova Scotia, the "Land of Evangeline," an "inspiration to poets;" of Newfoundland; the St. Lawrence; the "Habitants"; quaint Quebec and lively Montreal; of Kingston and Toronto; of the political conditions, banking and business methods, the religions, the arts and institutions of learning, the hospitals, the social conditions, immigration, police and military systems, and of the more remote (in space) and recent (in time) territories, as far as the Yukon. Besides numerous half-tone illustrations the book is embellished also with thumb-nail sketches in monochrome on nearly every page. It will, I am sure, be treasured permanently by all persons of taste who received it.—*St. Louis Medical Review*.

SURGICAL HINTS.

In the early stage of acute gonorrhœal endometritis it is important to abstain from applications to the uterine mucosa and to restrict treatment to simple measures of cleanliness, as vaginal douches and sitz-baths.

Men of healthy and vigorous appearance have not rarely been found to suffer from azoospermia, so that examination of the spermatic fluid of the husband in cases of sterility in the wife will often save the latter from much useless treatment and discomfort.

After operations for hemorrhoids bleeding sometimes recurs after a time. This is not always attributable to the incomplete removal of the piles or to the formation of others. It may be due to hemorrhoids which are seated high up above the sphincter and which often can only be discovered by rectoscopic examination.

Every case of retropharyngeal abscess demands prompt incision, as an attack of asphyxia may arise at any time and terminate fatally before the physician can be summoned, or should the abscess burst spontaneously, the contents may be drawn into the air passages and cause death immediately or from secondary pneumonia.—*International Journal of Surgery*.

Miscellaneous

Science and Medicine for Autumnal Coughs and Colds.

Have your patient bathe the feet in hot water before retiring and drink a pint of hot lemonade. Two Antikamnia and Codeine Tablets taken with the lemonade will quiet the nerves, produce sleep and help break up the cold.

Patients should be advised, when tempted to cough, to take a deep breath, filling every air cell, holding it until the warming, soothing effect comes, or so long as is reasonable, and mark the mollifying result on the cough, which, even when the cough seems unavoidable, will often be found under control. It will help to minimize the cough and in the milder cases will stop it altogether after a little perseverance. The explanation of this is that there is a liberation of nitrogen in the air cells, which has a quieting effect on the irritated mucous membrane.

If the cough is persistent or deep-seated, and especially if it is annoying at night, one Antikamnia and Codeine Tablet slowly dissolved in the mouth will quiet the nervous tickling and stop the cough.

The second annual meeting of the International Medical Association of Mexico will be held in the City of Mexico November 14, 15, 16 and 17. The papers and discussions will be in English, and a cordial invitation is extended to the members of the profession in the United States and Canada. Dr. R. D. Robinson is president, and Dr. W. R. Jamieson, secretary, both of Torreon.

Dr. J. R. Goffe recalls that at a meeting of the Obstetrical Society of New York, in 1882, Dr. Emmet, who had just returned from a visit to Europe, presented a number of Fallopian tubes which had been given him by Lawson Tait, and stated that while he believed that pelvic cellulitis was largely tubal trouble, and that Tait was curing it, he, himself, would never open the abdomen of a woman and remove a Fallopian tube. Thomas, who was present, evidently had no such scruples, for within three months he presented before the society a report of three cases in which he removed the tubes.

He also recalls that Fordyce Barker was a believer in the theory that puerperal infection was due to some mysterious influence floating about in the atmosphere. Thomas and Barker got into an active controversy on this subject over a paper in which Thomas had advocated rather extreme ideas regarding disinfection of the room in preparation for an aseptic accouchement, in support of the views of Oliver Wendell Holmes and Semmelweiss regarding the personal infecting possibilities of

the accoucheur. Barker, who was the great obstetrician of the time, had been the attendant at a number of accouchements occurring in prominent families, and in which infection followed, puerperal fever being epidemic at the time. He ridiculed the ideas advocated by Thomas, who subsequently came out with a paper on the subject which completely routed his popular and talented antagonist.—*The Clinical Review*.

That doctors are at present passing through bad times is undoubtedly true, for it has been estimated that during the last three years their incomes have fallen off 25 per cent., although there has been some improvement since 1904, which all look back upon as the lean year. The causes of this depression can hardly be those alleged by the correspondents whose letters we have quoted, for they were in operation long before the period mentioned; we must, therefore, look for more recent conditions to supply the answer. We believe the chief causes to have been, first, the gradual dying down of the epidemic of influenza which in 1900 caused a mortality of over 16,000, but in 1904 killed only 5,694; and, together with this subsidence of epidemic sickness, we have had mild winters, accompanied by a decrease of the type of illness which we may call "seasonable." The second cause is the depression of trade resulting partly from the frightful cost of the war, which was felt most acutely after the extraordinary war expenditure had ceased and trade had returned to its normal channels, and partly the normal reflux after the high-water-mark that trade had reached just before the war.—*British Medical Journal*.

The Struggle for Existence.

There was a pathetic advertisement in the *Times* the other day, and we are glad to see that it is already receiving quotation in various journals. It ran:

AN EAST-END (London) MEDICAL MAN, B.A., Cantab., who has never had a day's holiday or a Sunday's rest since he has been in practice, and who has not sufficient capital to purchase a more comfortable living, would like to change his profession. He has taken honors in Science, so judges himself capable of filling a Post as ANALYTICAL CHEMIST. Having good credentials and references, he hopes that manufacturing firms, &c., will give his advertisement their consideration.

Those who are in a position to judge know only too well that the East End (London) medical man is typical of a large class. A man may be well educated at a university, he may be competent in his profession, he may be diligent and industrious,