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Western Canada Medical Journal

A MONTHLY JOURNAL OF MEDICINE SURGERY AND ALLIED SCIENCES

VOL. I. · NOVEMBER, 1907 NO. 11 ·

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Western Canada Medical Journal

GEORGE OSBORNE HUGHES, M.D., *Editor.*

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ERRATA

PAGE 489—Line 10 should read "amount of mucus which is secreted for the purpose of protect-"

—EDITOR

VOL. I. NOVEMBER, 1907 No. 11

ORIGINAL COMMUNICATIONS.

*THE PRESENT CLINICAL ASPECT OF STOMACH SURGERY

BY A. J. OCHSNER, B.S.; F.R.M.S.; M.D.

Surgeon-in-Chief of Augustana Hospital and St. Mark's Hospital, Professor in Clinical Surgery in the Medical Department in the University of Illinois, Chicago.

It is indeed with great pleasure that I have accepted the invitation of your distinguished President to speak before this great Association on a subject which has been most interesting to me since its appearance on the field of surgery.

Stomach surgery has, since its introduction by Billroth, been fostered by the most active and brilliant members of our profession. In Austria, the names of Billroth, Woelfler v. Hocker v. Eiselberg; in Germany, those of Czerney, Mikulicz and thei'r assistants; in Switzerland, those of Kocher and Roux; in France, that of Hartmann; in England, those of Robson and Moynihan, and in our own country, those of Mayo, Murphy, Munro, and that of your President, Dr. Tuholske, are all so well known that it is scarcely necessary even to refer to them.

* Read before Surgical Section of the St, Louis Medical Society, October 18th, 1907.

been harmed by their surgical treatment, and only few showing permanent cures, that, therefore, surgical treatment must be bad, forgetting that there is no reason why he should come in contact with the many satisfactory results outside of the few cases which may have gone to the surgeon from his own personal practice, and this number must, of course, always remain small.

6th.—Moreover, the surgeon constantly encounters great indurated ulcers and advanced carcinomata, which the internist has attempted to heal by internal remedies.

7th.—On the other hand, the internist encounters patients suffering from neurosthenia, locomotor ataxia and hysteria, which have either had stomach operations advised, or actually performed, by over-enthusiastic surgeons.

In order that this difference may be eliminated as speedily as possible it seems most important that the internist make a regular practice of witnessing operations upon the stomach. If they see the pathological condition in the living body, in a large number of cases, they will become quite as thoroughly convinced of the value of stomach surgery, as they are now concerning the surgical treatment for appendicitis, gall stones and renal calculi.

Fortunately, many internists in the large hospitals are doing this and this may result in a vast amount of good to a large number of patients.

On the other hand, the surgeon should take the time to observe the progress of patients in the medical wards suffering from acute gastric disturbances, including ulcers in their early stages before a marked induration has taken place so that he may learn to appreciate what can be done in these cases by dietetic, hygienic and medicinal treatment.

This plan would result in convincing the surgeon that most patients suffering from disease of the stomach can be successfully treated to perfect and permanent recovery by dietetic, hygienic and medicinal treatment, the permanency, of course, depending upon long continued care in regulating the diet and hygiene of the patient after recovery from the acute condition. This point has been sadly neglected by internists

and quite as commonly by surgeons, after the patient has recovered from an operation.

The surgeon will also learn that barring cases of perforation and traumatism and uncontrollable hemorrhages and malignant growths, only those cases of stomach disease are suitable for surgical treatment that have failed to be permanently relieved by careful, persistent dietetic hygienic and internal treatment.

The internist, on the other hand, will also learn to place this class of cases under surgical treatment relatively early.

Conditions to be Secured by Surgical Treatment.—At the present time surgery of the stomach is limited in its results to three conditions:

1.—The closure of the defect following perforative ulcer or gunshot or stab wounds, or rupture of the stomach due to traumatism.

2.—The establishment of drainage in cases of obstruction of the pylorus due to neoplasms, cicatricial contraction, the presence of indurated ulcer or hour-glass stomach in the adult, and the presence of congenital stenosis in children.

3.—The removal of neoplasms; and possibly

4.—The correction of gastroptosis.

Whatever operation is performed for the relief of gastric disease it is reasonable to demand that conditions be established which will place the stomach as nearly as possible in a normal condition from a mechanical standpoint. On the other hand, it is reasonable to expect this organ to be somewhat less perfect in a mechanical or anatomical way than a normal stomach, even after the most perfect operation.

At this point it may be well once more to direct attention to the mechanics of gastric digestion. In order to make this more easily understood the accompanying diagram, Fig. I, may serve as an illustration.

We must look upon the stomach as a machine with five distinct functions:

1.—It serves as a storeroom for one meal.

2.—It secretes certain substances necessary in the digestion of food.

3.—It serves as a mixing machine which saturates these foods which are held in storage with the substance secreted.

4.—It grinds the food into fine consistency proper for the further steps which are accomplished after this substance has been forced through the pylorus into the intestinal canal.

5.—To a very slight extent absorption of food takes place directly from the stomach, but this is almost a negligible factor.

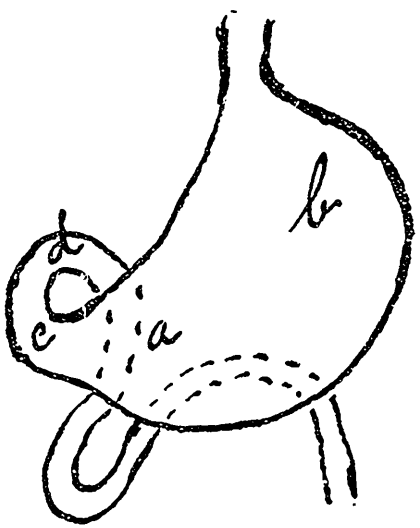

Figure 1.

As a matter of fact, it is always proper to consider the duodenum with the stomach, because the two portions of the alimentary canal are really one organ both as regards their embryonic origin and their physiological function and these two portions are also closely related in their diseases.

Referring to the accompanying figure, the portion (*b*) must be looked upon as the storehouse and mixing apparatus, and the narrow portion (*a*) as the grinding apparatus. The position of the stomach favors the accumulation of the finer portions of food at (*a*) where, according to Cannon, they are

crushed back and forth until a suitable consistency has been reached, when the pylorus (*c*) opens and a definite quantity is forced into the duodenum (*d*) which again serves as a mixer, the material added at this point consisting of bile and pancreatic fluid.

It may be plain that any one of the operations mentioned above, must interfere to some extent at least with some portion of this mechanism, and it is for this reason especially, that we should never interfere with this organ surgically if it is possible to restore the latter to even an approximately normal anatomical condition, by dietetic, hygienic or medicinal treatment. The result after the most perfect operation cannot produce a stomach which will bear the dietetic abuse that can be imposed upon a normal stomach.

There is no doubt but what many a patient would remain permanently well after recovering from ulcer of the stomach after a careful course of dietetic, hygienic and medicinal treatment if he would subject himself constantly to the care which becomes imperative after a stomach operation.

Those internists who appreciate this fact, and who tyrannise over their patients for years after their recovery from gastric ulcer are the only ones whose patients do not ultimately seek relief from surgery.

It may then be stated as an axiom:

1—That certain conditions like gastric perforation and gastric neoplasms should receive surgical treatment as soon as a diagnosis has been made;

2.—That other diseases of the stomach like gastric ulcer and its sequelæ should receive surgical treatment whenever it becomes apparent that the condition cannot be relieved by dietetic, hygienic and medicinal treatment.

That a vast majority of gastric ulcer will heal under careful and persistent dietetic, hygienic and medicinal treatment, has been demonstrated, not only by clinical observation, but also by many careful experimental studies upon animals, notably those by Fibrich and those by Fuetterer. In all of these cases one must, however, bear in mind that most of these patients started with normal stomachs and that as a result of certain

hygienic and dietetic conditions or abuses to which they were exposed this pathological condition has resulted. Taking for granted then, in any given case that the lesion has healed perfectly, it is not reasonable to expect this lesion to remain well unless the conditions which give rise to the disease primarily are permanently eliminated.

It is, therefore, extremely important not only in the after-treatment of patients which have been relieved of their gastric diseases by internal treatment, but also those that have undergone surgical treatment, that sufficient attention be paid to hygienic and dietetic conditions after the patient has fully recovered.

Relief of Pyloric Obstruction.—More real benefit is done the patient by relieving pyloric obstruction than by accomplishing all other surgical results in stomach surgery. This makes it proper to give this feature some especial attention in this discussion.

Whatever the cause of obstruction may be at the time the patient comes under the surgeon's care in a vast majority of cases the primary cause was an ulcer in this portion of the stomach which is most exposed to trauma from within, because of its special function.

The obstruction may still, although only rarely, be due to spasmodic contraction due to the presence of an ulcer; it may be due to the healing of an ulcer or to the implantation of a carcinoma in the base of an ulcer, or even to adhesions due to the threatened perforation of an ulcer.

The symptoms will vary with the extent of the obstruction and the acuteness of the condition, but there is usually quite a definite course which may be followed in most cases, which have persisted sufficiently long to come under the care of the surgeon.

Clinical Course of These Cases.—Clinically these patients either recover under dietetic and hygienic treatment, or the stomach undergoes anatomical changes such as are illustrated diagrammatically in Figure 2. The case in the meantime takes the following typical course. In non-congenital cases the obstruction at the pylorus in its early stages is accomplished with a considerable degree of pain, which is usually located between

the ensiform appendix of the sternum and the umbilicus. The patient feels distressed after eating, and the distress is more marked after the ingestion of certain foods. The patient begins to classify various articles of food according to the amount of discomfort they produce. Acids and raw fruits usually cause the greatest amount of distress. During this portion of the course of the disease the distress is usually greater if a large

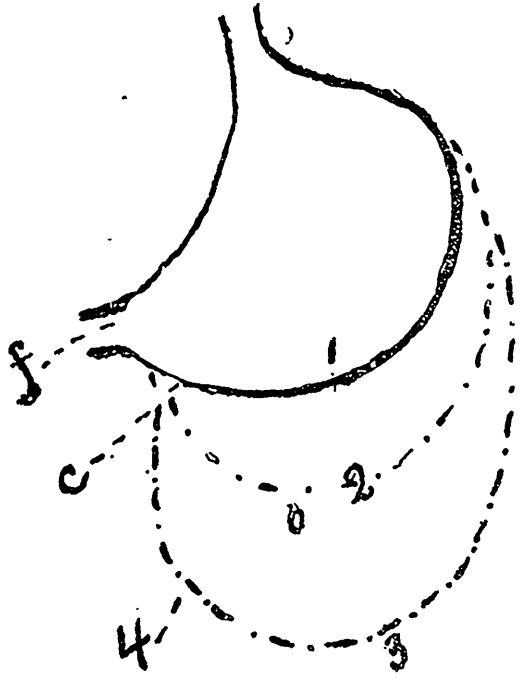

Figure 2.

amount of food is taken, than if the patient east but a small amount. Gastric lavage will show the presence of a great amount of food is taken, than if the patient eats but a small ing the painful point. At this time the stomach is not enlarged, and there is frequently a compensating hypertrophy of the muscular wall of the stomach to overcome the obstruction at the pylorus. If the latter persists, however, hypertrophy will give

place to dilatation; this will at first be slight in degree as shown at 2 in Figure 2: In the meantime, the accumulation of mucus interferes with the gastric digestion because it covers the surface of solid portions of food which have been placed in the stomach. To compensate for this condition, there is a physiological increase of hydrochloric acid which in turn causes an increase in pain, because of its irritating effect upon the pyloric ulcer. The difficulty of emptying the stomach contents into the duodenum will now be increased from one of two causes. The ulcer may become partly or completely healed and this may result in cicatrical contraction of the pylorus which will in turn increase the obstruction; or, the base of the ulcer and the tissue surrounding the ulcer will contract, thus causing a mechanical increase in the obstruction. A third condition which has frequently been mentioned as an important cause, is the spasmodic contraction of the sphincter muscle of the pylorus, due to the presence of an ulcer within the grasp of this muscle. It is likely that this factor is more active in the early than in the later stages of pyloric obstruction.

In the meantime, the dilatation of the stomach continues as indicated at 3, Figure 2, so that the greater curvature extends a considerable distance below the umbilicus. This dilatation may be so great as to permit the greater curvature of the stomach to rest in the pelvis of the patient, a condition observed in one of my patients. This condition induces another important factor in the mechanism of digestion. In the normal condition the food in passing from the stomach into the duodenum, must be elevated only the distance from C to F, in Figure 2, while in the extremely dilated stomach it must be lifted the much greater distance from 3 to F, Figure 2. Moreover, the course which the food has to pursue in passing from C to F extends over a smooth non-saculated surface, while in its course from 3 to F there is likely to be formed at 4 a valve-like projection which will serve as a serious obstruction to the passage of food through the pylorus into the duodenum. At this point of the course of the disease, the stomach becomes incompetent to empty itself completely and there remains constantly in this lower pouch a certain amount of residual food. Here, as in every

cavity in the human body, the retention of residual contents favors the development of micro-organisms and in a short time a severe degree of fermentation and decomposition will take place, and the patient will begin to absorb these products of decomposition instead of absorbing the products of normal digestion. At this point severe symptoms of malnutrition will appear. A careful use of gastric lavage, together with hygienic and dietetic treatment will frequently prevent the progress of malnutrition by removing these decomposing substances, and supplying food which can readily be absorbed. But it is not likely that in any of these advanced cases the mechanism can be restored to approximately normal conditions without the aid of surgical interference. In cases, however, which have not progressed to this extreme degree, it is undoubtedly frequently possible to restore the anatomical conditions to approximately a normal state.

It is well to emphasize especially the importance of hygienic measures. One frequently encounters a case of almost hopeless stomach disease in a person of sedentary habits, overworked mentally, who goes out on the plains, and returns after a number of months with the best stomach in town. So it is well to impress the importance not only of dietetic and medicinal, but also of hygienic measures.

We have, then, a stomach that is hopelessly ruined. After having tried all of these measures we find that the stomach is still in this pathological condition. At this point the condition may be accompanied by an open ulcer, or the ulcer may have healed and there may be a cicatricial obstruction at the point of its location, or this obstruction may be due to a more or less extensive induration at the base of the ulcer.

If the ulcer is still open, we have a number of very definite complications to fear besides the malnutrition, the discomfort and the disability of the patient. We have to consider the possibility of perforation of this ulcer and immediate sudden death of the patient, the latter losing his life by the loss of a great amount of blood suddenly, or by intermittent hemorrhage. We must also consider the possibility of having carcinoma implanted upon this ulcer.

That this condition occurs in many cases of chronic ulcer of the stomach has been observed by many surgeons. It has been investigated with great care in a very large number of cases by Graham.

At this point, it may be well to emphasize the fact that in this condition as well as in all other intra-abdominal conditions, such as pyosalpinx, appendicitis, extra-uterine pregnancy, gall bladder disease, the diagnosis has been perfected to a reasonable extent only as a result of the operation. When operations were begun for each and every one of these conditions, the views which we held were extremely vague. It has only been from the fact that as a probable diagnosis was made, and it was either proven or disproven by a surgical operation, we have been able to come to a reasonable degree of certainty in our diagnosis. So that both the surgeon and the internist should in every instance in which the abdomen is opened for the relief of a condition of the stomach be present at the operation, and should determine whether the ideas formed concerning the conditions to be found are correct or incorrect, because upon the ability to diagnose them properly will depend our ability to treat these cases properly later on.

Technic.—The general technic of stomach surgery must be learned at the operating table. More can be learned in a week's observation in the operating room of any one of the many great clinics in which gastric surgery is practiced in this country and abroad than by listening to descriptions or reading of them for months.

There are, however, a few fundamental principles which must be observed in order to secure permanently satisfactory results.

1—The amount of traumatism must be reduced to a minimum.

2—The intra-abdominal organs must be exposed as little as possible to cold air or cool pads.

3—The patient must be placed in a sitting posture as soon as possible after the operation.

4—In case of closure of perforation the direction of the wound must be chosen so as not to result in obstruction later as a result of cicatricial contraction.

5—In case of excision of a neoplasm all the tissue closely connected must be removed with the growth to the greatest extent possible in the presence of existing anatomical relations.

6—In gastro-enterostomy the lowest portion of the stomach must be chosen, no matter whether anterior or posterior gastro-enterostomy be performed, the latter, however, being preferable.

7—There must be no tension upon any sutures in any gastric operation.

8—Except in complete gastrectomy, the coronary artery must be always preserved.

9—In patients with an unusually fat transverse mesocolon in whom posterior gastro-enterostomy is performed, the opening should be torn very large and the edge should be sutured to the stomach in order to prevent obstruction.

10—In case of acute gastric dilatation following any stomach operation a stomach tube should at once be introduced and gastric lavage be employed, care being taken not to introduce more than one-fourth liter of water at a time.

11—The simplest possible technic should be employed preferably without the use of mechanical apparatus.

A CASE OF PRIMARY SARCOMA OF THE KIDNEY

BY R. W. KENNY, M.D.

WINNIPEG, MAN.

Clinical History.—E. D. S. Male, æt. 25, height, 5ft. 8 inches, weight, 190 lbs., an athlete, who had played football and hockey in the fall and winter of 1905-6.

The patient was first seen on March 9th, 1906. He appeared to be suffering from a typical attack of renal colic. He was lying on his bed, face flushed and at intervals moaned with pain, which was of paroxysmal type and radiated into the right groin, at times he writhed and drew up his knees. His pulse was 112, and temperature 100.6.

Examination:

Inspection showed knees and scrotum drawn up during the paroxysms of pain.

Palpitation: Great tenderness was found over the right kidney. The kidney itself could not be distinctly palpated, but an indefinite mass extending towards the liver could be made out. This mass was fixed in position and was larger than the normal kidney, it did not project ventrally.

Percussion: The liver dullness extended two finger breadths below the costal margin.

The Urine examined the following morning, March 10th, was practically normal. Amber in colour; 1024, acid; no albumen; no sugar; no blood; no blood or pus cells; a few calcium oxalate crystals were found.

The next day the pain continued severe and paroxysmal so the patient was removed to the Winnipeg General Hospital.

The chart attached best shows the progress of the patient from the 10th to 16th of March. The temperament returned to normal and the pulse fell somewhat. The sharp attacks of pain passed off, but the pain never disappeared in full, but took a constant dull dragging character.

The patient had a slight temperament until March 22nd, when this entirely disappeared. He was up and around without much appetite and unable to work for the constant dull dragging pain in the side which became worse on exertion. On April 7th, the urine for the first time showed a trace of albumen, blood and blood cells. The urine had been examined in the hospital three times and repeatedly in my office and on each examination *previously* was normal.

At this time, April 7th, an operation was advised, and the patient went to him home—Ottawa—where he was operated upon by Drs. Klotz and Webster, on May 7th.

Surgeon's Report—

E. D. S.—First consulted me on his return from Winnipeg, April 14, 1906. On examination he appeared slightly anæmic, was losing slightly in weight, and complained of some loss of appetite, more or less lassitude, with obscure and not well defined aches in the right loin. A urinalysis made at this time was in all respects normal. A mass not very well defined could be made out under the right lobe of the liver, but whether solid or not could not be determined.

He had an attack of renal colic May 4, 1906, when he was attacked with most excruciating pains in the right loin and right side and extending to the right testicle. During this attack, which lasted some hours, he was unable to pass any urine whatever and I found it necessary to use a catheter with the result that a small blood clot was found to be obstructing the prostatic portion of the urethra. A urinalysis made immediately afterwards showed only the presence of a slight amount of blood; there appeared no other abnormal ingredients. The mass on the right side had been slightly increasing in size since I first saw him on April 14th. On the 6th of May he had an attack similar to the one first described, and it was decided to send him to the hospital and operate. On May 7th I performed a Nephrotomy opening by the lumbar route and found a greatly enlarged and somewhat distended kidney. The urine now drained through the wound and it became evident

that the only course to pursue was to perform a complete Nephrectomy, and accordingly on June 8th, the entire kidney with the supra-renal capsule was removed by the abdominal Route, known as Langenbuch's operation. The mass involved was so large that it was found impossible to remove it *en masse*, and it was found simplest to split the capsule, shell out the diseased organ and by bisecting it render its extraction more feasible. The renal arteries and surrounding tissues were involved in such a conglomerate mass that it was impossible to distinguish individual features. Accordingly the vessels were clamped, the forceps being removed at the end of 48 hours. The operation consumed about an hour and a half and left the patient in a state of collapse. From this, however, by means of camphor, strychnine, hypodermic injections of ether combined with saline transfusion he rallied at the end of 6 or 8 hours. The patient, in spite of rallying for the first week or ten days, gradually lost ground, and finally succumbed on July 8th, 1906.

M. O. KLOTZ,
Ottawa, Ont.

Pathologists Report.—Macroscopically, little kidney tissue could be recognized, the greater part of the specimen being made up of a greyish pink tissue, which was soft and friable. Microscopically, the kidney substance which remained was much distorted. A dense fibrous tissue was present between the kidney tubules and the Malpighian corpuscles. The capsules of the Malpighian bodies showed no concentric fibrosis as is seen with chronic interstitial nephritis, but the general fibrous stroma was uniformly distributed between the kidney parenchyma. In the cortex, the tubules and Malpighian corpuscles showed but little sign of compression from the fibrous tissue, but the tubular epithelium was atrophied, leaving large lumina. Here and there, in the cortex, were collections of small spherical cells, a little larger than lymphocytes and having spherical dark staining nuclei. Within these collections no stroma or blood vessels were to be made out. In the pyramids of the kidney the tubules appeared larger than usual, but nevertheless no lumina were present in most of them. In

WINNIPEG GENERAL HOSPITAL

Temperature Chart, Etc.

Name E. ____ S. ___ Ward J No 5 March 10th 1906

MONTH March.

DATE	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E	M E
F°																					
107°																					
106°																					
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97°																					
96°																					
SLEEP M																					
SLEEP E																					
RESPN M		18	20	20	20	20															
RESPN E	20	20	20	20	20																
PULSE M		88	94	80	70	70															
PULSE E	100	76	80	78	74																
No. of Stools M	E.1	1.1.	E.1.		1.																
No. of Stools E																					
Days in Hospital	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21

Adm. 5.30 p.m.

Ice cap to side

Diet.

Light solids

Discharged

URINE			
DATE	March 15th	April 7th	
AMOUNT		Taken with by Catheter	
COLOR	Amber	amber	
REACTION	Acid	acid	
SP: GR.	1020	1022	
UREA			
ALBUMEN	neg	slight trace	
SUGAR	neg	neg	
DEPOSIT		blood cells	

this region larger areas of spherical-cell collections are present, and in some places kidney substance remains.

Sections made through the tumor mass show it to be made up of densely aggregated small spherical cells, which have occasional heavy bands of stroma passing through them. There is but very little stroma between the individual tumor cells, and blood vessels are infrequent. In places the tumor tissue appears to be in direct continuity with the cells of the collecting tubules, and the appearance is that there is a transition from the parenchymal cells of the kidney to those o fthe new growth. Certain areas of the new growth are noted to be undergoing necrosis, and in these places only a granular debris remains without any surrounding inflammatory zone.

The individual cells of the tumor are small, with a relatively large nucleus and little protoplasm surrounding them. At the borders of the tumor masses the cells appear more cubical—or rather of the type of cell as is present in the collecting tubules. Occasional collecting tubules appear tortuous, and are blocked by an overgrowth of the lining epithelial cells.

Diagnosis—Small celled sarcoma of the kidney (probably arising from the cells of the kidney tubules).

O. KLOTZ, M.D.,
Pathologist Royal Victorian Hospital, Montreal.

There are some points of special interest in this case. The pain at times was of the renal colic type with radiation into the groin and testicle. This is not the rule and was evidently due to some obstruction in the pelvis of the kidney or ureter either blood or portions of the tumor.

This view is further borne out by the repeated urinalyses giving no result. The obstruction in the pelvis or ureter prevented the urine from the diseased kidney reaching the bladder and so we were examining the urine of the normal kidney alone. And it was not until blood was found in the urine that the urine from the right kidney was obtained.

The rapid development of the tumor is worthy of note. The patient was first seen March 9th and died July 8th of the

same year. He was evidently healthy the preceding fall and winter as he was able to play football and hockey.

Adhesions occurred early and fixed the kidney posteriorly especially, and to the neighboring vessels and to the liver.

The ætiology of these tumors is interesting. Children are more commonly affected than adults, and females more frequently than males. The left kidney is the one usually affected. The tumor may be single or multiple. Single tumors are usually primary, and found in early childhood, i.e., from brith to the third year. The adeno-sarcoma in one of its forms is generally found between thirty and forty years of age. Shede divides sarcomata into two main divisions:

1. Hypernephroma: .(*a*) Those arising from the connective tissue; (*b*) those arsing from the vessels of the kidney, the Angiosarcoma.

II. Adenosarcoma.

1. (*a*) These arise from the inter-tubular and subcapsular connective tissue and are divided into: Small and large round celled; giant celled; spindle celled and melano sarcoma.

(*b*) Angiosarcoma, arising from the vessels of the kidney. In this class we find (1) Endothelioma from the lymph vessels.

(2) Endothelioma from the blood vessels beginning in the small veins or small capillaries.

(3) Perivascular Sarcoma or Perithelioma, beginning in the cells of the tunica adventitia of the vessels.

II. The Adenosarcoma form a class of tumors embryonic in origin in which at times sarcomatous elements pervail and at others the carcinomatous. A third group, the Rhabdomyosarcoma, contain, in addition smooth or striated muscle fibres. These tumors all seem to be "congenital misplacements of embryonic cells." They develop rapidly and attain considerable size at birth or from one to two years. Neighboring organs are affected slowly by pressure, they seldom spread to other tissues.

The Adenosarcoma are quite distinct from the Hypernephroma. These latter occur in adult life, the commonest period being between 30 and 40 years, while the former occur in the first three years of life. An early symptom of the hypernephroma is hæmaturia while this is almost never a symptom of the embryonic glandular tumors. In the hypernephroma an early involvment of the neighboring tissues is the rule and metastases are common.

*ARTIFICIAL DILATATION OF THE CERVIX

With Special Reference to the Use of the Modified Champetier Balloon

BY S. W. HEWETSON, M.D.

PINCHER CREEK, ALTA.

I feel somewhat diffident in introducing such a commonplace subject, my excuse, however, is, that while Appendicitis is *rapidly supplanting* Pregnancy in the high position of public esteem and favor which it occupied in our grandmothers' time, the latter—Pregnancy—is still of more frequent occurrence. I have decided to confine my remarks to the use of the rubber bag.

One of our leading Obstetricians has said "that with the modern hot-house patient—the product of our so-called civilization—" that the medical attendant has to do the whole thing, dilate the cervix, rupture the membrances, mould the head and drag the child through, remove the placenta, and then repair the damage done"; to this I might add, "that if convalescence is not complete in three weeks, the unfortunate medical attendant has a lifelong critic."

My object in selecting this subject is that the value of these bags is not fully appreciated by many medical men, for they sometimes save the life of the child, often save the mother several hours of pain and suffering, and the attendant, long and weary hours of waiting.

I have selected a few cases from my notes which serve to illustrate different types in which they often prove useful.

Case No. 1.—Primipara, æt. 24, memb. rupt. 2 a.m.; exam. showed a somewhat contracted pelvis, head not engaged, cervix thinned out, and dilated to admit index finger, no pains present, nor did these start until 7 a.m., from which time p. had severe pains until 11.30 a.m., when a second exam. revealed no change. P. was becoming exhausted, and the child

*Read before the Alberta Medical Association, Oct. 11th, 1907.

was beginning to show signs of distress, evidenced by slowing of the foetal heart and increased movements. A funnel shaped bag was introduced, expelled at 1.30 p.m. and child delivered artificially at 2 p.m. Convalescence—uninterrupted.

Case No. 2.—Multipara highly neurotic, first child stillborn; p. had passed the day of expectation and became more nervous and more and more depressed. Various sedatives were tried with no success, and she was gradually getting weaker from loss of sleep. The induction of labor was clearly indicated in this case. The cervix was sufficiently dilated by the hand to allow of the introduction of a rubber bag, which was followed by a normal labor and restoration to a normal mental condition.

Case No. 3.—Multipara, æt. 42, youngest child, 14 years of age. Marginal Placenta Prævia with intermittent hemorrhage for a month prior to the onset of labor; the latter began at about the end of 6½ months and was accompanied by increased hemorrhage. Examination showed a hard fibrous, badly-scarred cervix, which had an almost cartilaginous "feel," thick and dilated to about the size of a 25 cent piece. P. taken to the hospital at 3 p.m.; pains continued strong and regular, but at 12 p.m. had effected no change, and p. was becoming exhausted. Rubber bag introduced at 12.30 a.m., expelled at 1.30 a.m., and was followed by the foetus at 2 a.m. This is a most striking illustration of the value of these bags, one in which cause and effect were too closely connected to be explained by a mere coincidence.

Case No. 4.—Primipara—accidental rupture of the membranes occurred at end of fifth month; after waiting in vain for several days for the onset of labor, the latter terminating naturally after being induced artificially by the introduction of one of these bags.

Case No. 5.—Cases of this nature are comparatively common. Primipara, æt. 28, labor at full term, memb. unrupt., but Nature's Dilator—"the bag of waters"—fails to form; if the head is pushed up between pains the bag forms, but disappears at the onset of the next pain. After waiting two hours, during which time the cervix, which was already thin-

ned out and dilated to the size of a five cent piece, underwent no change in spite of the strong regular pains, a rubber bag was inserted. This soon produced complete dilitation, which was speedily followed by normal delivery.

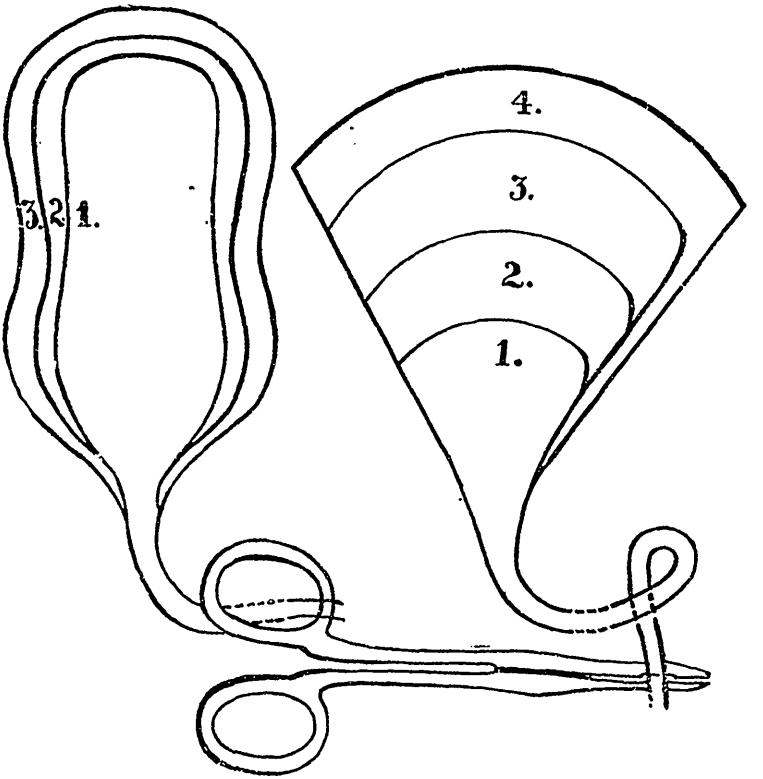
Case No. 6.—Multipara, æt. 40, memb. rupt. and uterus in a condition of primary inertia; time 10 p.m.; place, a two-room shack twenty miles out in the country. The sleeping accommodation is already over-taxed, and unless the case soon terminate, the accoucheur will have to sit up all night on a kitchen chair. Hot douches and the various oxytoxics might be tried, but the hydrostatic dilator is safer and surer as I have several times satisfied myself in similar cases. Its use results in the medical attendant getting home in time to have several hours rest instead of losing a night's sleep. Needless to say, no harm is done to the patient, and I might mention here that I have yet to see a case in which ill-effects could be attributed to this proceedure, that is, to this method of producing dilitation.

The Midifications of the Champ. de Rives bag are said under various names, but broadly speaking, there are two principal types, viz., the funnel and fiddle shaped bag, of which the former is to be preferred, for the latter has been known to rupture the cervix, in cases where too rapid distension was practiced; this is easily understood, when it is explained that the cervix embraces the constriction of the bag when the latter is in position. The position of the funnel—or pear-shaped bag—is entirely within the uterus. These are sold in sets of three or four and cost about $3.00 per set. In actual practice, however, it is better in insert at once the largest size one intends to use, when this is possible, although it may be necessary to dilate manually to a sufficient degree to allow the introduction of the bag. In labor at full term, one should employ a bag with a capacity of 300-400 C. C. and a diameter of 3-3½ in., the expulsion of which insures a sufficient degree of dilitation to permit of safe application of the forceps. Linen or silk is sometimes incorporated in these bags to prevent bursting from over-distension and also to supply sufficient strength to withstand the strain of

rythmical traction. · Over-distension is best avoided by having a syringe and bag of known capacity.

Barnes Bag; Cervix embraces construction. Actual Size. Three sizes

Voorhees' Balloon-shaped Bag. Actual size. Four in set. Cost $3 per set.—J. P. Hartz.



Mode of Introduction.—Chloroform is seldom necessary, nor is it often necessary to have the patient across the bed, unless, 1st, the patient is very nervous, or 2nd, the vulvar orifice is very small, or 3rd, where preliminary preparatory dilitation is necessary. Scrupulous cleanliness is imperative. With P. in Sims or dorsal position, as preferred, the post. lip is drawn down with vulsella forceps, and the bag, which has been tightly rolled up, is inserted by means of a heavy pair of

uterine dressing forceps or sponge holders. It is necessary to hold it in position until it is sufficiently distended to prevent its expulsion. Any syringe which can be sterilized will do, but one of a known capacity is to be preferred. A stop-cock on the tube of the bag is not necessary, in fact it is more satisfactory to clamp the tube with a pair of artery forceps.

Conclusions.—1st—The best hydrostatic dilator is the funnel-shaped bag, because it is the closest imitation of Nature's method. In the past seven years, the records of the Sloane Maternity Hospital show that manual dilitation has been resorted to on 73 occasions, and the bag used 281 times during the same period. Voorhees—attending physician to this institution—resorts to this method of dilitation in one case in every five in his private practice.

2nd.—In dry labor, when the child is in bad condition, their use has with few exceptions given the most satisfactory results, and I believe that this is especially true in the case of breech presentations, although here, I cannot speak from personal experience; in addition to hastening dilitation, they assist by plugging the os and often prevent the escape of more liquor amnii. The rule in the Sloane Maternity in dealing with cases of premature rupture of the membranes, is to introduce a bag if no pains result within 24 hours' time, or earlier, if the child shows signs of distress. In protracted labors due to posterior positions, small pelvis, large child, abnormal presentations, twins, or inertia, these bags strengthen the pains, shorten the first stage, and leave the P. less exhausted for the final effort. In some cases, their action is too slow, as in a certain percentage of Eclampsia, although Morris states "that in Eclampsia and Placenta Prœvia, the baloon has a field of usefulness which markedly lessens foetal and maternal mortality." Various authorities agree in stating that the bag is the most useful of all methods of inducing labor, and succeeds time and again, after the bougies have failed; it is safer than accouchement force, Edgar's bi-manual method, or the use of that dangerous weapon, Bozzi's dilator; a combination of bag and bougie is a favorite method; vide Am. Jour. Obst. Jan., 05.

At first thought, one might conclude that the bag would be too slow in Eclampsia, and that accouchement force would be the method of choice; Sloane Maternity statistics, however, show that since the following procedure has been adopted, both infantile and maternal mortality has been diminished. The method employed is as follows—immediate insertion of bag with regular traction on tube to start pains, stimulation of all the excretory organs and reduction of arterial tension. "temporizing only as long as patient's condition warrants it or until cervix is soft enough to stand rapid dilitation without tearing it, or with little shock to the patient." Am. Jour. Obst. Jan., 05.

Objection to Use of These Bags Are:

1st.—That they may cause prolapse of the cord — this seems to be largely theoretical, as is the case with objection number 2.

2nd.—That they cause increased tension.

3rd.—That they may cause sepsis; if this occurs, the attendant is to blame, for the bags can be boiled and are less dangerous than gauze.

4th.—That they may rupture membranes—this so seldom occurs that it may be disregarded.

5th.—That they may displace presenting part—if one carefully watches presenting part and distends bag slowly, this can be avoided.

For subject matter for these notes I have supplimented my own small experience by refereuce to the following- Wright's Obstetrics; The American Text Book of Obst.: Zeigler, Jour, Obst. Am., March, '06; Morris, Am. Medicine, May 20th, '05; Voorhoes, Med. Record, May, 1900; Voorhoes, Jour. Obst, Jan., '05; Coles, Ther Gazette, May 15th, '04; Hirst, Am. Medicine, May 6th, '05.

WESTERN CANADA MEDICAL JOURNAL

GEORGE OSBORNE HUGHES, M.D. *Editor*

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EDITORIAL

Medical Inspection of Schools

The question of medical inspection of schools is very much in the air. Physicians, teachers and the public are discussing it. Another point to notice is that many writers are fearing that the twentieth century will be known as an age of mediocrity. Intellectually, this seems possible. If with all our progress in many directions that of intellectual advancement is lacking, what can be the reason? Some say the over-zeal for making money instead of intellect. Our greatest thinkers mostly are thinking commercially. This is especially so on this continent. The future, commercially as well as otherwise, is bound to suffer if this continues. We are looking into the future regarding war, trade, etc., but are we looking sufficiently regarding intellectual development? Present monetary sacrifices are necessary for this, but "each for himself and Allah for all" repre-

sents the spirit of many. Dr. Tory, speaking on the University question to the Canadian Club, said that "in the ultimate analysis of things the crucial question would be not as to the amount of money made or controlled, but rather the height of intelligence to which those concerned had attained since the latter was infinitely more value to the good of mankind." A Canadian newspaper had a headline after Kipling's visit saying "Says Canada to be foremost nation." In 1900, the Rector of Glasgow University, in his address, said "the nation which will be foremost will be that which contains the greatest percentage of intelligent beings." Note the *greatest percentage* not *the most intelligent* being. We may be told that in Canada West we have not yet the great nor the unhealthy population of New York, London, etc. That is true, but a few years can do much, and Napoleon, it is said, won his victories by being *prepared* for defeat (not expecting it) and that the time when he was defeated was when he felt sure of victory. In every material sense Canada should have a great future, but unless there are healthy, well-trained intellects to look after its resources, the keener intellect will come in and reap the benefit. History has proved this repeatedly. To what are the Japanese said to owe their success? Their good and suitable training.

How are we to get the best use of our intellects? By seeing that they are housed in a healthy body. Of course, we have had men and women feeble in health, who yet have been of great use to their country, but what might they have been with health? Pythagoras taught that a man should be ashamed of being ill except through climatic influences or accidental causes. But we—a young and healthy nation—should be more ashamed, because the Almighty Dollar comes before public health; our infants die and our children suffer through a faulty educational system. How can this reform best be accomplished? By the co-operation of parents, teachers and physicians. "Prevention is better than cure," we often hear. Let us act so as to prevent the need of curing in the future, and get legislation for the children's health as we already have it for our food, houses, clothing, etc. In the same Rectorial address quoted, it is said, "The twentieth century will be a period of

keen, intelligent competition." This cannot be doubted with our ærograms, airships, telephony in the navy, etc., etc. To keep pace with all these must come of necessity new systems. We must not hug ourselves too much over our material resources lest they are snatched from us. The States are all alive. The East is wakening. China has its "Reformers." India is moving. Japan is very much awake. And all Europe is discussing educational questions, feeling the supremacy of a nation depends greatly on its having a right system. No nation desires to own degenerates. Yet faulty systems breed them more than anything else. How can we persuade the parents to our way of thinking? Simply by demonstrating to them the benefits to the family and the nation. Already competent judges have stated that the gain resultant on the advance of the medical profession in recent years, in lives saved and sufferings lightened, more than repays for any endowments given to institutions. Prove that the individual, civilized society and the nation will gain thereby. There never has been a time when all classes were so anxious for their children's welfare as now. The only delinquents being drunkards—and the number of these should lessen as our system improves.

In Sweden, compulsory medical inspection of all schools has been since 1868. The medical officer is an active member of the staff with full powers. He examines (1) physical condition of pupils; (2) adopts preventive measures; (3) superintends all sanitary conditions; (4) sees that children not overburdened with lessons; (5) attends poor children free. In Denmark, medical inspection is compulsory for elementary schools. Should be compulsory for all children as the pampered child of a millionaire needs such compulsory care as much and often more than poor, for that class contains many degenerates, physical, moral and mental. In Paris, as can be seen from an interesting article on "The Human Plant" in the Review of Reviews, August, 1907. The scientists are devoting their attention to Child Life with the object of discovering in what way it can best be ameliorated physically, mentally and morally. Professor Binet says that education is a question of adaptability, and that in order to adapt it to the needs of the child

we must make ourselves thoroughly acquainted with his or her mental and physical characteristics. Many feel now that the training of the body, of the imagination, of the religious and patriotic sentiments are more vital to a nation's welfare than the mere intellectual power of acquisition. Germany has medical inspection. There is a medical department now in the Board of Education for England and Wales. Scotland has it and also what Sir Victor Horsley considers necessary everywhere — Hygiene, compulsory in the Training College curriculum. A committee of teachers, physicians and laymen has been formed in the Transvaal whose objects are the creation of a Central School Medical Department either under direction of Education Department or Public Health, and the appointment of a staff of inspectors whose duties shall be (1) to examine pupils on admission and re-examine at stated intervals; (2) make bi-weekly visits to schools; (3) report on sanitary matters; (4) instruct teachers in principles of physiology, hygiene and temperance.

In Canada, Montreal has had medical inspection and it is understood it has been stopped because of the expense. The public cannot have been sufficiently educated to the benefits or the system—which needs great thought—has been faulty. Toronto is discussing the question. Vancouver has decided for it. Surely the rest of the West should also consider the question. Some may say, settle educational system first, then we'll take medical inspection—but that is what we ask, *Education is not merely the intellectual training,* though often restricted to that, but also the physical and moral, and these three should go together to form a right system. So far, it is clear that our systems have failed, or we should not have prisons full and degenerates. Sweden has had medical inspection since '68. What do we hear of this country? Much to its credit and its people are welcomed as good settlers everywhere. May not this be a result of their system? Glance at the possible good of medical inspection. We hear much of the "lazy child." Binet says that every child showing *prolonged* laziness needs medical inspection and not 100 lines! Many so-called "dull" children seem so because of defective sight or

hearing. These are often misunderstood and much unnecessary suffering caused them. Headaches come often from eye strain. All these defects cause inattentive, nervous, lazy children. On examination among school children 25 to 50 per cent. cases of defective visions have been found. Testing by Snellen test cards by the teachers is not sufficient. In Glasgow out of 52,493 children tested for visual acuteness, 18,565 were found below normal. Again, many deformities, if taken in time, could be prevented. Faulty postures sometimes cause these in the young. Their supple bones become unperceptibly but surely moulded into abnormal forms. Retarded growth is often simply need of proper nourishment and attention. Lack of nourishment comes from improper food and constitutional disturbances which impair nutrition as well as want of food. Defective hearing may be due to middle ear trouble, adenoids, polypus, etc. Dr. Newmayn, of Philadelphia, considers that many of so-called cases of meningitis are due to an extension upward of an inflammation—from acute or chronic otitis media. Owing to complicated ossification of the temporal bone there is often a way open to the meninges.

The chief factors in causing mental deficiency are chronic exhaustion, starvation, toxæmia, nervousness, defective hearing, sight or speech. From this class are drawn the inmates of our asylums and prisons and suicides, if wrongly educated. Of the feeble-minded in asylums it is said that 25 per cent. can be made normal men and women by correcting physical deficiencies and proper training, and 40 per cent. half normal. Early correction is what is needed. Many conditions taken at early age can be remedied—such as tubercular disease of the bones.

Regarding the benefits of early detection of infectious diseases the health authorities of Manchester have investigated the influence of school life on spread of disease for last nine years. Comparisons on a number of cases occurring during holidays showed a decrease till end of holidays and then four days after re-opening a sudden increase. All gymnastics and sport in schools should be medically supervised. Many a child has suffered in after life through joining these when unfitted. A child suffering from tuberculosis can infect many.

Good health will certainly enable a boy or girl to meet temptations of the world better than anything because of a balanced mind. This does not mean moral lessons should be omitted.

How are we to know a "dull" child. By the *time* not the *age* in a certain grade. The result of a child being physically unfit for mental work is a sullen, despondent, melancholy child. These enter often our asylums or prisons or join our "loafers." Such need special classes and individual care. From these "special classes" have gone forth in London many useful men and women. Mr. Mosby, in the New Orleans "Picayune," says, "Our country is rapidly accumulating a large population of tramps, loafers and criminal idlers—few of these are destitute of schooling." What a proof of something lacking in the educational system! More than ever we realize that our criminals are made by circumstances, faulty education and physical degeneration. An authority on prisons has written that prisoners can be divided into two classes: (1) those who should never be in prison; (2) and those who, once in, should never be let out. This says much to the thinkers..

This being so, is it not our duty to try and devise some wise system which shall as much as human power can give each child a chance to take his or her right place in the world. The West may answer we are yet a small population. Begin! It is easier to build on good solid foundation than to begin with a scamped one and have to start all over again. At present we are healthy comparatively speaking and intend to have strict immigration laws. It does not follow we shall escape preventible suffering and disease. "Let not him that girdeth on his harness boast himself as he that putteth it off." So let us start as we mean to continue.

ANNUAL MEETING OF COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

ELECTION OF OFFICERS.

On motion the following officers were elected for the ensuing year: *President,* Dr. W. Rogers; *Vice-President,* Dr. M. C. O'Brien; *Registrar,* Dr. J. S. Gray; *Treasurer,* Dr. Jas. Patterson.

On motion of Drs. Patterson and McCharles, Drs. Clark, Milroy and McFadden were appointed a committee to strike standing committees for the year. This committee retired to adjoining room and afterwards reported the following committees—the first named of each being chairman:

REGISTRATION—Drs. Gray, Hutchison and McFadden.

EDUCATION—Drs. Thornton, Gray, Milroy and Cunningham.

FINANCE—Drs. Hutchison, Moody and McCharles.

PRINTING—Drs. Gray, Clark and Ross.

DISCIPLINE—Drs. Moody, McFadden, Milroy, Hutchison and Harrington.

LEGISLATION—Drs. Milroy, Hutchison, Moody, Ross, Thornton and O'Brien.

EXECUTIVE—Drs. Moody, Patterson, Hutchison, Crookshank, O'Brien and Gray.

LIBRARY—Drs. Patterson, Milroy, Clark, Harrington and McCharles.

Some discussion took place as to the number of representatives to be sent to the University, as called for by the Medical Act, after which, on motion of Drs. Clark and Hutchison, the election of four members was proceeded with—the question of discrepancy, if any were found, between the Medical and University Acts, to be dealt with later by the legislation committee.

Drs. Clark, Moody, Milroy, Cunningham, Hutchison and Thornton were nominated and Drs. Clark, Thornton, Cunningham and Moody elected.

Drs. Clark and Moody were nominated for the Board of Studies, and Dr. Clark was elected.

The Minutes of the last meeting of the outgoing Council were read, confirmed and signed.

In giving notice of the following *resolution* to be moved at the next meeting, Dr. Thornton stated that he offered it as a basis for the consideration of new conditions now being produced by the suggested reorganization of Manitoba University, by the creation of new universities in the Western Provinces, and by the movement for *unifying the profession in the west,* that while he was in accord with the general tenor of the resolution he was not necessarily committed to it just as it stood but was prepared to amend or modify its terms, if the discussion showed that to be desirable.

Moved by Dr. Thornton, and seconded by Dr. O'Brien. *Whereas*: A commission has been appointed by the Government of the Province of Manitoba, to inquire into and report upon the present system of government and management of the University of Manitoba, with special reference to the relations between the said University and its several affiliated colleges; and such inquiry is of immediate concern to the College of Physicians and Surgeons of Manitoba, as one of the affiliated Colleges;

Whereas: under the existing arrangements, the College of Physicians and Surgeons has surrendered to the University its right of examination for license to practice medicine in Manitoba; and no other profession has thus surrendered its rights, each profession having its licensing board and licensing examination apart from the University; and in no other province in Canada has the College of Physicians and Surgeons of the province thus surrendered its rights, but has the right of medical license and examination for the same vested in itself apart from the University;

Whereas, from time to time attempts have been made to secure reciprocity in medical license between Manitoba and the other provinces, and these negotiations have so far failed, such failure being, in great part, due to the disparity which has thus been created, because the College of Physicians and

Surgeons of Manitoba has not the same rights regarding examination and license as have the Colleges of Physicians and Surgeons of the other provinces and has therefore been unable to enter such negotiations on the same footing;

Whereas, at the present time steps are being taken for the establishment of reciprocal registration between Saskatchewan, Alberta and British Columbia, from which it is proposed to exclude Manitoba specifically because of this disparity. *Resolved*:

(1) That the right of examination for license should be restored to the College of Physicians and Surgeons of Manitoba, thus placing it on the same footing as the Colleges of Physicians and Surgeons of the other provinces, with a view to being thereby enabled to establish reciprocal relations with the other provinces and especially with Saskatchewan, Alberta and British Columbia;

(2) That the University of Manitoba should be a purely educational institution whose degrees should not confer the right to practice in any of the professions, and that the medical profession should be placed in the same relation to the University as the other professions.

(3) That steps should be taken by this Council to urge these considerations before the University Commission;

(4) That in the event of legislation following on the Commission's report, an endeavor should be made to have the University Act, and the Medical Act be amended so as to give effect to these propositions.

Dr. McFadden referred to the small indemnity outside members of Council receive and on motion it was decided that such members should receive $5.00 per day for each day necessarily absent from home in attending meetings of Council.

On motion of Drs. Hutchison and Patterson, the minutes of Council were ordered to be printed and a copy sent to each member of the College.

On motion of Drs. Patterson and McFadden, the Auditors —Drs. Clark and Blanchard—were voted an honorarium of $25.00 each for past services.

COMMUNICATIONS.

The Registrar of the University wrote, reporting the names of those who had passed the spring examination in Medicine, both for M.D. and for license—30 for the former and 16 for the latter.

A letter was read from Dr. Pyne, Registrar of the Ontario C.P.S., giving the experience of that Council in prosecuting osteopaths.

A letter was read from Mr. Patterson, Deputy Attorney General, calling the attention of the Council to the verdict in the Scott suicide case in July last, which implicated one Axtel as having treated the case.

A letter was read from the Hon. R. P. Roblin, in regard to what is claimed had been promised as to exemption from prosecution of certain osteopaths, when the last amendments to the Medical Act were procured. Also a letter in reply from the Council stating that the Council was not aware that any such promises as stated had been made.

The Registrar reported that on this matter the Executive had met and had appointed a committee to interview the Premier and that that Committee had not finally reported.

The Registrar reported the prosecution and conviction of Axtel, and that a fine of $25.00 had been imposed by the magistrate.

TREASURER'S REPORT.

Dr. Patterson read his report as Treasurer for the year and presented the financial statement, and Dr. Clark presented the report of the Auditors. After some explanatory remarks by Drs. Patterson and Clark, on motion both reports were adopted.

Dr. Milroy complimented the Treasurer on the satisfactory presentation of the financial statement and considered that the Treasurer's salary was insufficient, and moved, seconded by Dr. McFadden, that it be increased to $200.00 per annum.—Carried.

On motion the Committee on legislation were to take up the question of having the by-laws amended and printed.

ADJOURNMENT.

The Council adjourned to meet at the call of the chair.

SUMMARY OF TREASURER'S STATEMENT, 1906-7.

Total Cash in hand at time of annual meeting of 1905-6 and Cash received by him since.		$8817 35
Deducting Cash on hand at end of 1905-6 ($3723.27) from above total leaves the actual cash received during year		5094 08
This latter amount was received as follows:—		
From license fees	$3525 00	
From annual dues	1192 00	
Nurses' fees	342 00	
Interest from bank	35 08	
		$5094 08

EXPENDITURES FOR 1906-07.

Transferred to Standard Trust	$2000 00
Legal Expenses	235 15
Books, etc., for Library	481 41
Fees to outside representatives	270 35
Salaries—Librarian and substitute	625 00
Registrar	500 00
Treasurer, 1905-6 and 1906-7	200 00
Rent	345 00
Light	30 00
Telephones	82 00
Insurance library	63 00
Sundry small items	96 70
Cash in Savings Bank today	3020 98
Cash in Open account today	867 76
	$8817 35

STANDARD TRUST ACCOUNT.

Total investment of principal	$13000 00
Interest accrued to 1st July, 1907	1702 35
	$14702 35

ASSETS OF COLLEGE.

Cash in Standard Trust Company	$14702 35
Cash in Savings Bank	3020 98
Cash in Open account in bank	867 76
Total Cash	$18591 09
Contents of Library, estimated value	5000 00
	$23591 09

Liabilities none.

GENERAL MEDICAL NEWS

MEDICAL SOCIETIES

The Saskatchewan Medical Society met at Indian Head November 7th. The principal question taken up was that of a revision of the Tariff.

Dr. Thomson of Regina is President, and Dr. Charlton the Secretary.

The members of the Association were entertained by the Indian Head Board of Trade to a banquet, automobile ride and a visit to the Experimental Farm.

The Provincial Medical Association of Alberta met on Oct. 15, at Edmonton. The following officers for the ensuing year were elected: *President,* Dr. H. C. Wilson, Edmonton; *1st Vice-President,* Dr. Malcolmsor, Frank; *2nd Vice-President,* Dr. H. R. Smith, Edmonton; *3rd Vice-President,* Dr. McEachern, Calgary; *4th Vice-President,* Dr. Hewetson, Pincher Creek; *Secretary-Treasurer,* Dr. Dunn, Edmonton. It was decided to hold the next annual meeting at Banff. The need of proper sanitary legislation was discussed. A number of papers were read which will be published later.

The Winnipeg Medical Association held a meeting November 1st, at which a paper was read by Dr. Webster, on Atropine and its allies—Daturin, Hyoscin, Duboiscin and Scopaline.

VITAL STATISTICS

October—	*Births.*	*Deaths.*	*Marriages.*
Edmonton	36	9	31
Strathcona	45	14	10
Vancouver	95	82	132
Winnipeg	128	284	202

The thirty-fourth Annual Report of Vital Statistics for British Columbia—for year ending 31st December, 1906, has just been issued. Returns show: Births, 2,470; deaths, 1,778;

marriages, 1,587; as against 2,427 births, 1,603 deaths, 1,252 marriages for 1905. This report does not include Indians as the Act does not apply to them.

The following abstract shows causes of death by classes:

Zymotic diseases	159
Constitutional	226
Local	853
Developmental	274
Violent deaths	305
Self defense	12
Natural causes	22
Murder	4
Suicide	24
Legal execution	1
Deaths by accident and negligence	276
Cerebral Tumor	1
Old age	55
Tuberculosis	178

Causes of deaths in Vancouver—October, deaths, 82 (6 Japs, 2 Chinese, 2 Hindus).

Heart Failure	10	Diphtheria	1
Tuberculosis	6	Cerebral Spinal Meningitis	2
Typhoid	5	Infantile Weakness	3
Convulsions	2	Drowning	3
Appendicitis	1	Cancer	2
Endocarditis	2	Cerebral Embolism	1
Entero Colitis	4	Dysentery	1
Gastro Enteritis	1	Septicæmia	1
Paralysis	1	Stillborn	3
Diabetes	1	Suicide	1
Bright's Disease	1	Murder	1
Accident	3	Tubercular Meningitis	1
Pneumonia	4	Diarrhoea	1
Epilepsy	1	Cirrhosis of the Liver	1
Old Age	3		
Bronchitis	1		

Regina—October—

Contagious diseases	49
Typhoid	45
Diphtheria	3
Measles	1

	Winnipeg Cases.	October Deaths
Typhoid	40	5
Scarlet fever	13	..
Diphtheria	46	1
Measles	3	..
Tuberculosis	2	..
Mumps	4	..
Erysipelas	1	..
Whooping cough	1	..
Chickenpox	1	..

CIVIC HEALTH MATTERS

There has been an outbreak of diphtheria among the Galicians at Ridgeville.

There has been a great decrease in typhoid cases in Brandon—and death rate is greatly below the average.

Dr. Ternan, Medical Health Officer for Edmonton, considers there is great need for legislation to prevent overcrowding of dwellings in the city. Council propose to frame a by-law to this effect.

Dr. Montizambert, Dominion Health Officer, on his return from Seattle, where he had been investigating the bubonic plague conditions, stated he considered extreme preventive measures necessary in all the ports on the coast. At Seattle, seventy extra inspectors have been appointed. The Public Health Department of Washington, D.C., has sent out seven experts. All vessels arriving at Vancouver and Victoria are closely watched. Vancouver council has paid bounty on over 1,000 rats.

The Provincial Government of British Columbia is having a pamphlet published for distribution giving the history of the plague and the treatment to be adopted. Regulations relating to precautions are translated into Chinese and Japanese and distributed through foreign quarters of the city. To defray cost of the precautions the Medical Health Officer was authorized to spend $1,000. The council are considering the advisability of erecting a crematorium in connection with the cemetery as in case plague got into the city, it is imperative bodies of those dying from it, be cremated.

MEDICAL NEWS

The American International Health Association is to hold its annual convention in Winnipeg next year.

At the International Congress of Hygiene, held in Berlin, in September, one section of the exhibition consisted of a display and exposure of Quack Medicines, old and new. Lectures were also given on the pretences of Magnetopathists, Occultists and other irregular practitioners.

The Health Commissioner of Pennsylvania—Dr. Samuel Dixon—has published an order forbidding pullman car porters to brush clothes of passengers in the aisles as the dust thrown from one person only lands on another. The unhygienic effects are obvious to all, and the proceeding is thoroughly unsanitary.

In November there is to be held in London, England, a preliminary conference of Sanitary authorities with the view of uniting in a kind of central union. The necessity of conformity of action is felt. Much time and energy is often wasted trying to carry out broad measures, formulating model codes and overcoming opposition of vested interests. Medical Health Officers often are not supported by their city councils, because the measure proposed effects someone's pocket. The proposal is for one central body which shall represent all sanitary authorities in the Kingdom.

The Toronto doctors west of Yonge street, have formed a union under the name of No. 11 Territorial Division of the

College of Surgeons and Physicians. The object of their organization is to improve the conditions of the profession. The fee for minor operations has been fixed at $10 and major operations $50. First visit $2, subsequent ones $1.

The Medical Officer at Southend, who refused to continue his work at a smaller salary, has been re-instated at his former salary. No other medical man would apply for the post.

It is said that no Japanese doctor ever asks a poor patient for a fee. Every physician is his own dispenser and there are few apothecaries' shops in Japan. A rich man does not even receive a bill from his doctor. The strict honesty of the people makes this unnecessary as all who can pay at the end of the visit present the doctor with what they can afford.

The Vancouver Hospital Board have decided to appoint a collector at $50 a month to collect bills of transient patients who give as their addresses hotels, etc. Frequently patients have given such addresses and when the bill has been sent to them after leaving the hospital they find "not known." The City Council of Edmonton decided against settling a bill for fees for medical attendance upon a man who had his hand frozen last winter. The man was to be cared for by the city, but the city solicitor stated that in his opinion the city was not liable unless the M.O.H. had authority by by-law or resolution to contract the liability.

Thirty-three candidates took the recent licensing exam. for British Columbia—among them three ladies.

The Board of examiners are: Drs. Fagan, Jones, Proctor, McKechnie, McGuigan, Walker. Dr. Fagan is the presiding examiner.

The annual report of the Indian Department just issued for nine months ending March 31st, states that they are enjoying unusual prosperity. Births, 2,274; deaths, 2,105. There was a gain in all provinces except British Columbia and Alberta. Loss in British Columbia, 62; in Alberta, 5. Total Indian population 110,345. Earnings for the nine months, $2,300,000.

Dr. Loir, a nephew of Pasteur, who was lately appointed Professor of Medicine in Laval, has withdrawn owing to Archbishop Bruchesi refusing to sanction his engagement because of his being sued for divorce.

The residents of Ashcroft, B.C., are trying to get the government to give some assistance to induce a doctor to settle there. The Provincial Government thinks the Dominion should also assist because of the large number of Indians.

Very close enquiry is being made into cases of sickness and deaths among Orientals at the Coast as a precaution against plague. Dr. Fagan also recommended all Orientals report for medical examination every six months and in emergency times monthly. No pigs or poultry are to be kept within 50 feet of Oriental dwellings.

Dr. Thompson, M.P., for Yukon, intends asking Ottawa to appoint a pure food commission for Yukon.

The pharmacentical Association of the Province of Quebec has instituted proceedings against the Modern Pharmacy Company, Hull, Que., for $10,500 for selling drugs without a license, for employing unlicensed clerks and for selling drugs without keeping a record.

The yellow fever record in Cuba for 1907, is the worst for several years. According to the *Medical Record,* Oct. 5th. the disease is now present in at least five places. There is a very good paper on "The Surgery of the Labyrinth," by Dr. Richards, of New York, in the "Laryngoscope" for November, 1907.

The official figures recently presented by the British Lunacy Commissioners seem to confirm the opinion of many that insanity is on the increase. There is a lower death rate among the female insane than the male; higher rate of insanity among widowed and unmarried women than single men. Below age of 35 male lunatics are more numerous than female—53 to 47. From 35 to 65, the situation is reversed. After 65 there are 61.3 per cent. females. One-fourth of all insanity occurs before 35 and one-eighth after. Insanity among aged, however,

is increasing. Fear of poverty and the struggle for existence are responsible for much lunacy.

The Council of Medical Education has a complete list of the Medical Teaching institutions in the world, including about 20 schools which give only part of course—the total number of schools in the world are 348. Of these the United States has 161. The States place little restraint on the incorporation of colleges and so colleges spring up without any fair laboratory equipment or facility for the important part of medical education—clinical teaching.

Dr. Brock, of Germiston, who contributed a paper on "Infant Mortality," in our August number draws our attention to the fact that his degree is M.B., and not M.D., as appeared in the Journal.

HOSPITAL NEWS

It is expected that the Tranquille Institution for Consumptives in British Columbia will be opened in about middle of November. Dr. Irving has been appointed Medical Superintendent and Miss Matheson (formerly matron of Kamloops Hospital), the matron. Dr. Irving has had experience at Gravenhurst Sanitarium, Gravenhurst, Ont. His appointment is for six months Already 27 patients have applied for admission.

Drs. Walker, Fagan, Underhill, Stephen and Proctor and the Medical Superintendent are to draw up rules and regulations for the admission of patients. The annual meeting of the Board of Directors, to be held next January, can revise the rules if necessary. A septic tank system of drainage has been installed. The first payment of $25,000 on the property purcased has been made and a mortgage for $32,000 will soon be executed.

W. W. Shaw, an experienced rancher, has been appointed superintendent of the farm in connection. The total cost of site and buildings is $57,000. The building now on the site will last for many years.

In view of the great amount of work the secretary—Dr. Fagan—has had to do in connection with the founding of the institution, it was considered advisable to appoint an assistant secretary. The thanks of the Board were tendered to the Victoria Society which had purchased many necessary articles for the Sanitarium.

Dr. Fagan reminded the Board that while the first stage of work had been completed, the second stage—that was a hospital for advanced patients, was urgently needed. The Provincial Government had agreed to give $10,000 for this. The question of a site for this was left to Dr. Fagan and a committee. Also the question of the purchase of a launch and telephone connection between Tranquille and Kamloops. The B. C. Electric Co. has increased its donation by $700. About $78,000 has been promised so far.

Dr. Fagan declared the Tranquille institution will be a credit to British Columbia and suggested His Majesty should be asked to extend the Royal Patronage. A very hearty vote of thanks was given Dr. Fagan for his arduous labors in this great work.

MEDICAL COLLEGE NOTES

The session for 1907-1908 started Sept. 30th. It is now 25 years since the foundation of the Manitoba Medical College. Of the original incorporators, Drs. Blanchard, Good, Patterson, Jones and Sutherland, are still in Winnipeg.

The latest news of recent graduates is as follows: Dr. Thom is surgeon on the Empress Liner to the Orient; Dr. "Vic" Williams is in London, Eng.; Dr. St. John is in the Old Country; Dr. W. Hart is at Saranac Lake Sanitarium; Drs. Currie, McMillan and Alex. McAulay are near Antler, N.D.; Drs. Andrew, Boardman, McGregor, MacArthur, McDonald, Armytage, are interns at the General Hospital; Dr. Guilmette is at St. Boniface Hospital; Dr. Philip McRitchie has been in charge of the G. T. P. work north of Ingolf. Nearly all the rest have gone farther west. About twenty freshmen have registered for the five years' course. So far there are eighty stu-

dents in all years. The Students' Association meets fortnightly to discuss medical subjects and matters of interest to the students.

PERSONALS

Dr. McDonald, of Brandon, has returned from his visit south and will resume his practice.

Dr. Stewart, of Brandon, has gone east for a month.

Dr. West and wife have returned to Vermillion after six months' stay on their homestead.

Dr. Claire, Assistant Resident Physician at the Provincial Asylum, in New Westminster, has resigned.

Dr. A. E. Archer attended the Medical convention at Edmonton ,and also paid a short visit to Fort Saskatchewan.

Dr. Baker, of Keewatin, has now returned from the east.

Dr. Carter of Victoria, who has been for nine months visiting Britain and the continent and some cities in the States, has now returned.

Dr. and Mrs. MacKay, of Wetaskiwin, have returned from their trip to Banff.

Dr. Simpson, of Winnipeg, has returned from England, where he has been for some months.

Dr. J. A. Gunn has been appointed Medical Superintendent of the Winnipeg General Hospital in succession to Dr. Campbell.

Dr. and Mrs. Harvey of Fort Qu'Appelle have been visiting Winnipeg. Dr. Harvey later goes south for a post graduate course.

Dr. and Mrs. Hasell, Vancouver, have been visiting friends at Cowichan Bay and Duncans.

Dr. O. M. Jones of Victoria has returned from his four months trip to Europe.

Dr. Brett of Banff has returned from his holiday trip east.

Dr. Lockburn Scott has sold his practice at Winkler, Man., to Dr. Weatherhead, and has come to practice in Winnipeg.

Dr. Casselman, of Napinka, visited Winnipeg on his way to British Columbia, where he intends locating.

Dr. Edmison, of Kenora, has returned from his shooting trip to Alberta..

Dr. and Mrs. Sutherland, who have been visiting Brandon have returned to Revelstoke, B.C.

Dr. and Mrs. Gibbs have returned to Victoria from their visit to Europe.

Dr. Thomas of Dawson City was visiting Winnipeg.

Dr. Pennefather, one of Manitoba's old timers, who has been practicing in Holland for several years, has returned to Winnipeg.

Dr. J. McDonald is appointed resident physician at Nobles Portland Canal from July 1st, 1907.

Dr. Octave Lacroix, R.N.W.M.P., will go north to Churchill as soon as the winter sets in. He is now at Norway House.

Dr. Darrell Hanington, surgeon in charge of Queen's Hospital, Rock Bay is visiting Vancouver.

Dr. C. H. Wells of Chilliwack has been visiting Vancouver.

Dr. Brown of North Battleford, has been visiting Edmonton.

Dr. Halliday of Daysland, Alta., has located at Hurley.

Dr. Greer of Vancouver will spend the winter in California.

Dr. Moir of Lenore has returned from his post graduate course in the east.

Dr. Christie, of Rocanville, has gone for a visit to Ontario. Dr. Munroe is acting as his locum.

Dr. Little, late of Alexander, Man., has been taking a post graduate course in Chicago and also visited Winnipeg.

Dr. H. G. and Mrs. MacKid have returned from their trip to Britain and the continent.

Dr. Stuart Wade has returned to Edmonton from his trip to British Columbia. He will in future reside at Mission Junction.

Dr. and Mrs. Boyle and family, of Vancouver, have left for several months' visit to England and the continent.

Dr. T. P. Stevenson, of Wetaskiwin, Dr. Tierney, of Prince Albert, and Dr. Donald, of Fort Saskatchewan, attended the Alberta Medical Association convention at Edmonton.

We regret to say Dr. O'Brien, of Dominion City, has been suffering from diphtheria, but are glad to know he is progressing favorably.

BORN

Turner.—At Victoria, Oct. 27, the wife of Dr. Henry Turner, of a daughter.

Sharpe.—At Winnipeg, the wife of Dr. C. F. Sharpe, of a son.
Poole.—At Neepawa, wife of Dr. Poole of a son.

MARRIED

At Ottawa, 7th September, Dr. Sutherland, of Revelstoke, B.C., to Miss O'Donohue.

Sept. 26th, Dr. W. W. Amos, of Lloydminster, Sask., to Miss Linda Maude Fowler.

16th October, Dr. Walter B. Toy, formerly of Toronto, and now resident of Bangkok, to Miss Annie Edelfsen. Dr. Toy was for 14 years medical missionary and is now in private practice and lecturer at the Royal Med. School.

BOOKS FOR REVEW

HUMAN ANATOMY, INCLUDING STRUCTURES AND DEVELOPMENT AND PRACTICAL CONSIDERATIONS. EDITED BY G. A. PIERSOL, SC.D., M.D., PROFESSOR OF ANATOMY IN THE UNIVERSITY OF PENNSYLVANIA, WITH SEVENTEEN HUNDRED AND THIRTY ILLUSTRATIONS, OF WHICH FIFTEEN HUNDRED AND TWENTY-TWO ARE ORIGINAL. (J. B. Lippencott Co.

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2nd.—Adequate emphasis and explanation of the many and varied relations of anatomical details to the conditions claiming the attention of the physician.

3rd.—The elucidation of such text by illustrations that should portray actual dissections and preparations with fidelity and realism.

With the co-operation of several of the best American teachers of anatomy, the editor has given us an excellent work on this subject. The consideration of the practical applications of anatomy has been dealt with by Dr. J. William White, Professor of Surgery in the University of Pennsylvania, who has treated the subject in his usual clear and accurate manner.

The description of the various parts is clear and the illustrations are in the main excellent.

The nomenclature is that used for the most part by English-speaking anatomists.

The chapter devoted to the Lymphatic System is deserving of special mention.

The book is written with fullness of knowledge and experience, and we can recommend it both as a text book and work of reference.

D. S. MACKAY, F.R.C.S., Edin.

Answers to Correspondents.

Practitioner—The last complete register of qualified practitioners of medicine in Manitoba was published in 1905. The Registrar of the College of Physicians and Surgeons attends to this.

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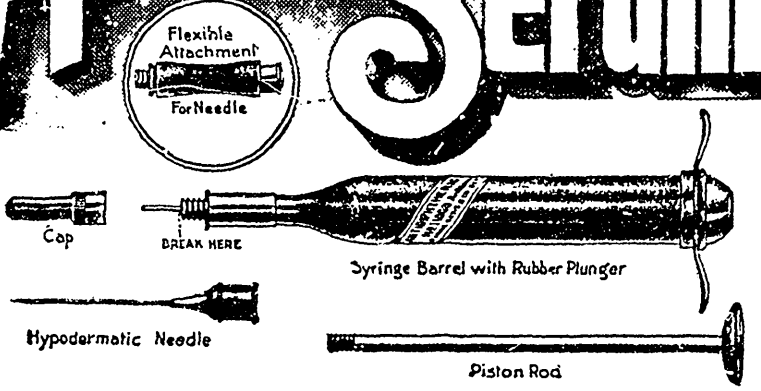

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