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## Original Communications.

### PRESIDENTIAL ADDRESS, TWENTY-FOURTH ANNUAL MEETING, ONTARIO MEDICAL ASSOCIATION.

By J. F. W. ROSS, M.D., C.M.,
Professor of Gynecology, Medical Faculty, University of Toronto.

GENTLEMEN,—There are pinnacles to which we reach, only to be hurled down from the dizzy height into the valley below to be hidden from the rude storms of the world, and where peace and quiet and easy-going hum-drum pervades the spot, while the green grass grows under the feet. This is the well-known valley of the "have beens." Hills have only two sides, one going up and the other going down, and when one has reached such honor as you have conferred upon me, he has climbed the up-side and must begin the descent. One is elated with the honor, but grieved with a retrospect of all that led up to it; one is pleased with the evidence of the good-will of his fellows—and a better lot of fellows never lived in any profession—but subdued with that soul-shading feeling that youth is fleeting and age is approaching. Each man naturally looks forwad to the day upon which he may occupy the presidential chair, but when the day comes he would give much to be able to postpone the honor for another ten years. And now it is time for the past presidents to move up and make room for me; but I do not intend to be placed upon the shelf, if health and strength remain. We all like to mingle with youth, but, unfortunately,

youth and age were never meant to mix, as Charles Kingsley has aptly put it:—

"When all the world is old, lad,
And all the trees are brown,
And all the sport is stale, lad,
And all the wheels run down,
Creep home and take your place there
The spent and maimed among,
God grant you find a face there
You loved when all was young."

It is a satisfaction, in dealing with the awful miseries of life, to know that others suffer, that suffering and death are the accompaniments of life, and from this springs much of the beautiful sympathy that is witnessed by our profession. We have a grand work to do. Charles Dickens has put it in the words of the doctor's wife where she says, "We are not rich in the bank, but we have always prospered and we have quite enough. I never walk with my husband but I hear the people bless him. I never go into a house of any degree but I hear his praises or see them in grateful eyes. I never lie down at night but I know that in the course of that day he has alleviated pain and soothed some fellow-creature in the time of need. I know that from the beds of those who were past recovery thanks have often gone up in the last hour for his patient ministration. Is not this to be rich?"

The young doctor must have as his main master faculty, sense, common sense, and he must have a real turn for the profession. A great divine has said: "The grace of God can do much, but it canna gie a man common sense." The danger of the present day is that the mind gets too much of too many things. A young medical student may have, as one author puts it, zeal, knowledge, ingenuity, attention, a good eye, a steady hand, he may be an accomplished anatomist histologist, analyst, and yet with all the lectures and all the books and other helps of his teachers he may be beaten in treating a withlow or a colic by the nurse in the wards, or by the Old Country doctor, who was present at his birth. The prime qualifications for a doctor have been given by Dr. Brown in the words, Capax, Perspicax, Sagax, Efficax. Capax, room, for the reception and proper arrangement of knowledge; Perspicax, a keen and accurate perception; Sagax, the power of judging ability to choose and reject; Efficax, the will to do, and a knowledge of the way to do it, the power to use the other three qualities.

The doctor must have a discerning spirit. There is a nick of time, or in other words a presence of mind, and this he must have on, as Dr. Chalmers has said, "Power and promptitude."

"Has he wecht, he has promptitude, has he power? He has power, has he promptitude, and, moreover, has he a discerning spirit?" The doctor must be as a general in the field or the pilot in the storm. I often think he belongs to no one in particular, but is a public property. His time is never his own. His children see little of him, and he leads a sort of Bohemian life, restless, active, thoughtful, worried, much beloved and occasionally cordially hated. He should be Bohemian in his tastes if he wishes for refinement to soften his manners and make him less of a wild beast. Art and literature, however, help to make noble only what is already noble, but such hobbies elevate and improve the mind and lift it above the rut of every-day life. A good education is a first essential. It is not necessary that everybody should know everything, but it is more to the purpose that every man, when his turn comes, should be abie to do some one thing. "The boy who teaches himself natural history by actual bird nesting is healthier and happier, better equipped in body and mind for the battle of life than the nervous, interesting, feverish boy with the big head and thin legs—the wonder of his class." It is well to have a pursuit as well as a study.

The doctor should marry, but his wife should be kept out of his work. Goldsmith said, "I was ever of the opinion that the honest man who married and brought up a large family did more service than he who continued single and only talked of population." By marriage a man's sympathies are extended and his views of life are broadened. A touching picture of the refining influence of sorrow has been given us by Dr. Brown, the author of "Rab and his Friends," in speaking of his father. He says, "a child, the image of himself, lovely, pensive, and yet ready for any fun, with a keenness of affection that periled everything on being loved, who must cling to someone and be clasped, made for a garden, not for the rough world, the child of his old age. This peculiar meeting of opposites was very marked. She was stricken with sudden illness. Her mother was gone, and so she was to her father the flower he had the sole keeping of, and his joy in her wild mirth, watching her childish moods of sadness, as if a shadow came over her young heaven, were themselves something to watch. She sunk at once and without much pain, her soul quick and unclouded and her little forefinger playing to the last with her father's curls, her eyes trying in vain to brighten his. The anguish, the distress was intense, in its essence permanent. He went mourning and looking for her all his days." But the affection, we learn, softened and refined him, and made him better fitted for his work. His son tells us further that "his affectionate ways with his students were often very curious. He contrived

to get at their hearts and find out all their family and local specialities in a sort of shorthand way, and he never forgot them in after life."

And such attentions are valued throughout life, and the clay is moulded and figured, and ornamented, and enriched, and burned in the fire, and fitted for the battle of life. And the defective articles must be rejected and the broken articles, may perhaps, be mended, but they are never the same again, and, perhaps, we would be better without them. Our ranks must be kept clean. We must have a good, healthy professional growth, and in Ontario I am glad to say that such exists. The regular who adopts the methods of a quack is a much more dangerous individual than the quack himself. But we have others who are by no means quacks, who unfortunately lack discernment, and who do not mean to do the harm that they certainly occasion. Our duty is to relieve and not to cause suffering. Some surgical procedures of the present day require severe criticism. Surgeons may be too conservative or not conservative enough. A few years ago we had an epidemic of the former, and now we are suffering from a plague of the latter. We are able to do so much that we are apt to do more than we should. I hope that the few dangerous individuals will soon be quarantined, so that the death rate and the cripple rate may diminish and the epidemic be checked. The epidemic has been spreading and has assumed large proportions, and seems to affect chiefly young and middle-aged nervous women. Men with exposed organs appear to be fairly free from its ravages.

But, as a profession in general, we have been making great strides. The State is being saved from the enormous losses incident to great epidemics, and the medical profession is out of pocket as a consequence. It does not appear that proper efforts have been made to reimburse the doctors. We are asked to do what our friends, the lawyers, would take good care not to do without an arrangement for the payment of a proper fee We are asked to register births, to register deaths, to notify regarding infectious diseases, and to attend the poor without remuneration. These are not charities. We are assisting and defending the commonwealth, and the commonwealth should pay us, and we should organize and agitate with this end in view. Unless such matters are attended to and a new method of payment of members of the profession is adopted, the numbers entering must be considerably reduced. In China the doctor is paid for keeping the family in good health. In Canada we, as a profession, protect the people from dangerous diseases, but the services are not paid for, and are scarcely recognized. A few officials take all the fees. Our real charity is not among the really needy, but among the

apparently well to do. A proper revision of the relation of medical and surgical fees to one another is much needed, and the ruling of the Association on the ethics of commissions is required. A special committee of this Association should be appointed to investigate these matters and submit a report at our next meeting. It has been said that knowledge is no barren cold essence, but it is alive with the colors of the earth and sky, and is radiant with light and stars. If we endeavor to follow along the lines of experimental investigation of natural phenomena, we must obtain a fondness for the impartiality and truth which such a study incites. Says Draper, "we will thus dedicate our days to the good of the human race, so that in the fading light of life's evening, we may not on looking back, be forced to acknowledge how insignificant and useless are the objects that we have pursued."

A paragraph that has greatly interested me by way of retrospect, is the following: "In olden times the surface of the continent of Europe was for the most part covered with pathless forests; here and there it was dotted with monasteries and towns. There were low-lying districts sometimes hundreds of miles in extent, that spread agues far and wide. In Paris and in London, the two largest cities, the houses were built of wood and daubed with clay and the roofs were thatched with straw or reeds. There were no windows and very few had wooden floors, until after the introduction of the saw-mill and such a thing as a carpet was unknown. A little straw scattered here and there in the room was the covering used for the floor. As there were no chimneys, the smoke of the ill-fed, cheerless fire, escaped Indian wigwam-wise, through a hole in the roof. It is needless to say that in such habitations there was but little protection from the weather. No attempt was made at drainage and the putrefying garbage and rubbish were thrown out of the doors. Men, women and children slept in the same apartment and not unfrequently with domestic animals as companions, and as a consequence, neither modesty nor morality could be maintained. The bed was usually a bag of straw, and a wooden log for a pillow. Personal cleanliness was unknown and great officers of the state, even dignitaries so high as the Archbishop of Canterbury, swarmed with vermin. Perfumes were largely used to conceal personal impurity. Many of the citizens clothed themselves in leather, a garment that with its ever-accumulating impurity lasted for many years. If a man could procure fresh meat once a week for his dinner, he was considered to be in easy circumstances. Not only was there no house drainage but there was no street sewerage. There were no pavements or street lamps. After nightfall the shutters were thrown open and the slops were unceremoniously emptied down,

to the discomfiture of the wafarer, tracking his path through the narrow streets, with his lantern in his hand." What a picture for us to criticize in the present day! And yet we scarcely realize all the hard work, ignorance, bigotry, persecution and glorious self-denial that have given us what we have to-day in our Western civilization.

Much progress has been due to the work of societies, such as that grand old society, the Royal Society of London. As university men and as educationalists knowing as we do that our present day conditions are due to the dissemination of knowledge, we should organize and promote similar societies and see to it that they hold as prominent a place in the community as the churches. It was by the Royal Society that Harvey's discovery of the circulation of the blood, was first accepted. The same Society gave so much encouragement to vaccination that Queen Caroline submitted her own children to the operation. All scientific observers are satisfied that Queen Caroline was right and the Royal Society was right. Then it was demonstrated that scurvy, the curse of long sea voyages, could be cured by the use of vegetable substances. We follow along and find jails and buildings ventilated and illuminated with gas. Cities were lit up and made much more habitable. If we expect to have progress, we must rally around our educational institutions and see to it that they are well provided with the means required to carry on efficiently and well the work of scientific investigation, and that they are untrammelled by the views of either church or state, remembering always that the slogan of the twentieth century is, "Knowledge is power." If this is done, man cannot lapse again into the dark days of the dismal centuries, when pestilences were looked upon as the visitation of God and not as we know them to be, the consequences of filth and wretchedness, easily prevented by personal and municipal cleanliness. In the twelfth century it was found necessary to pave the streets of Paris, as the stench from them was unbearable. Dysenteries and spotted fever, that had been prevalent, diminished and a sanitary condition was soon established, that approached to that of the Moorish cities of Spain, that had been paved for centuries. But alas for backsliding. Many of the Spanish cities have been allowed to lapse into an insanitary condition and the evidences of Spanish sanitation, as I saw it in Cuba, were not calculated to excite enthusiasm. Under the control of Western civilization and the proper application of knowledge matters have been changed. When it was decided that plagues were not a visitation of God, quarantine was established. Nothing has protected the human race to a greater extent than the establishment of proper quarantine.

When anesthetics were first introduced their use in labor

was discouraged, as it was believed that woman should not escape the curse denounced against them in Genesis. Now anesthetics are, I hope, very universally used, to prevent the awful agonies of labor, by an enlightened educated, scientific and humane profession. The very best evidence that can be brought forward to emphasize the benefits to mankind of improved methods of living has been obtained from the British Government reports of life insurance transactions, carried out in the seventeenth and again a hundred years later in the eighteenth century. In 1693, the British Government borrowed money by selling annuities on lives from infancy upward on the basis of the average longevity. The contract was profitable. Ninety-seven years later, another tontine of scale of annuities on the basis of the same expectation of life as in the previous century, was issued. These latter annuitants, however, lived so much longer than their predecessors, that it proved to be a very costly loan for the government. It was found that while ten thousand of each sex in the first tontine died under the age of twenty-eight, only five thousand seven hundred and seventy-two males and six thousand four hundred and sixteen females in the second tontine died at the same age one hundred years later, or in other words, 20,000 died in the first period and only 12,188 in the second period of one hundred years later, a very greatly diminished mortality, all conditions being identical except the improvements wrought by advanced sanitation.

Once fairly introduced, discovery and invention have unceasingly advanced at an accelerated pace. Each continually reacted upon the other, continually they sapped supernaturalism. The diffusion of knowledge by the newspapers and reviews has immensely increased the power of the press. Where ignorance reigns, crime is prevalent. In such cities as Naples, where the education laws, such as we have in Ontario, either do not exist or are not enforced, the streets are filled with street arabs, who are a nuisance and a menace to society, growing up in squalor, ignorance and filth. In our Western civilization such a condition of affairs cannot exist and I trust never will exist. The intellectual enlightenment, surrounding scientific activity, has imparted innumerable invaluable blessings to the human race. Science is not confined to any one nation, but is cosmopolitan. We are living in an age of electric progress. The marvels of electric force have been studied and utilized for the great benefit of mankind. To-day the mummified remains of an Egyptian King Amenophis, who lived thousands of years ago, are viewed in the original tomb, with the aid of the rays of the electric light. The telegraph and the telephone are to be found in the very heart of darkest Africa. The discovery of

the achromatic microscope has rendered us great assistance in studying the nature of disease, and the X-rays has enabled us to pierce what was before impenetrable gloom. The harvest is ready but not riper than it has been for centuries, but there are more enlightened and better educated and better equipped workers in the field. There is very much to be done and we must constantly be up and doing. I say this particularly to the young and enthusiastic. The foundation of our knowledge as modern doctors is science and the superstructure must be built upon scientific lines. Hospitals are needed, not such as those that were first established, but modern, properly equipped and up-to-date institutions, with modern up-to-date methods.

Many hospitals have been erected through the munificence of individuals in the towns throughout our country. Every town of any size should have its hospital. Such institutions are not intended to do the work of the larger ones in sixteen larger centres; but there is a certain amount of work that can never reach the larger centres that can be done very satisfactorily in smaller hospitals properly equipped and served by a properly educated profession. Assistance from the larger fields of observation can be obtained when required and under improved conditions such aid will be of great service. The almost universal use of the electric light aids our work very materially.

Our prisons have been improved. Our younger criminals have been cared for. Our insane have been kept off the streets. Our poor are being looked after, and now health and comfort go hand in hand. The true function of our study and deliberation is to prevent rather than to cure disease, and we are fulfilling our functions. But yet death reigns everywhere and at all times, and in all places, and we know it. But he is not the stalking giant that he was. He has been marvellously reduced in stature. Our medical press requires considerable regeneration. The articles published are not censored as rigidly as they should be. Much that is written and published is incomplete, speculative and inaccurate, and hence is misleading. Our journals should be purely scientific publications and not the hot beds for the propagation of unstable theories. Looking back is not always a pleasant pastime, but there is a definite certainty about it, that it does not belong to the future. All that has been printed is liable at any time to be reviewed.

And now in closing, let me say that during the year that has passed, a much desired amalgamation has been effected between two of our greatest educational institutions, Trinity and Toronto University. At first the task looked like a hopeless one, but owing to the good feeling existing between the rival faculties, it was finally achieved. Our province stands high in the bank-

ing world, in the musical world and in the educational world. I was gratified to hear our provincial University so well spoken of in the mother land and even in Egypt. The Medical Faculty of the University of Toronto, as now constituted with its ever increasing facilities, stands second to none in Canada at least, and the work accomplished, as evidenced by the standing obtained by our students abroad, is of a very high order.

Fathered by this Association, is an institution intended to be a guardian and repository of our archives. We must be prepared to preserve our records for the use and assistance of those who come after us. A calamity befell the world when the Alexandrian library was burned, and a calamity would befall the profession of this province if the books, collected under the name of the Ontario Medical library, should meet with a similar fate. We are about to occupy new premises, but we need more money to carry on the good work. This is not a municipal matter but a provincial and professional need, and I hope that many of the out of town members of this Association will assist us. Such an institution to do the work well must be liberally endowed.

Three trustees have been appointed, and through the generosity of the members of the profession of Toronto, of our good friend, Prof. Wm. Osler, of Mr. Geo. Gooderham, of Mr. E. B. Osler, Mr. Timothy Eaton and the executors of the Estate of the late H. A. Massey, ten thousand dollars are already in sight.

I desire to thank this Association for the great honor it has conferred upon me, and to thank those who have organized and arranged this meeting.

I feel sure that the hope and desire of every member of this vigorous twenty-four year old Association is that it may long be spared to write, to teach and to guide the medical profession of this our great Province.

# A CASE OF APPENDICITIS IN PREGNANCY.*

By Dr. JOHN SHEAHAN, St. Catharines.

My only excuse for bringing to your notice the subject of appendicitis is that I hope to call your attention to it as a most unfortunate complication of pregnancy in which instead of one, the lives of two human beings are involved.

Perhaps the most common complications of the abdomen in pregnancy are ovarian tumors and fibroids of the uterus. Shring, of Sydney, claims that hydatid cysts occupying the pelvis are seen occasionally in Australia as complications of pregnancy. These cause mechanical conditions that interfere with the pregnant uterus by pressure.

Any one of these may or may not be sufficient to terminate pregnancy by abortion or may threaten life by gangrene from torsion of the pedicle of the tumor.

Other complications of pregnancy are more dangerous, viz.: The acute infective processes that may occur within the abdomen. Under this heading may come appendicitis, salpingitis, cholecystitis or peritonitis due to perforative ulcer in typhoid fever, tuberculosis, actinomycosis, carcinoma, or gastric ulcer.

Under any of these conditions we must determine whether to deal directly with the pathological condition by operation and leave the physiological pregnancy to terminate naturally, or whether we should adopt an expectant plan of treatment hoping that the pathological conditions may not become serious to life—and not operate because pregnancy exists.

Up to recent years one may safely say the teaching has been to adopt a policy of non-interference; but in the light of the modern aseptic surgery the opening of the abdomen even in the pregnant state has become a comparatively frequent operation, and one not to be dreaded under proper conditions. Of course no one would feel he was using the best judgment if he operated in a case where it could safely be avoided. But in cases of the acute infective type, as already enumerated, that demand active interference if pregnancy did not exist, operation ought not to be decided against if pregnancy happens to be a complication or rather a coincidence.

The case I desire to call your attention to come into the St. Catharines L. & M. Hospital on December 10th, 1902, and was operated on immediately.

These few notes I have obtained from Dr. Campbell,

* Read at meeting of Ontario Medical Association.

who attended her prior to her entry for a few days. Mrs. B. aet. 25, primapara, four months pregnant, no history of previous appendicitis, but history of chronic constipation.

She was on a trip from Salt Lake City to her home in Thorold, when she was taken with pain in the hepatic region, in the sleeping car on December 4th. She couldn't straighten out her leg properly next day, but otherwise felt little inconvenience except some slight tenderness in the abdomen. Arriving home on December 6th, in the evening she consulted Dr. Campbell.

Temperature and pulse normal. Frequent desire to urinate with pain in the bladder and over the liver. Catheter passed, ℥ ss of urine drawn off. Morph gr. $\frac{1}{8}$, given hypodermically. She slept all night. December 7th, patient felt better. Temperature normal, pulse over 100, no pain. Frequent urination, pain in hepatic region and tenderness over the bladder. December 8th, a.m., chill. After this temperature was 104°, pulse 140, Resp. 30. Vomiting occurred a few times during the day. Pain in hepatic region severe and tenderness over liver and over McBurney's point, though the rigidity of the muscles of the part was not especially marked. In evening, temperature dropped to 98°, with pulse 120, but later both went up to temperature 101°, pulse 125. December 9th, a.m. Temperature 103°, pulse 140. Tenderness over right half of abdomen marked. P. m., temperature 102°, pulse 140. Tenderness marked over McBurney's point with guard tension of muscles. She was taken to the hospital and operated on in the early morning hours of December 10th. A thick and inflamed appendix was removed entire. There were no adhesions. Recovery complete and convalescence uneventful.

This case was operated on practically within 48 hours from the onset of acute symptoms, though she had been complaining of indefinite pains for a day or two before. The condition of the appendix was such that she would probably have recovered from that attack, though the symptoms were urgent enough to suggest a more severe pathological condition than was found.

I might remark that the patient developed albuminuria at about the seventh month and premature labor was induced in the eighth with the birth of a dead child. Just a year after this she bore a normal healthy child and was perfectly healthy herself. I cannot believe that the albuminuria was in any way connected with the appendicitis or operation but was due to other causes.

One point of special note was the location of the pain first in the hepatic region and later in the bladder, and again in both places before the pathognomonic indication in McBurney's point. She was perfectly relieved of pain by the operation.

Koenig summarizing the literature of this subject states

that until September, 1899, nearly one hundred cases had been placed on record, of pregnancy complicated with appendicitis. Gestation was more frequently affected by the recurrences of abortion. Where the pregnancy continued to full term the fœtal mortality was over 50 per cent., being due in some cases to direct intrauterine infection of the fœtus either by continuity or by the blood or lymph streams.

Vinway, in France, records four cases of appendicitis in pregnancy, and refers to a total of thirty-two cases. The comparatively small number tends to show that pregnancy does not set up torsion of the appendix or colitis, conditions which would increase the virulence of the colon bacillus and so induce appendicitis. In the thirty-two cases there were ten deaths, a percentage of 31 per cent., which is higher than that of Armstrong in his series of 517 cases of ordinary appendicitis with a mortality of 12.8 per cent.

Of these were recorded nearly one hundred cases from December, 1894, when the first case was reported by Dr. Mundé, until September, 1899. There will probably be another one hundred cases in the next five years which brings us to the present year.

The first case brought forward by Mundé is of such universal interest that I feel like giving the details, first, as showing that the case recovered, and second, that an abscess developed—a condition which we try to forestall by early diagnosis and operation.

CASE I.—Mundé—Mrs. F. P., eight months pregnant on Sept. 15th, 1894. She was seized with pain and tenderness in the lower part of the abdomen equally in the median line and on both sides. Temperature, 101° and 102° F.; temperature fell to 99° and the patient was expected to sit up next day. On 21st, about 9 a.m., she suffered an attack of violent pain in the pelvic region, accompanied by a pronounced chill and fever; temperature, 101.5° F., while at the same time labor commenced. On 22nd, about 2.30 a.m., a dead child was naturally delivered. The birth of child was followed by semi-delirium and prostration. The abdomen still continued universally tender. Twelve hours after, decided dullness could readily be made out, together with a very acute pain on pressure in the right iliac region, the outlines of the uterus being free. Vaginal examination being negative now, the pain was localized Temperature, 102°; Pulse, 120.

*Diagnosis.*—Perforative appendicitis. On 24th and 25th the temperature was nearly normal; on 26th it jumped to 102°; on 27th, 101.8°. On 28th operation was done; abscess found completely closed off by a thick wall of agglutinated intestines. Recovery uneventful.

CASE II.—Mundé—Had history of appendicitis; confined at

term; localized abscess found in appendiceal region at operation seven days after. Patient died three days later.

CASE III.—Mundé—Much the same history; operation; death.

CASE IV.—Abrahams—History of constipation; nine weeks pregnant; pain for three days; miscarriage; relief from pain for a day. Patient operated on eight days after abortion, and eleven days after the occurrence of pain Dr. Mundé opened a big appendiceal abscess with gangrenous appendix. Patient died.

Other cases, such as a recent one reported by Huing, of Sydney, Australia, show that an operation may be successful in gangrenous appendicitis, even if not operated on until the ninth day, and the patient went on to full term and was delivered of a healthy, living child, the line of incision remaining sound. This case is given in full in *Practitioner* for June, 1904.

*Etiology.*—The causes that produce appendicitis in pregnancy must be the same as produce it in man or in the unimpregnated woman with, perhaps, the one exception, where the appendix hangs over the pelvis and is exposed to pressure and injury by the enlarging uterus. R. T. Morris finds the appendix in this position in thirty-five per cent. of his cases, and considers the possibility important of the enlarging uterus breaking down adhesions about a previously inflamed appendix and thereby lighting up an acute attack. Pressure of the enlarging uterus on an appendix would be a very probable cause of acute trouble if the appendix contained a coprolith or fecal concretion. This traumatism might occur during labor, and the acute attack of appendicitis arise as a complication of the first few days after, and be the explanation of the rise in temperature, etc., when the obstetrician would naturally be looking for infection of the parturient passages.

There is almost always a history of chronic constipation, perhaps long-continued and obstinate, and if one considers that constipation stands in a causative relation, we have a direct indication for prophylactic treatment in always being careful to see that the bowels in our pregnant patients are properly regulated.

It is also claimed by some, that over-eating will frequently induce an acute attack of appendicitis in persons subject to it, hence another indication for prophylaxis.

*Pathology.*—The frequent occurrence of abortion in pregnancy complicated by appendicitis, estimated by Vinay at forty per cent., is higher than occurs in pregnancy complicated by the acute infectious diseases, and is referred to the intimate vascular and lymphatic connections existing between the appendix and

the uterine adnexa. Clado described an appendicular ovarian peritoneal fold as being constantly present, and considers that that this carries the lymphatics from one to the other. Lafforgue, however, finds it in only twenty per cent. of the bodies examined. In two of Vinay's cases the appendicitis was due to spread of the infection from the uterus. In the first there was post puerperal infection, which lighted up old appendicular mischief. The appendix was resected with the right tube and ovary. In the other case, a primipara with a history of membranous colitis, there was hemorrhagic metritis due to retention of placental tissue with subsequent appendicitis.

Pinard reports a case of abortion in appendicitis, where the child died very rapidly as a result of direct infection.

It would be interesting to know how the infection passes from one organ to the other. Surely it could not pass along the lymphatics both ways, unless it be in cases where the appendix is attached to the uterine structures.

Late cases of appendicitis with abscess formation are most unfortunate when the uterus forms one wall of the abscess cavity. All appreciate how important it is to preserve the integrity of the walls of the abscess cavity so as to prevent extrusion of the pus into the peritoneum, but the contraction of the uterus in abortion or labor, or the gradual growth of the uterus during pregnancy may so alter the relations of the structures involved that the walls of the abscess may rupture and pus escape into the free peritoneum with fatal results. This is a source of anxiety after operations in these cases when labor pains threaten.

*Diagnosis:*—The diagnosis of this condition is difficult for many reasons. A uterine tumor of variable size filling the pelvic and abdominal region offers resistance and prevents palpation. The abdominal muscles are on the stretch, rendering it difficult to estimate the amount of guard tension. The intestines are pushed up so much, that in one case reported by Mixter, the appendix was found at the lower end of the kidney. In the case reported to-day, the original pain was located as high as the edge of the liver, and in two days as over the bladder. Great difficulty is experienced in working out the outlines of an appendical tumor. Abraham declares however that there is always a certain uniformity in the symptomology differing only in the severity of its expression.

1. Almost always a history of constipation.
2. The sudden onset of acute abdominal pain, especially severe in the right iliac fossa.
3. The subsidence of the diffuse pain and its localization over the region of the appendix.
4. Vomiting.

5. Rise in temperature and acceleration of pulse.
6. Rigidity of muscles over McBurney's point.
7. Almost always the negative result of a vaginal examination, under ordinary circumstances.

An array of symptoms such as this would undeniably point towards appendicitis. It would however be advisable usually to examine these patients under anæsthesia, as this would allow greater freedom. The same anæsthesia could be prolonged for the operation if thought advisable to proceed; if nothing abnormal is found, no harm has been done.

*Differential Diagnosis.*—From 1st, right tubal pregnancy. As tubal pregnancy never exists without rupture beyond four months, it is plain that appendicitis could only be mistaken during the first four months, or while the uterus is still in the pelvis. The symptoms that might suggest right tubal pregnancy are the following: subjective signs of gestation as nausea, morning sickness, pains in breast, etc., enlarged uterus, soft cervix, vomiting and colicky pain in the right side of the pelvic cavity. Then at the time of rupture of the tube the patient is attacked by a sudden sharp lancinating pain confined mainly to the right side of the abdomen and just as in gangrenous appendicitis the rupture may be followed by peritonitis. The absence of the following symptoms would exclude extrauterine pregnancy:

1. History of sterility.
2. Irregular menstruation.
3. Skipping of one menstrual period.
4. Escape of decidual membrane.
5. Constitutional evidence of internal hemorrhage, as sudden pallor, thin rapid pulse, sub-normal temperature, and a few other well known symptoms, as restlessness resulting from hemorrhage. On vaginal examination one might feel a doughy tumor on the right side which might be a hæmatoma from rupture of a tube or a continuation of an appendiceal abscess.

From 2nd, acute salpingitis or pyosalpinx. This would probably be a source of difficulty only in the early months of pregnancy, and if it is borne in mind that there is usually a history of infection, specific or otherwise, in salpingitis, that furnishes a guide to some extent, though the pain, tenderness, and fever simulate appendicitis low down. Exploration alone could determine positively.

From 3rd, cholecystitis—acute infections. Osler says this diagnosis is by no means easy. Nausea, vomiting, rise of pulse and temperature, prostration, distension of abdomen, rigidity, general tenderness, form a picture easily mistaken for appendicitis. Jaundice is not often present but the tenderness will probably become localized soon over the gall-bladder, though it may be deceptive in its situation.

From 4th, attacks of gall stone colic due to contraction of the gall-bladder on large gall stones, whose size prevent them from becoming engaged in the bilious duct, and later on in the common duct, one especially likely to be mistaken for appendicitis because of the absence of jaundice, a history of dull pain over the liver radiating beneath the right shoulder blade can usually be elicited, and the pain or tenderness persist in the region of the gall-bladder. Some morphia will generally relieve this pain, leaving very little tenderness over most of the abdomen and none over the appendix.

*Prognosis* ought to be good in cases operated on early, and of the simple catarrhal form not operated on.

Vinay reports thirty-two cases with ten deaths, a percentage of thirty-one. The only complication noted of importance was abortion in forty per cent. This accounts for the fact that in half the thirty-two cases the children died. Abrahams says the prognosis is gloomy. He observed sixteen cases with eight deaths, and the mortality of the children was eigthy-five and five-sevenths per cent. Dunlofoy considers the prognosis more serious when the patient is pregnant, although an operation, if done in time and according to the rules, is no more serious than in plain cases of appendicitis.

Deaver says: "Appendicitis may complicate abortion. If the inflammatory condition occurs during the early stage of gestation, abortion generally follows. The usual risks of leaving a diseased appendix in the abdominal cavity are much increased by the pregnant state and the evil consequences of another attack, *i.e.*, gangrene or perforation will be correspondingly greater."

*Treatment.*—The rule holds good here especially that an inflamed appendix is a source of extreme danger with an abdomen. The removal of the appendix is attended by few if any additional dangers to the mother and fœtus. Mundé's doctrine is: "Treat the case early regardless of pregnancy:" a safe rule for anybody to follow.

Willy Meyer, of New York, lays down rules that will, I think, commend themselves to anybody:

(1) Operate early—within twelve hours—in acute perforative appendicitis.

(2.) Take the pulse as your guide. A quick, rapid pulse (116 to 120 per min.) is an indication for operation, particulary if it is out of proportion to the accompanying temperature.

(3.) In case of doubt operation is better than waiting. If an appendicitis or an abscess is found the effort is well rewarded; if not, the woman is none the worse for it, except an abdominal scar. The fear of interrupting gestation by an exploratory incision is counteracted by the accumulated

instances on record in which pregnant uteri were operated on, cauterized, etc., where an ovarian and other pelvic tumors were removed, and yet pregnancy remained undisturbed.

(4.) Another strong indication for operation is a sudden lull for ten or twelve hours in the symptoms, and then a sudden recurrence of all the symptoms.

(5.) The last indication is a recurrent attack of an old appendicitis during the pregnancy. Operation should be done if it is ever so mild, and especially when it takes place in the early months of gestation. The laparotomy is then easy aseptic, and removes the possibility of future attacks occurring late in the pregnancy, when the proceedure would not be so easy and safe.

*Conclusions.*—Pinard, of France, has collected forty-five cases of appendicitis complicating pregnancy, the diagnosis being confirmed in thirty by operation or post-mortem. He concludes from these (1) that appendicitis may attack a pregnant woman at the beginning or at any time during pregnancy or the puerperium. (2) In most cases it causes abortion. The child dies, as a rule, very rapidly, as the author's case proves, from infection. (3) It is only possible to save both the mother and the child when the abscess is limited and encysted. (4) Every type of appendicitis may occur. (5) The diagnosis may be difficult owing to the enlarged uterus, or still more so during the puerperium, but is usually possible with care. Treatment consists in operating as early as possible. Induction of premature labor is unjustifiable since pregnancy is not always interrupted if the mother recovers. (7) Prophylaxis consists in operating in every case of relapsing appendicitis in a young girl or non-pregnant woman, during the period of sexual activity to prevent future complications during pregnancy.

# A RE-STATEMENT OF THE ATTITUDE OF THE PROFESSION TOWARDS PLACENTA PRAEVIA.*

By K. C. McILWRAITH, M.B. Tor., F.O.S. Ed.
Associate in Obstetrics University of Toronto.

I have been asked by the committee to present to the meeting a re-statement of the attitude of the profession toward placenta prævia, and to limit myself to fifteen minutes in doing it. As the time is so short I shall discuss treatment alone. I have gleaned the opinion of the profession abroad mainly from the proceedings of the London and Edinburgh Obstetrical Societies, the American Journal of Obstetrics and Gynæcology of the British Empire, and such text-books as my library contains. The Canadian opinion is harder to get at. Prof. Adam Wright's book will no doubt aid us in the future, and we hope for many expressions of opinion from those present to-day.

I. The first question that arises is, should we always proceed to delivery as soon as hæmorrhage comes on, whether the child be viable or not?

There are many diverse opinions on this subject, but all are agreed that there should be no temporizing unless the patient can be placed under constant trained supervision within easy reach of the physician. There must also be considered:—

(1) The extent of the first hæmorrhage, and its effect on the mother and fœtus. If the fœtus dies there can be no object in further delay. If the mother nearly dies, further delay is not justifiable, except for resuscitation as mentioned under treatment.

(2) The certainty or uncertainty of the diagnosis. There must be some uncertainty about this until the placenta can be felt through the os. At the hospitals I have had many cases come in with a provisional diagnosis of placenta prævia in which the hæmorrhage was later found to be due to some other cause.

(3) Whether the hæmorrhage was unavoidable or brought on by causes which could be avoided in the future. Accidents are more likely to cause hæmorrhage when the placenta is prævia than when it is normally situated. There is no doubt that unviable children have been saved by waiting, and when the conditions, as detailed above, are satisfactory it should be tried. The patient should be kept in bed and given opiates if necessary.

II. The next question is, what to do?

By far the most popular, and in my judgment the best, treatment, is to do a Braxton Hicks' version: bring down one leg, *and then leave the delivery to nature*, making only sufficient

*Read at the 24th Annual Meeting of the Ontario Medical Society.

traction on the leg to check hæmorrhage in the interval of the pains, and giving such aid as may be required to deliver the after-coming head. In partial cases the membranes, and in complete cases the placenta must be perforated with a sharp instrument, as the endeavor to push the finger through detaches the placenta. Detaching the placenta is one method of treatment, but not the one I am advocating. Rapid delivery in the interests of the child results but too often in laceration or rupture of the uterus, post-partum hæmorrhage and death of the mother. Bi-polar version can be done as soon as the os will admit two fingers. This amount of dilatation is present in about 99 per cent. of cases in which hæmorrhage has occurred. In the remaining 1 per cent. the cervix and vagina should be packed with iodoform gauze. To do this put one pair of tenaculum forceps on the anterior lip, and one on the posterior lip and draw the cervix gently down. Pack in and around the cervix with iodoform gauze. The remaining part of the vagina may be tamponed with a kite-tail tampon of absorbent cotton steeped in 1 per cent lysol solution. This tampon should be left from four to six hours and renewed if the dilatation be still insufficient. While the hæmorrhage is being controlled in this way, or if when the patient is first seen it have ceased from syncope, it is better to give the exsanguinated patient a subcutaneous infusion of normal saline solution before proceeding to further operative measures.

III. Some of the other methods.

(1) Many men advocate the use of Champetiers de Ribes' bag. I have used it and found it to answer very well mechanically. It has never been in order since, and it caused the patient excruciating pain. If the bag is to be used it must be passed within the amnion; otherwise it detaches the placenta. The objections to this treatment are:—

(*a*) The bag easily gets out of order.
(*b*) It causes pain sometimes.
(*c*) It is difficult to sterilize.
(*d*) It displaces the presenting part.
(*e*) Sometimes ruptures the uterus.

The average fœtal mortality with this plan, so far as recorded, is 61 per cent.—not a very good record.

(2) De Paoli reports 19 cases treated with Bossi's dilator and delivery by forceps or version with the loss of one mother and three children—an extraordinary record. I doubt if it will soon be duplicated, for the dangers of dilatation by any method are great. Whitridge Williams recently published the history of a fatal case of placenta prævia. He dilated the os with seeming ease with his fingers and delivered. Post-partum hæmorrhage commenced. He drew down and sutured a lacer-

ated cervix, but the woman died. The autopsy revealed the fact that the tear had extended up the uterus and that the lower part of it only had been stitched. I greatly prefer fingers to any of these branched steel instruments as a means of dilating the os. (Bossi's and Walscher's dilators passed around). They have, as you see, an indicator outside to show how far the points are being separated; but one cannot tell how much dilatation and how much laceration is being produced. When one uses one's fingers in the method advocated by Harris, one can tell what he is doing and when to stop. Remember, however, that I do not advocate dilatation in placenta prævia by *any* method except gauze plugging as detailed above.

(3) Lawson Tait advocated Cæsarian section for placenta prævia, perhaps because he seems to have placed the maternal mortality from other methods at 50 per cent. Gustave Zinke in 1901, quoted eight cases of Cæsarean section and two Parro's operation; five mothers and six children lived. Two mothers were said to have been moribund at the time of operation, but even leaving these out the death-rate was 1 in 8, whereas the estimated mortality by other methods is only 1 in 18 or 20.

(4) Rupture of membranes.

When the pains are strong and the head comes down into the pelvis, rupture of the membranes may be sufficient, as the head presses on the placenta and controls the hæmorrhage. We must remember however, that rupture of the membranes is sometimes followed by a pause in labor, and this pause may allow dangerous hæmorrhage to take place, which we are then without means of controlling.

IV. Post-partum hæmorrhage.

The cervix is drawn down as for tamponing in ante-partum hæmorrhage, and the uterus, cervix and vagina tightly packed with iodoform gauze. One writer has had good results from flushing the uterus with a solution of suprarenal gland, 30 grains to the pint of water.

V. Sepsis.

The obstetrician should always be as aseptic as possible, and he cannot therefore take especial precautions in these cases; but in giving a prognosis the very great danger of septicæmia should always be borne in mind.

# ABSTRACTS OF PAPERS READ BEFORE THE ONTARIO MEDICAL ASSOCIATION JUNE 15th AND 16th.

**Occipito-Posterior Presentations.** — DR. A. A. MACDONALD, Toronto.

Since the advent of antiseptics and anesthetics a new era has arrived in obstetrics, as in surgery. They are exceedingly useful in correcting faulty presentations. Occipito-posterior presentations occur in 1½% of all labor cases. Formerly the single blade forceps were used to cause the head to rotate. Herman, in his "Difficult Labor," gives three directions for the use of forceps in treatment: (*a*) pull, (*b*) flex, (*c*) rotate. The practice I advocate is, briefly, as follows:—If you are called to a case late, but before the membranes have ruptured, wait until the os is dilated, then introduce the hand and rotate one-quarter turn, converting the case into an Occipitic-anterior. To do this, fully anæsthetize the patient, sterilize the parts and your hands, insert the whole hand and grasp the head. The occiput now being anterior, flex the head and hold it in position until the forceps are applied and locked. There is no injury to the child's neck, as the turn is only one-quarter. With the forceps on delivery is readily effected, and without laceration.

**Congenital Bilateral Dislocation of the Hip.**—Dr. H. P. H. GALLOWAY, *Toronto.*

Dr. Galloway exhibited a patient with congenital bilateral dislocation of the hips, treated by the Lorenz Bloodless Method. He also gave a brief review of the present status of the Lorenz Method. The case presented, Dr. Galloway explained, was one of the fortunate ones in which he had been able to secure a perfect result. He showed a number of photographs illustrating the various stages in the treatment of this patient.

The results gathered from an exhaustive study of reports of cases treated by the Lorenz Method may be summarized as follows: Lorenz reports 50 per cent. of unilateral cases cured, and 25 per cent. of bilateral cases cured; 50 to 60 per cent., good results; 20 to 30 per cent., failure. By good results is meant that anterior transposition is accomplished, the head of the bone not being replaced in the acetabulum, but considerable improvement in the gait being effected. By Hoffa's Method, which differs slightly from that of Lorenz, 30 per cent. of unilateral cases, and 7.7 in bilateral cases, are reported cured, with 50 to 60 per cent. anterior transpositions.

The results of the Lorenz American tour are exceedingly disappointing. Most cases have relapsed, and the results are

not at all good. Sherman gives the following dangers in the method: (*a*) paralysis from injury to the nerves; (*b*) fracture of the pubis or femur; (*c*) gangrene of the limb.

It would appear from the study of these statistics that to get one perfect result ten cases must be put up in dressings for from six to eight months. This is highly undesirable, as, in 60 per cent., a few weeks only are necessary to accomplish anterior transposition. Dr. Galloway pointed out that the great difficulty in reducing the dislocation is the construction of the capsule which exists between the head and acetabulum. He advised cutting down anteriorly, slitting this contruction and replacing the head. In concluding he expressed his opinion that the Lorenz Method was fast losing ground.

**The Relative Importance of the Clinical and Bacteriological Evidences in Diphtheria.**—DR. SHEARD, Toronto.

Mr. President and Gentlemen:—I have not thought it wise to present to you a set paper this evening, but shall submit some ideas with the object of eliciting an expression of opinion from those members of the profession assembled here. Many physicians imagined that the discovery of the Klebs-Loeffler bacillus and the proof, by injection into Guinea pigs and cats, of its production of diphtheria, settled the question beyond further discussion. But I make bold to state that the physician who imagines we know all about diphtheria is confronted with difficulties and troubles at every turn. I am fully convinced we cannot depend exclusively on the findings of bacteriological examination in these cases. There are many cases which present no physical sign, but in which the bacilli are undoubtedly present, and the generally accepted opinion that when the Klebs-Loeffler is present we have diphtheria is not always true. Whether the absence of symptoms is due to a personal immunity or not I am not prepared to say.

There are four distinct varieties of Klebs-Loeffler bacilli: the long forms, the short, the attenuated and the pseudo-bacilli. They produce soluble toxins and are sometimes associated in their action with pus organisms. These toxins produce the symptoms which we designate diphtheria.

I have a series of seven cases diagnosed as posterior fibrinous rhinitis in which a series of bacteriological examinations failed to reveal the presence of Klebs-Loeffler, but each case was followed by paralysis. We generally admit with paralysis we have diphtheria. The virulence of diphtheria varies much according to the seed, the mortality sometimes being over ninety per cent I remember a man from Buffalo, who stopped at the Brown Hotel. Seven new cases developed from exposure, of whom six died. Some time ago a Russian family of

nine set out for Toronto. Two of them died at sea of diphtheria, two more at Montreal, and two others in Toronto. All this bears out the teaching that diphtheria is due to a particular form of vegetable organism, and as such, is subject to the laws which govern the growth of all seed in various soils.

The sequelæ are due entirely to the toxins, the extent of the membrane being of no consequence in this connection. If we have the cellulitis and no adenitis the condition is most serious, the toxins entering the nerve trunk and destroying their vitality. The sequelæ may be expected at any time from the third week to the third month.

Many conditions are due to the associated pus organisms, such as the secondary eruptions, which are identical with those of septicæmia, and in no way dependent upon the Klebs-Loeffler

Another form of bacterial diphtheria is the post scarlatinal type in which, during the second week of the fever, the patients have the Klebs-Loeffler but exhibit no symptoms—they invariably get well and are not infective. I have records of sixteen such cases. Again we have the association of scarlet fever and diphtheria, the diphtheria not following the scarlet fever, but both diseases existing simultaneously in the same patient as a result of two separate exposures, the incubation period of scarlet fever being four days, whilst that of diphtheria is about six days. At the Isolation Hospital we have a separate ward for these mixed cases. Again we have those cases of post-diphtheretic scarlet fever, where the scarlet fever follows closely on the heels of the diphtheria, and where, in spite of any form of treatment, we have a mortality of over eighty per cent. And, as these cases occur as frequently in private houses as in hospitals, they cannot be accounted for by infection from one hospital patient to another. A frequent experience at the Isolation Hospital is to have whole families sent in, half of whom are suffering from diphtheria, the other half from scarlet fever, showing the correctness of Sydenham's contention that there exists a far greater intimacy between these two diseases than the private physician would care to admit.

I can report several cases in which, after weeks of most energetic treatment, the bacilli could not be gotten rid of, and though such patients were discharged, no new cases have been known to result from them. One patient in the scarlet fever ward developed otitis media in the discharge from which the Klebs-Loeffler bacilli were found. He was discharged and no cases resulting have been reported. From these experiences I am convinced that when the bacillus of diphtheria exists in pus it is innocuous and non-virulent.

In conclusion, these questions naturally arise: (1) Is scarlet fever antidotal to diphtheria? The answer appears to be

in the affirmative. (2) Does not diphtheria aggravate scarlet fever? The answer again is "yes." (3) Is the difference in the two diseases due to the evolvment of a soluble toxin by the Klebs-Loeffier bacillus? Osler once said to me, "If the rash appears, disappears and re-appears, it is in all probability a septic rash." The scarlet fever rash, we know, does not disappear and re-appear, but there are many septic cases such as recurring erysipelatous rashes, all closely connected clinically with diphtheria and scarlet fever.

**Enlargements of the Prostate Gland.** — DR. F. W. MARLOW, Toronto.

Dr. Marlow gave a very comprehensive account of the anatomy of the prostate, explaining most carefully the position and variations of the anatomical middle lobe.

Prostatic enlargement, he said, does not necessarily mean prostatic obstruction; according to Sir Henry Thompson, while 30 per cent. of men beyond the age of fifty-five have prostatic enlargement but 5 per cent. have obstruction. The etiology of the condition is still obscure, two theories most in vogue at the present time are, (a) prostatic enlargement is a local result of a general arterio schlerosis (held by Guyon and the French school). This is opposed by Freyer, Casper, Bruce, Clark, etc., who regard arterio schlerosis as conductive to atrophy and not hypertrophy. (b) On account of similarity in the structure of the prostate and the uterus Velpeau claims the existance of an analogy between prostatic enlargement and fibro-myoma of the uterus.

The enlargements may be uniform or more frequently asymmetrical, the enlarged portion raising the vesicle outlet, stretching the urethral walls and forming a pouch in which residual urine collects. The symptoms of the trouble are increased frequency of micturition due first to irritation of the growth, but later to diminution of the blader capacity. There is difficulty in starting the stream which is small without its normal projection curve, and followed by dribbling. With proper attention to the history and symptoms, and careful digital examination the diagnosis should be easy.

**Surgical Treatment of Enlargement of the Prostate.** — DR. G. A. BINGHAM, Toronto.

The methods employed will depend entirely upon the individual case. One man with no symptoms but increased micturition, may be carefully and scientifically introduced to catheter life.

While in another case with overflow, cystitis and possibly pyelitis, drainage by median perineal cystotomy done under a local anæsthetic is demanded. Between these extremes are a number of cases amenable to radical treatment, and for these the following operations have all been done.—(a) Orchidectomy—the shock is severe and the operation not generally useful and is now abandoned. (b) Vasectomy, slow and uncertain and applicable to but a limited number of cases. (c) Perineal and suprapubic prostatectomy. Of these the most rational and scientific procedure is the suprapubic. In this the field is freely exposed, the gland readily reached and easily shelled out of its attenuated capsule. The results are usually most satisfactory.

**The Treatment of Prostatic Hypertrophy.**— DR. T. K. HOLMES, Chatham.

From a careful consideration of the subject Dr. Holmes concludes—that castration and vasectomy are of little value, that the Bottini operation, while not in general favor, has many good points and deserves of a more careful study and a wider employment; that suprapubic prostatectomy is difficult in fat subjects the perineal method is the one most generally useful. The gland is drawn down into the wound by means of Syms' rubber bag and carefully enucleated from its capsule. If is it desirable to avoid damage to the ejaculatory ducts Dr. Young's (Baltimore) device for pulling down the gland and performing the operation visually is recommended. Dr. Holmes gave the history of two successful cases, in one he employed the Bottini operation, in the other median perineal prostatectomy was done. In conclusion he warned the profession against advising the constant use of the catheter, as it almost invariably resulted in cystitis. "There are 100 men in this room and probably 20 of us will have to seek relief for an enlarged prostate. We should advise to others the same treatment that we ourselves would like to receive."

**Neurasthenia in Some of its Relations to Insanity.**—DR. J. CAMBELL MEYERS, Deer Park, Toronto.

Further experience has confirmed Dr. Meyers in the opinion he expressed at the Canadain Medical in '98, "that neurasthenia in certain of its forms frequently terminates in insanity, and moreover, certain symptoms usually classed as neurasthenic are really incipient stages of mental disorder by early treatment of which insanity may be averted."

Cerebrasthenia, or brain exhaustion, (to which the paper was largely confined) arises chiefly from mental overwork accom-

panied by excitement, worry, disappointment, grief, trauma, physical shocks, pregnancy, lactation and various toxemic conditions. An exactly similar series of causative factors we find operating in idiopathic insanity. The symptoms are: Difficulty of concentration, lessened will-power and self-confidence. The patient becomes introspective, is morbidly self-conscious and discusses freely his morbid symptoms with non-medical men in a distinctly thoughtless manner. Loss of family affection, insomnia, dreams, slovenly habits, &c., are all early and prominent symptoms. Comparing these symptoms with those of simple melancholia, we find them to be much the same, the only difference being that in the latter they are intensified. The patient, after repeated attempts to be relieved of his ailments, has gradually been forced to the conclusion that he can no longer be cured, and consequently, it is useless to try. Finally he can be roused only with difficulty from his torpor. The neurasthenic is now a melancholic, and more advanced stages of melancholia show but an intensification of these symptoms. "I believe," continued Dr. Meyers "that there should be no boundary between neurasthenia and insanity, they being but different stages in the same disease."

*Treatment.*—Giving the case sufficiently early treatment can accomplish as much in these patients as in most other troubles. The first essential is isolation, which removes the irritation and permits of the useful action of drugs. Hydrotherapy, electricity and massage are important adjuncts in all stages. Travel is not advisable until the patient has had a complete rest.

Clinic on Skin Diseases.—DR. A. MCPHEDRAN,

*Impetigo Contagiosa.*—The disease is contagious, most commonly occurring on the face or pubic regions, and due to the streptococcus or staphilococcus, or, some believe, to a specific organism. It tends to recur from time to time.

*Treatment.*—Thorough cleansing and the application of antiseptic ointments such as ung. hyd. amm. chlor. or better, resorcin, 20 to 30 grains in an ounce of lanolin. The principle underlying the treatment is: Cleanse and apply soothing or stimulating antiseptic applications.

(2.) *Erythema Multiforma.*—The trouble commenced in March four years ago as a vesicular eruption, occurring on the hands, face and neck, that is, the exposed parts only. The eruption lasted all summer, faded in the fall, leaving no marks. It returned in March of the following spring and went through the same cycle. The lesions are first vesicular, the pustular, and finally coarse crusts form, which drop off in a few weeks leaving faint marks. No inflamation precedes the vesiculation.

It is doubtless purely a congestion with serous exudate, followed by on exudate of leucocytes and ultimate crusting.

(3.) *Acne and Eruption on the Leg* (syplilitic or tubercular). *Treatment.*—Acne.—Difficult to cure in phlegmatic types. Stimulate until slight desquamation, and then soothe. ℞. Resorcin, gr. 20; B. naphthol, dr. 1.2; sulphur, dr. 2; green soap and vaseline, āā, oz. 1.

To soothe a leg ulcer, use Unna's paste: Zinc oxide, 1; gelatine, 2; glycerine, 3. Add, if necessary, ichthyol, 2, 3, 4 or 5 per cent. Apply when liquid, daub over with cotton, and let the patient wear it several days.

(4.) *Tinea Tonsaurans.*—Difficult to cure as the microsporoon is deep down in the hair follicles. Two principles to be observed—thoroughness and perseverance—that is, use any parasitic and keep it up. ℞. Sulphur, dr., ii, in an ounce of lanolin; or chrysarobin, dr., 1 to the oz.

**Strain in Heart Disease.**—DR. H. B. ANDERSON, Toronto.

The influence of severe bodily exertion in inducing rupture of the heart or blood vessels in patients with arterio sclerosis, or in those unused to physical exertion, was illustrated by the exhibition of a number of specimens, with a short history of each.

(1.) A patient dropped dead on the street following rapid walking. The specimen showed rupture of aorta. Presented by Dr. Powell.

(2.) A woman aged 60 died suddenly during the passage of a stomach tube. Specimen reveals rupture of the left ventricle.

(3.) Captain on a boat attempted to carry a heavy tie, fell unconscious suffering from tachycardia; died nine months later, aged 55. Specimen shows rupture of the sinus of valsalva, with aneurismal dilation pressing on to the right heart.

(4.) Patient a moderate drinker, good liver, no history of syphilis, after a week of unusual exertion was seized with a sudden pain and sense of weakness, and died the same night. The autopsy showed a dissecting aneurism involving the whole of the descending aorta, down to the bifurcation of the iliacs. The blood had burst the middle and inner coats of the aorta, making a false passage for it self under the adventitia.

**The Surgical Treatment of Epilepsy.**—DR. A. PRIMROSE Toronto.

Dr. Primrose presented the history of two cases of traumatic epilepsy operated on with good results so far. The first patient was a young lad about 20, who gave a thrilling history of shipwreck and exposure at sea, after which the fits developed. The

seizures always commenced in the first two fingers of the left hand, the wound however was on the left side of the head. Was this then a case where the pyramidal tracts did not cross, or had there been a lesion on the right side owing to bursting as a result of the blow on the left side? The left rolandic area was first trephied and electrodes applied in the hand area, causing immediate movement of the fingers of the right hand. This proved that the pyramical tracts did cross. An opening was immediately made on the right side which revealed a thickened dura mater, and but little other change. Some of this was removed, tension relieved, and the wounds closed up. The patient had two or three fits the night after the operation, but since then (some six months now) has been free from them. The second case was the result of a depressed fracture involving only the inner table of the skull, the result of a pitchfork wound. The operation revealed an abcess, which was opened and drained. The patient has since been free from seizures.

**Diagnosis of Functional Heart Murmurs.**—DR. R. D. RUDOLF, Toronto.

Functional murmurs as first described by Laennec, are soft and blowing in character, occurring most commonly in the position of the pulmonary area, opposite the second left costal cartilage, and are in no way connected with valvular diseases. They are due not to the anæmia as so often taught, but to a condition of hypotonus of the muscles of the circulatory system. That is there is a relaxation of the sphincter muscles guarding the mitral and tricuspid orifices, and permitting of a leakage. In the pulmonary area, the fibrous band around the orifice permits of no dilatation, but the muscular construction of the pulmonary artery permits it to dilate, and consequently we have a condition in which the blood stream flows from one chamber, that is the right ventricle, through a relatively constricted orifice, into the dilated pulmonray artery. This is the most favorable arrangement for the production of a murmur. Dr. Rudolf laid down the following rules to aid in the diagnosis of functional from organic murmurs:—

1. They occur in adolescence and young adults.
2. They are more common in males than females.
3. They all occur during ventricular systole.
4. While the pulmonic area is the most common situation for functional murmurs, it is a rare site for organic murmurs (congenital stenosis being the only one found).
5. Functional murmurs are heard in the neck, *e. g.* Brutix de Diable.
6. As the general health improves, functional murmurs tend

to disappear, organic murmurs on the other hand tend to get louder with increasing strength.

7. Functional murmurs are soft, and accompany rather than displace the first sound.

8. They are not so widely propagated as are organic murmurs.

9. They vary under certain conditions, *e.g.*, they are louder after exertion, and are especially increased on lying down.

10. The pulmonic second sound is accentuated early, even before the murmur is heard; this is not so in organic pulmonary stenosis.

11. They are accompanied with little signs of dilatation or displacement of the apex.

12. Cardio-respiratory sounds are sometimes mistaken—ask the patient to hold his breath and they will disappear.

13. Signs of failing compensation are rare in functional cases.

14. The patients are not conscious of the existence of the murmur. An analysis of the patients in the surgical wards of the H. S. C. showed that in 60 per cent. functional murmurs were present. An analysis of a number of wards in the T.G.H. and St. Michael's Hospital showed the existence of functional murmurs in 50 per cent. of the patients.

15. Fever gives rise to functional murmers. They occur in 66 per cent. of scarlet fever cases, and are apt to occur in rheumatic fever. A useful rule in this connection is, "functional murmurs tend to occur late in fever (e.g. rheumatic fever) while endocardial murmurs appear within the first ten days.

16. Pressure has not much effect as a rule in altering functional murmurs.

Finally, we are all too apt to conclude that there is organic disease when we hear a murmur, and we are too easily soothed into believing the patient organically sound when no murmur can be discovered,

**The Diagnosis of Modified Small-pox.**—DR. HODGETTS, Secretary Ontario Board of Health.

Dr. Hodgetts employs the word "modified" to designate those cases where the course is in any way atypical, not to cases modified by vacination—the so called varioloid.

About five years ago the disease appeared in Essex County and Northern Ontario and was variously diagnosed as chicken-pox, impetigo and syphilis. The spread of the affection and the fact that those unvacinated were its victims, soon however established the nature of the epidemic. Since then the disease has continued from year to year with the maximum number of cases in January and the minimum during the summer months. The

virulence of the contagion has been variable, during the earlier stages (preceding pustulation) but slightly contagious, and in many mild cases the contagion seems slight throughout. The regulation incubation period of twelve days has been the rule, but many cases of 15, 16 and 18 days have occurred necessitating the period of quarintine being extended to eighteen days.

The initial symptoms have varied all the way from a passing malaise to severe headache and back ache accompanied by nauseau and vomiting. The initial temperature has been from 100 to 102 F. The mildness or severity of the onset, however, has been no indication of a mild or severe attack. The fever drops with the appearance of the characteristic rash in about 72 hours. The rash runs through its regular series of macules, vesicles, pustules and crusts.

The affection is most frequently mistaken for chicken-pox, impetigo and pustular syphiloderm, and in the differentition the following points are important:—

*Chicken-pox*:—(1) A disease of childhood. (2) Runs a rapid course, lesions are papules, vesicles and scabs all in twenty-four hours. All over in a week. (3) Premonitory symptoms slight or none. (4) Temperature appears with the rash. (5) Vesicles soft and irregular. (6) Eruption occurs on covered parts. (7) No scar or pigmentation left.

*Impetigo*:—(1) No elevation of temperature. (2) No initial stage. (3) Begins as a vesicle or vesicular pustule. (4) Occurs on the face, hands and exposed parts. (5) Unsymmetrical and superficial, large blebs. (6) Crust friable, leave no scar. (7) Finger-nails carry the infection.

*Pustular Syphiloderm*:—(1) The large indurated base of the vesicle, which lacks umbilication, and the history and persistence of the symptoms should prevent mistake.

Inflamations of the Lachrymal Apparatus. — Dr. Burnham, Toronto.

Inflamation of the lachrymal sac is the result of the struma, violence, or the entrance of irritating fluid, or most commonly stricture of the nasal duct. This last condition results in insufficient drainage to the duct and a chronic blenorrhœa is set up. This mucocele is attended by much suffering and constant disturbance and demands effective treatment. Initial leeching, calomel, et , usually fail to abort the attack; hot linseed poultices and free incision on fluctuation are necessary in the acute stage. To remove the cause and consequently relieve the condition Dr. Burnham operates as follows,—having slit the canaliculus into the sac, he introduces, by means of a syringe, a 3 per cent. solution of cocaine and passes probes No. 1 and 2 only. He then irrigates freely with adrenlin followed by potassium

permanganate 1 in 12000, and last of all passes a silver style which is allowed to remain in position. In three or four days the style is removed, the cocaine, adrenlin and permanganate irrigation repeated and the style replaced. This method of treatment is much less painful and much more effective than the old method of passing the largest probe possible and using no medication. During the process of healing little fibrous bands appear along the floor of the divided canaliculus which act as dams preventing the free exit of the tears and which must consequently be divided.

**The Arid Regions of the United States, their Therapeutic Indications in Pulmonary Tuberculosis.**—DR. J. FRANK MCCONNELL, Las Cruces, N.M.

Dr. McConnell, a recent graduate of Toronto, gave a very concise and interesting account of the climatology of the great arid regions, to which so many hundreds of patients flock annually, hoping to ward off the ravages of pulmonary tuberculosis. The value of the arid belt consists in the abundance of sunshine, the clear and bracing atmosphere, which is free from dust when protected by the alfalfa meadows, and the fact that it is not subject to sudden change in temperature. Nearly all patients in the early stages of the disease do very well, they are very kindly treated by the residents, and when the disease has become arrested are usually able to obtain employment. It is unfortunate, the doctor said, that so many patients are sent out every year in such advanced stages that they die on the road or live but a few weeks after their arrival. There was little difficulty in arranging for comfortable lodging—food was of much the same variety and price as here. On account of the equable climate patients were very comfortable living in tents, and expenses could be kept down in that way to a very reasonable figure.

**Some of the Newer Methods of Diagnosis in Kidney Cases as applied to Renal Surgery.**—DR. W. A. HACKETT, Professor of Genito-Urinary Diseases, University of Michigan, Detroit.

Dr. Hackett briefly reviewed the more important devices and methods introduced since 1885, pointing out the use and advantages of each. Chromocystoscopy is a useful method of determining the activity of the kidneys. The patient is given a dose of methyl blue or indigo carmine which are normally excreted by the kidneys in 15 to 30 minutes. By watching the uretral openings with a cystoscope the exact time of the appearance of coloured urine from each kidney can be determined. If one is manifestly slower than the other it is evidently the diseased kidney.

Uretheral catheterization and segregation enable us to collect the urine from the individual kidney. The former method while becoming more and more popular is expensive, and demands skill and patience on the part of the operator. Segregation is open to the objection that the bladder may be diseased.

The history of cyroscopy, or the determination of the freezing point of urine, and the application of Dr. Coppet's law, that the lower the freezing point the greater the concentration was considered in some detail. The method combined with segregation has been shown to be a most valuable aid in diagnosis, and has removed the fear of the surgeon after nephrectomy to a large extent.

Phloridzin Test—after the hypodermic injection of phloridzin a diseased kidney is found to excrete sugar less rapidly than a normal one. Electrical conductivity of urine, X-rays, and various bougies were briefly mentioned also. In concluding the writer explained that these new methods of diagnosis are gradually replacing the old exploratory operation.

**Lympho-Sarcoma.**—DR. B. Z. MILNER, Toronto.

The tumour occurred in a young man about nineteen, a strong athletic fellow. It was situated in the neck, and examination showed it to be a round-celled Sarcoma. It was removed by operation but the glands in the neighborhood were found to be involved and the growth recurred. The patient was treated with X-rays with no apparent improvement. Coley's fluid was then used and after a thorough trial was abandoned, no benefit having resulted. Finsen's rays also proved useless. The patient was seen at various times by Dr. Powell (Toronto) and Dr. Coley (New York). It was now about a year since the first appearance of the trouble, and the patient was in bad condition. As a last resort X-rays combined with quinine-flunnesence (the quinine being given internally before the raying) were tried. Under this the growth made no further progress and some improvement even was noted. The patient however was so exhausted that he succumbed.

**Notes on an Uncommon Case of Rectal Surgery.**—DR. E. CLOUSE, Toronto.

Dr. Clouse recounted a remarkable instance of a patient's unfortunate adventures with hæmorrhoids. The patient, a prominent clergyman, fell into the hands of a quack who attempted to do Whitehead's radical operation, but was so unfortunate in the result that the mucus membrane and the skin outside would not unite. Shortly after, having moved to British Columbia, he came under the care of a friendly jeweller. This ingenious individual invented for the hapless minister a manner

of stem pessary by means of which the rectum was kept in position. The clergyman wore this device for six long years, suffering the inconvenience and discomfort of having to remove it once or twice a day. Dr. Clouse now saw him again, and had in consultation several other prominent surgeons. They decided that nothing could be done to relieve the situation except a colotomy. This the patient refused and again besought Dr. Clouse to do something for him. Dr. Clouse consented to try what could be done, and with the patient under the anæsthetic, discovered that by snipping the skin just beyond the red border he was able to relieve the tension on the bowel, and a perfect cure was wrought.

# Progress of Medical Science.

## MEDICINE.

IN CHARGE OF W. H. B. AIKINS, H. J. HAMILTON, C. J. COPP AND F. A. CLARKSON.

### Pulmonary Tuberculosis and its Relation to Other Diseases.

Weber (*Indian Med. Record*) reviews this subject carefully. Diseases which tend to passive hyperemia of the lungs have a hindering action on tne growth of the tubercle, whilst anemia of the lungs favors tuberculosis. Hence patients suffering from congenital pulmonary stenosis often die of phthisis, while those who have leakages in the mitral or aorta valves seldom fall victims to the white plague. Biel's treatment of tuberculosis of the joints by artificially produced hyperemiam, has suggested the treatment of pulmonary tuberculosis by certain positions and local thermal methods with the object of increasing the amount of blood in the lungs. Amyloid of the liver is rarely associated with phthisis, but cirrhosis is fairly common (twenty per cent. or more), while fatty liver is found in almost every case. In the kidney we find similar conditions, the amyloid degeneration being comparatively rare, while parenchymatous, fatty and intestinal nephritis are frequent. Both gout and rheumatism seem to retard the growth of the tubercle. Great meat-eaters, too, rarely become phthisical. This would suggest an increase of meat in the diet of those young persons who are predisposed to phthisis.

It is not always true that cancer and tubercle are antagonistic. Cancer of the pharynx, oesophagus and air passages is often accompanied by tuberculosis. Tubercle so often accompanies lymphadenoma and diabetes that we almost look upon it as the natural ending of these diseases. F. A. C.

### Heredity and Cancer.

Authorities have differed widely on this subject, but most of them agree that the probability of cancer is greater in one whose ancestry showed a history of malignant tumor, and all life assurance companies investigate this point fully. The earlier statistics seemed to show that cancer was a family disease. Paget, for example, found in 1857 from an examination of 411 patients, that there was a probable hereditary transmission in twenty-two per cent. Lichtenstern placed the figures at seventeen per cent., while nearly all other tables compiled show that a patient with a family taint is from ten to twenty per tent. more likely to have cancer.

But now comes the archives of the Middlesex Hospital (1904), in which Prof. Karl Pearson, by biometric methods and the construction of "skew curves," arrives at quite a different conclusion. Out of 2,368 female cancer patients, 359 had a history of cancer—15.1 per cent., as against 13.5 per cent. among the ordinary rate, the non-cancerous patients. From these statistics, as valuable as any that have been compiled, we may feel safe in advising our patients with cancerous relatives, that they have no reason to feel alarmed about their own susceptibility to the disease. Inheritance is probably of little importance.

Prof. Pearson also brought out another interesting fact:—That the onset of the disease is later in males than in females by nearly six years. In women the avarage age ws 43.8; in men, 53.3 years. F. A. C.

### Bather's Earache.

McAuliffe says (*Wis. Med. Rec.*) this painful trouble comes from water forced up into the eustachian tube by swallowing or by clearing the nose after coming out of the water. It is not caused by water entering the external canal, for there the drum is protected by epithelium, which is tolerant to fluids. Hence the habit of plugging the meatus with cotton is fatuous. F. A. C.

### Disinfection of Thermometer.

The dangers of carrying infection by this necessary instrument are patent to every practising physician. Denny (*Boston Medical and Surgical Journal*) found by careful bacteriological examination that a few drops of formalin on a piece of cotton placed at the bottom of case would keep the thermometer sterile, and would destroy all the common mouth-bacteria most effectually. F. A. C.

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## OPHTHALMOLOGY AND OTOLOGY.

IN CHARGE OF J. T. DUNCAN, M.B., M.D., C.M.

### "Absorption" Treatment of Cataract.

The editor of the *Journal of the American Medical Association* thus answers an enquirer concerning the efficacy of the so-called absorption or disintegration cure of cataract by means of local applications and manipulation of the eyeball.

The ordinary forms of cataract are due to structural changes in the lens, whose fibres, previously as transparent as clear glass, are converted into an opaque substance comparable to ground glass. In rare instances, such as in the early stages of

cataract from diabetes, the opacity in the lens may be due to exudates thrown out between the fibres, and not to actual destruction of the lenticular tissues. This form of cataract is a rare exception to the rule, and if the disease that gives rise to it progresses (as it commonly does), the crystalline fibres themselves are eventually destroyed, and their place taken by opaque material, as in the senile or other common forms of cataract. Bearing in mind these facts one can readily understand how absurd is the "absorption" or any other "cure" of genuine cataract. Neither manipulatian of the eyeball nor local applications, however mild or severe, will avail to restore the destroyed lens fibres. One might as well expect to "absorb" an organic lesion of the cardiac valves by rubbing liniment over the left breast. Apparent improvement or cure of cataract by these methods are mostly due (1) to the imagination of the patient, (2) to the fact that the dulled vision arose partly or altogether from a curable eye disease not situated in the lens (some corneal affection for example), or (3) to the absorption of a diabetic deposit in the lens substance which underwent a partial or total absorption coincident with improvement in the systemic condition. In all these cases the improvement might occur with or without treatment. It must be remembered, also, that improvement in the vision of cataractous eyes sometimes takes place for a time if the local health of the occular apparatus is improved by rest and soothing applications, or if the pupil be kept dilated by atropia or other mydriatics. Finally, there are such lenticular opacities as "stationary" cataracts; the disease progresses to a certain extent and then, without any particular reason, remains in *statu quo* for many years. Doubtless the "absorption cure" has often received credit for this form of "improvement."

**Malignant Glaucoma.**

W. H. Searles (*The American Journal of Ophthalmology*) reports three cases under this heading. He remarks that he has seen no case of this form of glaucoma reported as successfully treated, but that he has seen several instances of total blindness from it. There is no prodromal period. In the first case the patient had been asleep for an hour on the floor, where the wind blew over his face and head. He was awakened by a sharp pain in the right eye. He was brought to the office, and in less than an hour the eye was stony hard, totally blind, pupil widely dilated, and he was suffering intensely. Paracentesis was done at once. He was put to bed, made to sweat by jaborandi and stimulants; hot water applied every fifteen mnutes, for five minutes at a time, and two per cent. atropine in a four per cent. solution of cocaine used after the hot water for eight or

ten times; then a hypodermic of morphia to put him to sleep. Atropine-cocaine was tested from start to finish, fluid extract of jaborandi, twenty drops at bed-time, followed by morphia if necessary, with quinine during the day. He perfectly recovered his vision in ten days. The other cases reported had essentially the same treatment, but in neither of them was paracentesis employed. Both of them recovered, and in one of them two years has elapsed without any return of the disease. According to every authority, the use of atropine is plainly forbidden in such cases. That glaucoma occurs incidentally with the exhibition of atropine is most true, but it is due to a different cause than the one recognized, namely, obstruction by thickening of the iris base. The glaucoma charged to the use of atropine can always be cured by the further exhibition of atropine. Atropine now comes to the front in a new role It is to become our chief weapon in treating its inflammatory side. Atropine is anti-inflammatory always, because it contracts blood vessels and reduces secretions. and, of course, swelling and tension as well, therefore it is anti-glaucomatous. Atropine removes for the time being one side of the iritic angle, in maximum dilatation, as completely as the best iridectomy, and better still, does it throughout the entire circle. At the finish it leaves no mutilations behind. The author concludes: "Atropine-cocaine reduces volume, blood supply, secretion, intraocular tension, soothes pain, improves nutrition and secures complete rest, and hence, is the logical answer to every glaucomatous process. In every glaucoma there is always sluggish absorption, and we logically turn to jaborandi to meet this defect."

# Editorial.

## A RECEPTION HOSPITAL.

Psychopathic hospitals or reception hospitals for the insane, or for those whose condition cannot well be differentiated from insanity, are generally approved of and would be a great boon. Senator Foley's bill providing for an appropriation for this purpose has been before the Legislature of the State of New York, and it is hoped that funds will shortly be reported for the purpose.

A simpler and in some respects a better plan would be to have a psychopathic ward attached to General Hospitals, where for a reasonable time, patients in need of isolation and medical treatment might be placed until their symptoms (as often happens) disappear, or until diagnosis of insanity can properly be made and they can be taken to a hospital for the insane. At the recent meeting of the Ontario Medical Association this idea was received with marked favor. We hope to hear that some progressive hospital in Ontario has actually opened such a ward.

## THE ROYAL INSTITUTE OF PUBLIC HEALTH.

The Council of the Royal Institute of Public Health is at present considering the establishment of branches of the Institute in the various colonies. The Institute was established in 1886, and was originally founded to obtain Statutary Recognition of Diplomas in Public Health, a recognition which was secured by the Medical Act of 1897. Further in the Local Government Act of 1888 it was provided that all Medical Officers of Health (with but a few exceptions as to small districts) appointed after January 1st, 1892, must possess a registrable qualification in public health.

Besides accomplishing these things, the Institute has published for some time a journal of its own called "*The Journal of State Medicine*," and has founded a library. Her late Majesty Queen Victoria, in recognition of the influence and

work of the Institute, conferred upon it the title of "Royal" and became its patron. The present patrons are His Majesty the King and the Prince of Wales. The President is Professor W. R. Smith of King's College, London.

## ONTARIO MEDICAL COUNCIL.

The recent meeting of the Ontario Medical Council was a somewhat uneventful one. The election to the presidency of the able and genial Hon. Dr. Sullivan, of Kingston, was satisfactory to the whole profession of the Province. It is expected that the President for next year will be Dr. Albert Macdonald, of Toronto.

Two of the most prominent members of the Council, removed by death last year, Drs. Moore and Harrison, were much missed. Their successors, Dr. Herald, of Kingston, and Dr. Horace Bascombe, of Uxbridge, are both able and progressive men, and were warmly welcomed by their fellow-members.

The Complaints Committee considered carefully the protest of a number of students who were rejected at the final examination. The most important complaint was that the candidates did not have sufficient time for their clinical work. The Committee reported that the complaints were unfounded, but made one exception in the case of Mr. A. M. Aylesworth, who had taken an excellent stand, but was slightly below the standard in one subject, and recommended that he be passed. The report was adopted by the Council.

One of the most important questions considered was that of Reciprocity of Registration with Great Britain and certain Provinces of Canada. The matter was referred to a special committee, which brought in a report to the effect that they had not sufficient information to enable them to arrive at a definite conclusion.

The Council ratified the recommendations of their special committee on patent medicines to the effect that the Dominion Government should be asked to make it compulsory for manufacturers of patent medicines to display the formulæ of the ingredients on each bottle, one of the objects being to limit the

amount of alcohol in bad cocktails, which have recently been placed on the market.

The financial condition of the Council is said to be fairly good. After paying $7,500 for clearance of mortgage, the Council had a balance of $5,000. The total assets of the Council are $137,000, and the liabilities $50,000, leaving a good surplus to their credit.

There is a general consensus of opinion among the members that the present building should be sold as soon as possible, and a new one more suitable for their purposes erected in a less noisy part of the city.

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## AMERICAN INTERNATIONAL CONGRESS ON TUBERCULOSIS.

This Congress will be held October 3rd, 4th and 5th, 1904, under the Presidency of Dr. E. J. Barrick, Toronto, and under the auspices of the Universal Exposition, St. Louis, 1904, and of the American Congress on Tuberculosis.

It is considered by the Committee on Organization that all problems and controversies of the pathologists and bacteriologists are comparatively unimportant when compared with the fact conceded by all that consumption is communicable.

On this account the campaign before the Congress will be pre-eminently one of education, not alone of the masses of the people, but also of the professions of laws and medicine. Two issues will be placed before the Congress.

1. To educate all as to the necessity of suitable legislation to arrest and resist the spread and ravages of the disease.

2. To educate and influence public opinion among all classes of our people, so as to secure the passage of wise legislation through legislative bodies quite outside of partisan political considerations, and to so solidify and strengthen public opinion as to sustain the authorities in the enforcement of such laws when once enacted.

It is not considered advisable that such issues should be limited to medical men only. Special invitations are therefore being sent out to those who are interested in this work, and

papers on the prevention of tuberculosis are solicited from all the professions. Those who send contributions but are unable to attend, are assured that their papers will be read before the proper sections of the Congress. Contributions may be written in any language, with a brief synopsis in English.

## CANADIAN MEDICAL ASSOCIATION.

We desire again to remind our readers that the 37th annual meeting of the Canadian Medical Association will be held this year in Vancouver, August, 23rd to 26th inclusive. Our friends in the West tell us that Victoria joins hands with her sister city in extending the hospitality of the Pacific province to all the members of our great International Medical organization.

The cost of the trip from Toronto will include the following items:

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|---|---|
| Return ticket | $ 62.40 |
| Pullman, both ways | 34.00 |
| Meals | 25.00 |
| Five days in Victoria and Vancouver | 20.00 |
| What may be called necessary incidental expenses. | 15.00 |
| Total | $156.00 |

In addition to information given in previous issues, we desire to add something with reference to special entertainments and side trips, going and coming.

### Entertainment at Calgary on Way Out.

The Calgary Medical Association is desirous of extending an entertainment during one day on the way out to Vancouver. This entertainment will be a typical western one, and will take the form of an Indian gathering in costume, Indian racing and games, roping and cowboy feats. Those who would like to stop over at Calgary for this entertainment so kindly offered through the Calgary Medical Association, should notify the General Secretary without any delay.

### The Social Side at Vancouver and Victoria.

In Vancouver arrangements have been made for various excursions, yachting trips, steamer, rail and tram to surrounds ing points of interest; receptions, private and public; a dinner or a ball. On one of the days of the meeting the delegater

will be taken by tram to New Westminster, visit the asylum there and other points of interest, then take the boat down the mighty Fraser to Steveston, visit some of the canneries, so that visitors will have the opportunity of verifying the stories of the salmon industry; then take the train back to Vancouver —a trip of great interest from start to finish.

In Victoria a committee is arranging a series of entertainments there, viz., reception at Government House, conversazione at the Parliament Buildings, a visit to Esquimalt and William Head Quarantine Station, beside other excursions to points of interest in and about Victoria.

### Yellowstone Park.

Yellowstone National Park is situated mostly in the State of Wyoming, in its north-western corner. Those contemplating visiting this "Wonderland" after the meeting in Vancouver, should see that their tickets are routed on return journey *via* the Northern Pacific Railway. From Vancouver the return trip is made over the C.P.R. to the boundary where the Northern Pacific is taken at Sumas. Thence through Auburn and Spokane to Livingston, where change is made for Gardiner, at the entrance to the park. A six days' trip by stage-coach through the park, including meals and lodging at the hotels, which are all first class, will cost $49.50. The park is sixty-two miles from north to south and fifty-four miles wide. The General Secretary will be glad to hear from all those intending to take in this trip on return journey, having been assured that a party of from twenty-five to fifty will receive better attention than smaller ones.

### Return Through California, Salt Lake City and Colorado.

As announced above, the Canadian Medical Association has no arrangements in force for return *via* California. For the benefit of those, however, who wish to return that way to St. Louis, the information may be tendered that there will be in force at the same time as our convention an open rate $70.25 from Toronto to San Francisco, good going *via* Canadian Pacific Railway to Vancouver, allowing liberal stop-overs in each direction; final return limit 23rd of October. No certificates are required for this trip, as it is an open rate to all. In taking this trip, members of the Canadian Medical Association going to Vancouver should be routed on return *via* Southern Pacific, Portland to San Francisco or Los Angeles; Southern Pacific San Francisco or Los Angeles to Ogden; Union Pacific to Kansas City and St. Louis. Mr. H. F. Carter, T.P.A., Union

Pacific Railway, 14 James Building. Toronto, will supply any further information regarding this route.

### Special Certificates.

All delegates must have for themselves, their wives and daughters, if going, a special certificate from the General Secretary, in order to secure reduced transportation rates.

### Future Information.

Should anyone require any further information as to accommodation at Vancouver or Victoria, side trips, hunting, etc., they will kindly address the local secretary, Dr. W. D. Brydone Jack, Vancouver, B.C. For certificates and general information address the General Secretary.

### Provisional List of Papers.

President's Address, Simon J. Tunstall, Vancouver.
Address in Surgery, Mr. Mayo Robson, England.
Address in Medicine, Dr. —— ——.
Address in Gynecology, Dr. E. C. Dudley, Chicago.
Paper, title to be announced, Dr. A. McPhedran, Toronto.
Paper, title to be announced, Dr. J. H. Elliott, Gravenhurst Ontario.
"Surgical Treatment of Trachoma," Dr. G. Stirling Ryerson, Toronto.
Paper, title to be announced, Dr. A. Armstrong, Arnprior, Ontario.
Paper, title to be announced, Dr. A. E. Garrow, Montreal.
"The Operative Treatment of Spina Bifida," Dr. E. R. Secord, Brantford, Ont.
"The Business Aspect of the Medical Profession," Dr. James E. Hanna, Ottawa, Ont.
Paper, title to be announced, Dr. D. J. Gibb Wishart, Toronto.
Paper, title to be announced, Dr. J. W. Stirling, Montreal.
Paper, title to be announced, Dr. B. E. McKenzie, Toronto.
"Hernia of Bladder Complicating Inguinal Hernia," Dr. Francis J. Shepherd, Montreal.
"Gastric Ulcer and Its Treatment," Dr. J. B. McConnell, Montreal.
"La Syphilis Canadienne et Diffirents Facteurs et Gravite." Dr. D. E. LeCavelier, Montreal.
"Case Reports," Dr. Robert H. Craig, Montreal.
Paper, title to be announced, Dr. James S. Edwards, Grand Rapids, Michigan.
Paper, title to be announced, Dr. Henry Howitt, Guelph, Ont.
"Chronic Cystitis," Dr. J. O. Camirand, Sherbrooke, Que.

"Iniencephalus, with a Report of Three Cases," Dr. Maud E. Abbott, and Dr. F. A. L. Lockhart, Montreal.

"Actinomycosis," Dr. James Bell, Montreal.

Paper, title to be announced, Dr. Ingersoll Olmsted, Hamilton, Ontario.

"Prostatectomy Under Local Anesthesia," Dr. H. H. Sinclair, Walkerton, Ont.

"High Frequency Currents in Functional Disease, more particularly Functional Neuroses," Dr. S. F. Wilson, Montreal.

"Therapeutic Hints from Bacteriology," Dr. G. R. Cruickshank, Windsor, Ont.

Paper, title to be announced, Dr. C. H. Mayo, Rochester, Minnesota.

In addition there will be a number of papers from Western men, whose names have not yet been received.

Any further particulars required will be gladly furnished by the General Secret. ry.

129 John Street, Toronto. GEORGE ELLIOTT.

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## INTERN STAFF, TORONTO HOSPITALS.

The staff for the Toronto General Hospital for 1904 and 1905 has been chosen, and the names appear in the following list:

*House Staff.*—A. B. Wright, Toronto; N. McLaurin, Toronto; W. A. McCauley, Warkworth; A. J. Fraleigh, Bloomfield; T. W. Rowntree, Thistletown; R. O. Fisher, Ashgrove; E. K. Culien, Toronto; J. A. Oille, Sparta; G. E. Smith, Toronto; W. E. Gallie, Barrie; T. Hair, Lavender; G. E. Greenway, Little Britain; W. B. Hendry, Toronto; H. R. Elliott, New Sarum.

*Externe House Staff.*—A. W. Canfield, Woodstock; E. A. McCullough, Thomasburg; A. C. C. Johnson, Toronto; W. S. Turnbull, Goderich; J. P. McKinnon, Toronto; W. S. Fawns, Udora.

It is the intention of the board to appoint two official anesthetists; also one medical and one surgical registrar, and one resident pathologist.

The board invites application for the above appointments to be sent to the Secretary, with qualifications.

*Hospital for Sick Children Staff.*—B. C. White, M. H. Embree, K. D. Panton, W. W. Wright.

*St Michael's Hospital Staff.*—P. J. Mugans, Hodgins, Chambers, E. De Haitre.

*Western Hospital Staff.*—F. J. Sheahan.

*Grace Hospital Staff.*—S. Ross, S. B. Walker.

*Home for Incurables.*—A. J. Jackson.

## MEDICAL ITEMS.

The new wing of the Isolation Hospital, Toronto, was opened July 14th.

The position of House Surgeon in the Vancouver General Hospital will be vacant September 18th. Application may be made to the Secretary, Mr. William Skeane.

The degree of Doctor of Laws was conferred upon Dr. Trudeau, of tuberculosis fame, especially in connection with the Saranac Hospital, by McGill University at the June Convocation.

The Department of Medicine of the Congress of Arts and Sciences at St. Louis will be opened September 20th, under the chairmanship of Dr. William Osler. Two general addresses will be delivered by Dr. W. T. Councilman of Harvard Medical College and Dr. Frank Billings of Rush Medical College.

The Second Congress of French-speaking physicians was held in Laval University, Montreal, June 28th, under the presidency of Dr. Foucher. The attendance was large, and among those present were many physicians from sister societies. Professor Pozzi, of Paris, was present as the official delegate of France.

The last meeting of the American Medical Association, held in Atlantic City in June, under the presidency of Dr. Frank Billings, of Chicago, was a very successful one. A large number of Canadians were present and took part in the proceedings. The next meeting will be held in Portland, Oregon, under the presidency of Dr. Lewis S. McMurtry, of Louisville, Ky.

The American Medico-Physiological Association held its Sixtieth Annual Meeting in St. Louis in June. It is the oldest medical society in America, having been founded in the year 1844, as the Association of Medical Superintendents of American Institutions for the Insane. Dr. J. T. W. Burgess, of Montreal, was elected President for the ensuing year.

The Thirtieth Annual Session of the Mississippi Valley Medical Association will be held at Cincinnati, Ohio, October 11th, 12th, 13th, 1904, under the presidency of Dr. Hugh T. Patrick, of Chicago. The headquarters and meeting places will be at the Grand Hotel. The annual orations will be delivered by Dr. Wm. J. Mayo, of Rochester, Minn., in Surgery, and Dr. C. Travis Drennen, of Hot Springs, Ark., in Medicine. Request for places upon the program, or information in regard to the meeting, can be had by addressing the Secretary, Dr. Henry Enos Tuley, Louisville, Ky., or the Assistant Secretary, Dr. S. C. Stanton, Masonic Temple, Chicago, Ill. The usual railroad rates will be in effect.

# Personals.

Dr. Geo. Bingham, of Toronto, is enjoying a holiday on the Georgian Bay.

The *Practitioner*, London, England, has removed its offices to 149 Strand, W.C.

Dr. W. P. Caven, of Toronto, sailed from Liverpool for Canada July 23rd.

Dr. Graham Chambers, of Toronto, sailed from Liverpool for Canada July 27th.

Dr. Price Brown is at present in Europe, and expects to return home early in September.

Dr. Thomas Millman, of Toronto, has returned from a trip through the Maritime Provinces.

Dr. J. S. A. Graham returned to Toronto July 9th. He expects to go back to England shortly.

Dr. Bertha Diamond, of Toronto, has removed from 23 Brunswick Avenue to 66 Brunswick Avenue.

Dr. A. Orr Hastings, of Toronto, sailed for England July 27th. He expects to return the first week in September.

Dr. Kennedy McIlwraith returned to Toronto July 26th, after spending three weeks on the lakes north of Peterborough.

Dr. W. T. McArthur, Tor. '95, F.R.C.S. Edin., of Los Angeles, Cal, was married on June 16th to Miss Mary Delia Smith, of York, Pa.

Dr. Burnham, 134 Bloor Street East, Toronto, is now in Great Britain, and expects to return to resume practice September 23rd.

Dr. Ingersoll Olmsted, of 16 Bay Street South, Hamilton, announces to the profession that in future he will confine his practice to surgery and consultations.

Dr. John T. Fotheringham, of Toronto, after a trip through Europe, going from Naples to Edinburgh, returned home July 10th. His friends were delighted to discover that he had recovered from the effects of his attack of septicemia.

Dr. Euston Sisley, after practising in the village of Maple for fourteen years, sold his residence and practice to Dr. Logan. Dr. Sisley was banqueted on Tuesday evening, June 28th, by the members of the Masonic Lodge, and presented with a Past Master's jewel. He is now taking a trip in the North-West Territories.

Dr. J. Arthur Sutherland of Dawson spent part of July in this city.

Dr. C. H. Britton of East York spent part of July in Muskoka.

Dr. J. A. Roberts has obtained his F.R.C.S. Eng. and returned to Toronto July 25th.

Dr. Edmund E. King of Toronto is spending the month of August at Hastings on the River Trent.

Dr. Logan of Maple, who was suffering from typhoid fever and was nursed in the Toronto General Hospital recovered, and left for his home July 31st.

Oxford University conferred the degree of D.S.C., *honoris causa*, upon Dr. William Osler, of Baltimore. Dr. Osler was described on presentation as being for many years the leading exponent of the principle that the art of medicine should be based on exact scientific knowledge. The University intended to confer the same degree on Dr. T. G. Roderick, Dean of McGill Medical Faculty, Montreal, but he was unable to leave Canada on account of the illness of a near relation.

# Obituary.

## JAMES H. McCULLOUGH, M.D.

Dr. James H. McCullough, formerly of Owen Sound, died at Battleford, July 10th of pneumonia.

## JOHN ROBERT HAMILTON, M. D.

Dr. John Robert Hamilton, of Port Dover, died at Clinton, July 12th, aged 56.

## ROLLO CAMPBELL, M.D.

Dr. Rollo Campbell, of Montreal, died of typhoid fever, May 30th. He had been for years connected with Bishop's College and the Western Hospital, and also certain military organizations. He was a son of Dr. Fred Campbell, Dean of Bishop's College.

# Correspondence.

*To the Editor of* CANADIAN PRACTITIONER AND REVIEW :

DEAR SIR :—Replying to your request for an article on affairs medical in the Yukon, I take pleasure in submitting to you the following general observations :—

Each year since 1898 has seen a marked improvement of the public health in the Yukon. In the early days of the camp, two diseases seriously menaced the health of new-comers to the Territory—typhoid fever and scurvy. The former is lessening every year; the latter has practically disappeared. During the last six months of 1903, only three cases of typhoid fever were reported as originating in the City of Dawson, and only seven during the year ending June 30th, 1903. Although accurate reports were not kept, it is estimated there were several hundred in 1898. This large falling off in the number of cases of enteric fever has resulted from the adoption of the usual preventive measures—good drainage, complete removal of garbage and excreta from the city limits, and the securing of a pure water supply.

Reports from the creeks (where the miners live) and other outlying districts, however, do not show the same enviable record. During the last half of 1903, 20 cases of enteric fever were brought therefrom to Dawson for treatment, and 42 during the year ending June 30th, 1903. This somewhat unsatisfactory showing may be accounted for by opposite conditions from those which obtain in Dawson: lack of proper drainage, non-removal of excreta, and the consequent contamination in places of a rather poor water supply.

The disappearance of scurvy is due to the disappearance of the causes which produce it—poor food, badly cooked; dirty cabins, poorly lighted; bad ventilation; inattention to personal cleanliness; insufficient exercise; and nostalgia. With the advent of wives and children and accompanying home comforts, with the use of fresh meat, fruit and vegetables, scurvy has become practically a disease of the past.

There were two or three threatened epidemics of small-pox, but by the prompt action of the local authorities in placing the patients in an isolated hospital, the exposed persons under quarantine, and enforcing vaccination, the disease was on each occasion quickly stamped out, though at immense cost.

The first outbreak occurred in June, 1900. "The disease was brought in to Dawson (to quote from the M. H.O. at that time) by a man from Seattle arriving on a scow on the 10th of June, 1900. He was never isolated, being quite recovered before the police were able to locate him on the creeks. The disease

gradually spread and formed new foci by the men who had contracted a mild attack not reporting themselves and so infecting the neighbors in an hotel or bunk house. In this way small-pox spread from Dawson to Nome, Grand Forks, Discovery on Hunker, Bonanza, Cheechaco Hill, Eldorado, Gold Run and White Horse, until 42 cases were reported in all in the Yukon Territory. It was found necessary to petition the Yukon Council to extend the limits of the Dawson Health District, so as to be able to enforce the regulations respecting infectious diseases on the creeks. Later, when the disease had spread, an Ordinance was passed enforcing general compulsory vaccination and re-vaccination, unless in the case of those who could make a declaration to the effect that they were successfully vaccinated within the past seven years, or during their life had contracted small-pox. The small-pox scourge gradually disappeared with the advent of the winter snow and frost, so that at the end of the year the hospitals which were built for the accommodation of the small-pox patients at the Mouth of Bonanza, Grand Forks, and Gold Run were closed down, and the nurses and doctors were discharged.

Of the cases that developed nothing extraordinary requires mentioning: 27 or 64.29 per cent. were unvaccinated; 13 or 31 per cent. were vaccinated in childhood; two were not reported. No case had been previously re-vaccinated; 2 were successfully vaccinated 6 days after exposure, but this did not prevent the attack; 1 successful vaccination 6 days after the rash appeared; 6 of the patients had rather serious attacks, but owing to the good attention and accommodation provided all recovered.

Twelve thousand tubes of glycerinated vaccine were ordered and five public vaccinators were appointed. Schedules and vaccine were also forwarded by mail to the Medical Officers at the various Police Stations on the River.

The extreme cold we experienced in the Yukon has no effect on the virus of vaccine. Drawing our conclusion from this we have no reason to suppose that small-pox which is held in abeyance at present by the winter snow and frost will not break out worse than ever next spring. To prevent this all or nearly the whole of the population of the Yukon Territory are now being vaccinated, and next spring they will be well protected."

Perhaps in no young community in the world has there been so much money spent per capita, in the relief of sickness and indigency. From 1898 to June 30th, 1903, the Territorial Government spent $399,697.85 in the support of hospitals and the relief of poverty.

Dawson possesses two modern hospitals under good management. The attendant physicians and surgeons are skilful and

the trained nurses in charge thoroughly competent. Misses Smith, Moody and Graham, of the "Good Samaritan" staff, were trained in the Toronto General Hospital. Their work is highly praised by the Dawson doctors. Major operations of every description are performed here, and the results compare more than favourably with those obtained in the hospitals of the larger cities outside.

To give an idea of the classes of disease affecting the Yukoners, herewith is a list of the cases treated in the two Dawson Hospitals, for the year ending June 30th, 1903:—

| DISEASE. | HOSPITAL. | |
|---|---|---|
| | No. at Good Samaritan. | No. at St. Marys'. |
| Alcholism | 10 | 16 |
| Accidents and Injuries | 31 | 57 |
| Affection of the Eye, Ear, and Throat | 5 | 12 |
| Child Birth | 6 | 0 |
| Disease of the Digestive Organs | 11 | 7 |
| Disease of the Circulatory System | 8 | 7 |
| Disease of the Respiratory System | 21 | 32 |
| Genito-Urinary Diseases, including Disease of the Kidney | 14 | 73 |
| Frost Bite | 11 | 7 |
| Erysipels | 0 | 3 |
| Scurvy | 0 | 2 |
| Rheumatism, Sciatica and Lumbago | 7 | 28 |
| Enteric Fever | 19 | 30 |
| Malaise | * | 29 |
| Other Cases | **40 | 21 |

* Not specified. ** Including Malaise.

From five years' observation I am convinced that the climate of the Territory is a healthful one. The elevation of Dawson above the sea is 1,200 feet, and that of the Dome 4,250 (the head of the principle creeks), between which elevations the majority of the population live. From the beginning of May to the end of August the Territory is bathed in continuous sunlight, either direct or reflected, the fine effect of which on the metaholic processes, and coincidently on the mental, the reader can surmise. The extra store of health acquired in the summer is not altogether lost in the dark days of winter, because the lack of sunlight is to quite an extent counterbalanced by the presence of a dry, cold, condensed atmosphere, which is exceedingly invigorating. Daylight, even in the shortest day, lasts from about 9 a.m. to 3 p.m.

As a rule at first only the vigorous entered into the camp, now people in all degrees of health (competent to perform the usual business of life) are making their home here. Children are particularly healthy, but the old and very debilitated do not stand the winters well.

In the springtime some of the miners show signs of anæmia. This is due not so much to the absence of sunlight as to the fact that they work so much underground, consume so much canned food, and live in cabins dimly lit and poorly ventilated.

I should, perhaps, qualify the statement in the first paragraph, because two other diseases have caused some apprehension in the Yukon—glanders and rabies.

During the year 1903, 48 horses suffering from glanders were destroyed by order of the veterinary inspector. Five others which were isolated died or were put to death by their owners. At the end of the year 22 horses were under isolation. Six stables were burned, and all the others disinfected. There are about 1,000 horses in the Territory. The mallein diagnostic test was tried; it gave satisfactory results.

## Rabies.

I am indebted to Mr. E. Shoff, druggist (who has been doing considerable practice among dogs) for the following note on an epidemic of Rabies which occurred here commencing in the autumn of 1902.

"Noted suspicious case September 1st. Came from Nome, Alaska. Ordered confined. Broke loose next day. Never seen again.

September 15th, first case, unable to diagnose. On 18th saw second case with two M.D.'s. Died in two days. Cases then began to come every other day. Isolated all, keeping them under careful supervision.

From September 15th to October 1st, had probably 50 cases. All isolated. Five of one litter all bitten at once. In this litter one case developed in 14 days, and the other four on successive days. All died within 60 hours of the onset of disease.

Noticed preponderance of the dumb form, ordinarily shewn in only 20 per cent. of cases affected. Many of the violent cases were killed, and so were not brought to my attention.

Native dogs of wolf strain developed symptoms early, 12-16 days. "Outside" dogs, 20 to 90 days. One case kept under observation for nine months did not shew symptoms until the end of that time.

Each of the above cases was under observation of from 3 to 5 physicians. Dr. Bourke, of Dawson, and Dr. McLeod, of Bonanza, were the only physicians who had seen the disease before. Each instantly made a diagnosis of Rabies.

During the prevalence of the disease about one dozen people were bitten by dogs—some, no doubt, by non-affected dogs. Heavy clothes and quick disinfection were responsible for non-infection from bites of infected dogs. One case developed in

the human subject. The case was treated by Dr. Clendennan, now of Edmonton.

The chief feature noticable in the dumb form was parlysis of the lower jaw, followed by complete paralysis of the hind quarters. Death in all cases ensued inside 60 hours from onset. Some cases showed features of the dumb form alternating with the violent form.

Post mortem shewed accumulation of foreign matter, slivers of wood, straw, etc., in the stomach. No examination made of nervous system.

The epidemic lasted 6 months. Some 250 dogs were effected."

I regret that my department work prevented me from making a closer study of the above diseases.

Yours faithfully,

J. N. E. BROWN.

DAWSON, Y. T., JUNE 21ST, 1904,

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**The Safety of Ethyl Chloride as an Anaesthetic.**

This new agent whose virtues were quite evident, yet whose dangers were an unknown quantity through the relatively short period of its use up to 1900, by more recent figures promises to come into recognition as the safest of all. The mortality is now put down as one in from ten to fifteen thousand, although the very few cases of death have occurred in persons known to have been suffering from some grave cardiac or respiratory difficulty. —*Clinical Review.*

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"BY the way," said the gentlemanly-looking person in the black broadcloth suit, "*if you mention my name in connection* with the accident, you may say that 'Dr. Swankem was called, and the fractured arm was suitably bandaged,' or something to that effect. Please spell the name correctly. Here's my card." "Thanks," said the reporter, looking at the card. "You are next door to Dr. Rybold, I believe. Are you acquainted with him?" "No, sir," replied Dr. Swankem, stiffly. "We do not recognize Dr. Rybold as a member of the profession. He advertises."—*Chicago Tribune.*