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**Original Articles.**

No paper published or to be published elsewhere as original, will be accepted in this department.

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**TUBERCULOSIS TESTIS.\***

By JOHN W. S. McCULLOUGH, M.D., C.M., Alliston.

MR. PRESIDENT AND GENTLEMEN :—I beg to present to your notice two or three surgical cases of interest, the specimens of which I here show you.

The first specimen is a testicle removed for tuberculous disease on Nov. 15th, 1895. This patient had, when he came to me, a hydrocele of the right tunica vaginalis. There were two fistulous canals leading to the epididymus, which free drainage, swabbing with pure carbolic acid, curetting under anæsthesia, and gauze packing failed to heal. The left testicle was somewhat hardened, and I strongly advised its removal as well, but the patient, a married man thirty years of age, as strongly objected, and I acceded to his wishes. Just a few days ago I received a letter from him (he lives in New York State) in which he tells me his condition. He had no further trouble until nearly two years had elapsed, and from what he says I judge the left testicle is in much the same condition as the right when I removed it. I expect him to come for operation in a few days. In this case it would have been much better to have done a double orchidectomy at once. Note.—Operation on left testicle done Feb., 12th, 1898.

**APPENDICITIS.**

The second specimen is an appendix from a young man 23 years of age. He was a baggage man for the Grand Trunk Railway. Last April he was obliged to quit work on account of pain, confined chiefly to right iliac fossa, which at times radiated to the left side of the umbilicus. He lost weight to

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\* Read at the last meeting of the Simcoe Medical Society.

the extent of fifteen or twenty pounds. When he was at rest the pain would disappear. It was provoked by manipulation of the region of the appendix, and I was able to repeatedly feel the organ roll under my fingers. Diagnosis chronic relapsing appendicitis. Operation, August 21st, 1897. Incision three and a half inches with centre over McBurney's point. The internal oblique and transversalis muscles were caught up by a guyline of silk, and thus kept from disappearing. Ligated mesentery in two parts with chromic catgut, stripped back the peritoneum from appendix, and ligated latter with fine, iron-dyed silk and cut off; dipped the ligated end into cæcum and sutured peritoneum. Lembert sutures over the wound. The abdominal incision was then approximated by sutures embracing, first, the peritoneum, another layer for the muscular portion, and a third for the skin. The wound was dressed with aristol, a strip of oil silk over sutures and bichlor. dressing. It was not opened for thirteen days when union was perfect. The patient has been perfectly well and free from pain ever since.

#### HYDRONEPHROSIS.

The third case was a nephrectomy for hydronephrosis. This, upon which I operated nine days ago, is a most interesting and instructive case.

The patient, a fine young girl 20 years of age, came to me complaining that three months ago she noticed a tumor in the left loin umbilical region, which continued to increase in size until I saw her about three weeks ago. The tumor was about as large as a good sized head and slightly resonant in front, dull behind and had an apparent feel of fluctuation. Urine was lessened in quantity, specific gravity 1011; no albumen, casts nor sugar. She had some dyspeptic symptoms, was constipated, and though she had very trifling pain, was noticeably going down hill. I diagnosed a hydronephrosis and prepared to aspirate merely to confirm my opinion. In pressing the tumor back into the loin, the patient, when I had scarcely passed the needle in an inch, and the wall of loin being frozen with ether, screamed with pain, and went into a condition of extreme shock which it required a large dose of morphine to relieve. The pain she suffered was, I am sure, very severe. She is very "good stuff," but on this occasion simply writhed in agony. When she had recovered from the pain and shock, I was surprised to find that the tumor had disappeared, and she thereupon passed a large quantity of urine. The tumor, however, returned in the course of four or five days, and last Tuesday week I operated with the intention, if I was able, to fasten the organ up so as to empty itself properly, and it was not too badly disorganized to do a nephrorraphy and failing this, a nephrectomy. After making a lumbar incision oblique from behind forwards, the kidney was aspirated of about a quart of urine. Then we found that its substance, with the exception of lower part, was pretty well gone, the proper capsule loose, and this, with the uncertainty of getting a good result from nephrorraphy, induced me to remove the organ. The incision was enlarged by a vertical one at the outer edge of quadratus lumborum muscle, the pedicle secured and ligated in two parts with chromic gut and a ligature was, for extra safety, thrown around the whole pedicle and the organ removed. We did not use any drain. The wound was sutured by two layers of catgut, the first uniting the muscles of skin, and the second the skin. Dressed with aristol and bichlor. gauze. We were unfortunately compelled to give ether as an anæsthetic, the patient taking  $\text{CHCl}_3$  very badly; on this account I was rather apprehensive of the result, but as a small amount was very carefully given by my friend Dr. Mackay, of Cookstown, and I was able with the assistance

of Dr. Kingston, of Everett, to hurry the operation over, I am thankful to say that, so far, there have been no ill effects. The quantity of urine has materially increased since operation; specific gravity is 1030, and otherwise normal. The only trouble we have had has been from a very nasty complication of intestinal flatus which resisted everything we tried until we used an enema of  $\frac{3}{4}$  ss Tr. Assaf. in a pint of warm water. The shock of operation was pretty severe for an hour or two, combatted this with hot bottles, hypos. of morph., strych. and whiskey. The highest temperature and pulse since day of operation have been 101.1-5 and 102 respectively. Note.—Feb. 12, patient convalescent.

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## ACUTE TRAUMATIC GANGRENE.\*

By W. E. STRUTHERS, M.D., Huntsville.

Acute traumatic gangrene is a disease so rarely seen nowadays that I hope a few words about the disease and a report of a case that entered the General Hospital, Huntsville, in December last, will prove interesting to you. The specific organisms producing the disease are supposed from experimental evidence based on the study of organisms producing similar processes in the lower animals to be anærobic bacilli, and closely allied to the bacillus of malignant œdema. It is specially noticed to develop in wounds that have been soiled with either earth or dung. The organisms spread into the tissues with remarkable rapidity, and the rapid sinking and death which so quickly follows is due to the powerful toxins which they produce, assisted possibly by the violent inflammation and extensive stasis set up. The course of the disease is very rapid, averaging about three days before the death of the patient. This form of gangrene is almost always of the moist variety, and the streptococcus, staphylococcus, bacillus of malignant œdema, and other organisms have been formed in the wound. The shock of the traumatism may continue, or the patient may feel better for a few hours. Then the patient becomes uneasy, restless, loquacious and frightened, the pulse irregular, the wound painful and tense. The part becomes hard, shining, œdematous tense and white, but within 24 hours becoming mottled, with spreading shades of dusky brown, green, blue and black, and color streaks extending up the limb. These tints may appear like the effects of ecchymoses, and afford the earliest and best sign of the progress towards death or the return to a more perfect life. Becoming darker and duller with a browner red is the sure precursor of death; brightening and assuming a more florid hue is as sure a sign they are more actively alive. Doubtless the varieties of color indicate the stagnation and the movement of the blood in the parts which thus situated may, according to the progress of the inflammation, be added to the dead or become the apparatus of repair. A remarkable and striking feature is the formation of large quantities of gases, mostly hydrogen, carburetted hydrogen, ammonia, sulphuretted hydrogen, sulphide of ammonia and volatile fatty acids. The gases may even be seen extending up the limb, crepitation becomes very marked and the part even resonant on percussion. Bullæ, full of serous or blood-colored fluids, form at the most injured parts. The parts become soft, cold and insensible, and a thin brownish, stinking fluid issues from the wound. The tissues soften as in inflammation but to a greater extreme, becoming

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\* Read before Simcoe Medical Association.

utterly rotten, and there is rapid absorption of septic matter with profound constitutional disturbances so that within thirty hours after full development of the disease the patient dies, first becoming somnolent with rapid pulse and respiration.

Treatment. Prophylactic first ; free incisions may relieve tension and permit escape of foul gases. But amputation far above the gangrenous part, and with every precaution that nothing from the gangrenous part touches the fresh amputation wound, should not be delayed. There are few cases in surgery more urgent, and in spreading gangrene the loss of even hours may prove fatal to the patient.

The case I spoke of in beginning came into the General Hospital on Tuesday Dec. 21, 1897, with a duckshot wound of the right leg. The inner aspect and front of leg was pretty well riddled from ankle to knee. The leg was flexed, dark, swollen, tense across the ankle, and somewhat painful. His drawers and pants were rank with stable filth, and fragments of these were found in three or four larger wounds on front of leg just above ankle when shot had entered in bulk. Temperature was 104°, and pulse 120. As many shot as could be located were removed ; some were found flattened against the bone.

The leg was antiseptically dressed, thoroughly irrigated, bandaged and patient put to bed with leg resting on pillows. Next day temp. was 101°, pulse 112, and fairly strong ; anterior aspect of leg was quite black, mottled on inner side, soft and not painful to touch, small quantities of gas escaping from wounds, crepitation felt, pink red streaks extending up leg and a perceptible odor noticed. Patient was urged to consent to amputation at once, but refused saying he felt first rate. He was given calomel and Quin. sulph. and stimulated freely, later liq. strych. Thursday the odor was very strong, gas abundant, pain throughout the leg, area of inflammation and gas extending above knee and red streaks up the thigh. Patient was restless, loquacious, sometimes delirious, pulse weak, thready, and irregular. After consultation, patient finally consented to amputation, and on Friday, assisted by Drs. Howland and Hart, I removed the leg at the upper third of the thigh, but with little hope of saving patient's life. For a few hours he rallied, but Friday night odor again became marked, pain and swelling in stump, and gas extending into body. He again became delirious, then comatose, rapidly sinking and dying at midnight Saturday. The free use of stimulants was of no avail.

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### A PECULIAR CASE IN PRACTICE.

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I was called on November 12th to see a young shop girl, aged 17 years, who had "fallen in a faint" at the store the day previous. When I saw her she had a temperature of 100.3, pulse 120, complained of general pain in abdomen nowhere localized. Head ached and bowels rather constipated. I made no diagnosis, and gave her some laxative and febrifuge mixture of liq. ammon. acct., etc. She remained in much the same condition except that the pain seemed to be extending to left shoulder. I saw her daily, and found the temperature rise to 104, and vary between that and 101. At the same time she complained severely of extreme pain when anything was introduced into the stomach, while she could scarcely bear the clothes on her, and as for the least manual pressure it could not be tolerated. This pain in the epigastric region was the most noticeable feature of the case, and, being

localized, accompanied with hyperpyrexia and great pain, lasting an hour or more, after swallowing any substance, water causing as much pain as anything else, without either vomiting or the feeling of nausea, made a chain of symptoms that I could not reconcile to any known complaint. On the eighth day of her sickness her bowels previously having been constipated, rather than the reverse, and normal in color, she was taken with diarrhoea, consisting of six stools of a tarry consistence and color, which I did not see as they were thrown out. The stools were, no doubt, mixed with changed blood. There was no apparent change in her condition until the 22nd, for having run the gamut of bismuth, ammonia, pepsin, lime water, iron, opiates, etc., etc. I determined on the 21st to try Woodbridge's tablets No. 1, which I gave every fifteen minutes, and on the 22nd she was in every way decidedly on the mend; temperature 100, pulse 96, pain much less, and looked and felt much better. The next day everything was normal, and she made a rapid and uninterrupted recovery. What was the matter with her I cannot say, but certainly Woodbridge's tablets get the credit, from my point of view, for having cured her. I might add that her periods came on on the 15th, three days after I first saw her, the first time in three months, previous to which time she had been quite regular in that respect.

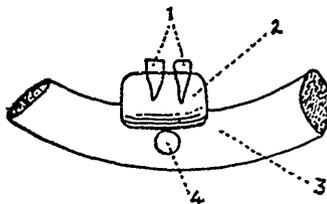
### CASE OF ANOMALOUS DENTITION.

By H. H. OLDRIGHT, M.D., Toronto.  
Assistant Surgeon, St. Michael's Hospital.

The following case of anomalous dentition occurred, or rather arrived February 17th, 1897, when Baby — first entered this cold world with his two lower central incisors cut.

When two days old he took his first bite and wounded his mother's right nipple, from which, in spite of careful antiseptic treatment and the use of a shield, an abscess resulted.

Strümpbell advises, in his excellent text-book on the practice of medicine, that where the teeth are loose they should be drawn. In this case, as the mother was not able to nurse and we were using the shield, I decided to let them remain. The accompanying diagram will best illustrate the anatomical relation of the parts.



FRONT VIEW.

1. Teeth set in. 2. A hinge-like movable process of the alveolar margin of (3) the jaw, on which there was exostosis at the symphysis. 4. A large round exostosis.

The child inherited syphilis, the father having contracted it twelve years before, and in the first week had a pemphigous eruption on trunk and head

At six weeks developed snuffles and a papular syphilide. The teeth in the meantime had become firmly set and the hinge had lost both its elevation and mobility. Shortly after this the crowns of the teeth softened, losing their salts, leaving the pulp cavity exposed and the roots as they are at present level with the gum. We will probably scoop out the pulp and fill with gutta percha or cement. No other teeth have since arrived. Will it impair the nutrition of the second teeth to do so?

DEAR DR. OLDRIGHT,—The editor of the *Edinburgh Medical Journal* sent on to me your record of an interesting case of congenital teeth. Allow me to thank you for this record which contains several new features. I find the after history of these teeth when they are not removed at once is rather obscure. In some cases they are certainly replaced by milk teeth and are then really supernumerary as well as precious, but in other cases they seem to be the only milk teeth which the infant has. The exostosis is interesting but its meaning is far from clear. Since I wrote my paper I have had several records sent me, and two of these I have embodied in an article on "Congenital Teeth" in the forthcoming supplementary volume of "Keating's Cyclopædia of Diseases of Children." In one of these the child presented by the face and the teeth were diagnosed before delivery—a truly unique circumstance, I suppose. I send you a reprint of my paper, also one of another curious case of abnormal dental development. I am specially interested in all congenital anomalies and shall always be glad to hear from you regarding such. The syphilis may have had to do with the early decay of the congenital teeth in your little patient, but I scarcely think it could be regarded as the cause.

Believe me, yours faithfully,

J. W. BALLANTYNE.

24 Melville Street, Edinburgh,  
Feb. 7th, 1898.

## Reports of Societies

### TORONTO MEDICAL SOCIETY.

The regular meeting was held on the 20th January, 1897.

Dr. T. F. MacMahon presided.

Dr. Oakley moved, seconded by Dr. Brown, "That the Executive Committee be empowered to hire a boy to answer the telephone on the nights of meeting." Carried.

The adoption of the minutes was postponed.

In the absence of the gentlemen who were to take part in the programme, the evening was devoted to reports of cases in practice.

Dr. F. Oakley reported a case of fatal pelvic peritonitis, resulting from Viavi treatment. The patient had consulted "these people" for some uterine complaint, apparently trivial, and, among other things, she was ordered to take a douche of carbolized water. The husband poured a quantity of carbolic acid into the fountain syringe, and then hung the syringe to a height of seven or eight feet. In a few hours the patient began to experience great pain. This was followed by fever and rapidity of pulse. The tissue around the uterus became swollen. There was a frequent desire to make water. The bowels would move only with great difficulty. Pelvic cellulites suspected. Two consultations were held, and diagnoses of pelvic hematocele and appendicitis were made by the visiting consultants. Dr. Macdonald was called in; he held that the case was one of pelvic peritonitis. The case terminated fatally.

Dr. Macdonald considered that something should be done to put a stop to the work of these irregular practitioners, who were flourishing in our midst. Their audacity was becoming unbearable; they were taking most extraordinary risks. Regarding the diagnosis, he thought

the sudden onset, following the douche, together with the symptoms, pointed to peritonitis; there being regularity of menstruation excluded hematocele. The feeling of the thickening was characteristic, as also the fixation of the uterus.

Dr. McIlraith described the insidious way in which the Viavi Company carried on their work. The question was whether they could be reached by the Council or not.

Dr. Oakley stated that the capsules used in this quick treatment had been found by Dr. Ellis to contain opium. He said that women who underwent treatment had been known to acquire the habit.

Dr. Carveth said the amount of opium was very small.

Dr. Macdonald did not think enough could be absorbed by the vagina to have much systemic effect.

Dr. Carveth reported a case of slow respiration. The patient was a girl, aged eleven. There were no other symptoms.

Dr. Noble reported a case in a nervous young woman aged twenty-six. She recovered.

Dr. McPhedran said these cases were hysterical, or they might be due to tumors pressing on the floor of the fourth ventricle.

Dr. MacMahon reported a case of extensive post-diphtheritic paralysis in a girl aged nine. There was difficulty of deglutition, nasal voice, very weak heart, paralysis of the diaphragm, ptosis of the right eyelid and strabismus. The urine contained albumen and some general oedema. She was improving.

Dr. MacMahon related a second case of asthma due to dilated stomach. Treatment by lavage made a cure.

Dr. MacMahon reported a case of eclampsia, in which he was called to assist by Dr. H. T. Machell. Patient was seven months pregnant. It was

decided to induce premature labor, which was accomplished in ten minutes.

Dr. Scadding and Dr. McPhedran briefly discussed the first case.

Dr. H. H. Oldright reported two cases of morphia poisoning.

Dr. Noble reported a case in which he had administered 1-32 of a grain of morphia to a child a few weeks old, and was complimented by the family for his assiduity and ability, because he labored five hours to check the "inward convulsions" from which they had decided the child was suffering.

Dr. Noble reported a second case. The patient, being tired of life, took four grains of strychnia which he got a druggist to sprinkle on a piece of raw meat intended for a dog, but of which he cheated the dog. This notacting with the rapidity desired, he drank two ounces of laudanum. The influence of these antidotal remedies on the would-be suicide was noted by the doctor. After a few attacks of opisthonos, the patient recovered.

The society then adjourned.

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## TORONTO MEDICAL SOCIETY.

The regular meeting was held on the 27th of January.

Dr. T. F. MacMahon presided.

Present: Drs. Dickson, Reeve, McPhedran, Starr, MacMahon, Fisher, Rudolf, Oakley, Smith, Wm. Oldright, Carveth, Britton and Brown.

Dr. Henwood was nominated as a member of the society. The minutes of the last meeting were read and adopted.

Dr. R. A. Reeve presented a young woman with exophthalmos of the left eye, the result of pseudo angioma in the orbit behind it. Thirteen years ago she had received an injury to the left temple as the result of a fall, but there were no signs nor symptoms till recently. Under chloroform the cyst was opened, and found to be a

diverticulum of an orbital vein. After the discharge of a quantity of venous blood, the hæmorrhage was checked by pressure. The wound healed kindly, and the exophthalmos was disappearing.

Dr. A. McPhedran read a paper on the "Treatment of Internal Hæmorrhage." In the commencement of his paper the essayist criticised recent works which cited a large number of remedies for this such as tannic acid, lead, iron, ergot, etc., without assigning any reasons for their efficacy. He holds that with few exceptions bleeding will stop in spite of the use of remedies. This was well illustrated in a druggist-patient of his, who, suffering from severe hæmorrhages, resorted to ergot, but being assured that he would do quite as well without it, gave up its use with the predicted result. By drawing attention to the pharmacological action of the ergot, Dr. McPhedran showed that it was clearly contra-indicated in cerebral, intestinal and pulmonary hemorrhage. In regard to astringent remedies, he contends that there is no good ground that they have any influence. If they were disappointing in external bleeding, such as epistaxis, the inference would be that they would be of no greater value internally. To act efficiently drugs should possess the following qualities: To lower the blood pressure so that the resistance to its escape might be equalized; to increase the coagulability of the blood; or to combine both these qualities. Of the first class, opium and the nitrites were the best examples, the first acting as a sedative to the heart and circulation; the second, by dilating the arterioles, lowered the blood pressure. To the second class belonged calcium chloride and the iodide of potash. He called attention to the value of salines and nitroglycerin in a case of arterio-sclerosis, where pulmonary hæmorrhage, he believed, saved, and gave warning of, a cerebral attack.

Dr. MacMahon agreed with the

essayist. He thought that opium by lessening the cough tended to the checking of pulmonary hæmorrhage.

Dr. Price Brown had found good results from using astringents in epistaxis. He had employed, in some cases, cocaine on a swab to the anterior portion of the septum, after having made the patient throw the head back. In two cases of hæmorrhage following tonsilotomy, he had used tincture of iron applied on a swab. The pressure had, no doubt, a good deal to do with the arrest of the flow. After using gallic acid in half-drachm doses repeated, he had found pulmonary hæmorrhage cease.

Dr. Oakley thought the value of opium was not sufficiently emphasized. One of its effects was to contract the capillaries.

Dr. Wilson agreed with the views expressed in the paper. He thought that complete rest should be always strictly enjoined. He would rather endure the epistaxis than the application of iron to his nasal mucous membrane.

Dr. Britton spoke of the value of complete rest and quiet. He had great confidence in opium. He had been taught to use, and had used, pure acetate of lead in drachm doses in post-partum hæmorrhages with good results.

Dr. Reeve concurred in the value of acetate of lead.

Dr. Oldright spoke of the value of pressure on the carotid in cerebral hæmorrhage, and of elevation of the hips in the intestinal form.

Dr. C. Dickson spoke of the value of acetate of lead in obstetric cases, too. He had found turpentine good in cases of renal hæmorrhage.

Dr. Carveth had used opium successfully for five years past. He said that it was important in cases of internal hæmorrhage to investigate the condition of the other organs of the body, as the bleeding often pointed to a lesion in some distant part of the system.

Dr. Starr spoke of the custom of

the late Dr. Aikens of ligaturing the extremities in these cases. He did not like iron in epistaxis.

Dr. McPhedran replied.

Dr. McPhedran then reported two cases of obstinate vomiting following laparotomy for gall stones which yielded, after many remedies had been tried, to lavage.

Dr. MacMahon said that the ingestion of warm water acted similarly. In case there was little or nothing in the stomach, the ingestion of small quantities of very hot water had acted well.

Dr. Oldright reported having seen in consultation a boy who, it was thought, was suffering from pyæmia or rheumatism. He discovered a small abscess at the right of an abrasion on the foot by a skate strap, which pointed to the correct diagnosis.

Dr. Britton reported briefly three cases of post-operative mania. He thought that there was still an element in the causation of these cases not yet discovered.

Drs. Oakley, Dickson and McPhedran discussed the question.

Dr. F. N. G. Starr moved that the president of the society and the treasurer be a committee to negotiate for a more commodious place of meeting. Carried.

The society then adjourned.

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#### SIMCOE MEDICAL SOCIETY.

The Simcoe Medical Society held its regular meeting in Barrie on the 3rd of February, 1898. Dr. Aylesworth, of Collingwood, presided.

Among those present were :

Drs. Aylesworth, Hunter, Langrill, Evans, Kingston, Struthers, Peart, McArthy, McKay, Brown, Pauling.

Dr. Struthers, of Huntsville, presented a paper on "Traumatic Gangrene." (See page 41.)

In addition to his paper Dr. Struthers said that certain points struck him as being noteworthy. First was the rapid darkening of the

wound, which occurred within sixteen hours after the accident. It was mottled to a considerable extent on the inner side. Formation of gases had taken place in the larger wounds just above ankle. Strong malodor was noted within thirty-six hours. Patient lived five and a half days altogether. The temperature on admission was 104, which was attributed to traumatic fever. A small dose of antefebtrin reduced this to 101, at which it remained. The pulse, at first, although rapid was fairly strong. But toward the end it became very rapid, thready, weak, and irregular. It was a question whether he would stand the operation. During the last few hours of life he became quite exhausted but rallied for four or five minutes. But prior to this exhaustion he was very restless and loquacious. The death agony was painful to witness.

Dr. R. Raikes was sorry he had not heard the whole of the paper. The case reminded him of a similar one he saw two years ago—a compound Colles' fracture in a man addicted to drink. In two days gangrene set in, the third day extending above the elbow. He advised amputation, which advice was followed. Amputation was done below the shoulder. The patient rallied beautifully from the operation, but succumbed in twelve hours. There was the characteristic smell referred to by the reader of the paper, due to chemical changes set up by the action of saprophytic and other organisms. The speaker said he was surprised to note the rapidity with which the swelling spread into the body. The patient was in perfectly good spirits. There was no terror. He (the patient) seemed surprised to think there was any danger of death.

Dr. McCullough recalled a case where the patient had a leg run over by a train. The crush was near the knee. Amputation was delayed on account of the shock. The smell was very bad. The patient never seemed to rally and died without operation, although placed on the operating-

table with a view to amputation of the leg.

Dr. McCarthy considered that the name "Traumatic Gangrene" was not a correct one for the condition. He did not think it should be looked upon as being due to the traumatism pure and simple. It was hardly possible to suppose that the gun-shot wound, although injuring the larger blood vessels, was responsible for so much disturbance as was described. He held that the septic condition resulting from the presence of the micro-organism carried into the wound caused the rapid changes which occurred in such cases as here related. The symptoms which follow these accidents are not those of shock or traumatism, but rather those of sepsis. And this last condition was what had to be fought against. This explained, too, generally, the unsuccessful results of a successful amputation. A similar septic condition might follow a scratch of the finger. Amputation did not alone fulfil the requirements. It was necessary to stimulate as hard as possible. Antiseptics should be freely used internally and externally. At present we had no good one.

Dr. Struthers agreed that the condition was a septic one. A portion of the filthy drawers had been carried into the wound. Cheyne had pointed out the wounds contaminated with earth or dung were dangerous, but he held in every case of gangrene amputation should be done first and then the sepsis should be combatted. Stimulants should be freely given.

Dr. Raikes said that in his case the patient was cleanly. The treatment from the beginning was according to aseptic principles.

Dr. Jas. Evans spoke of the varieties of gangrene. The case spoken of by Dr. Raikes may have been one of spreading gangrene, and that of Dr. Struthers spreading infective gangrene. The different varieties required different treatment. In traumatic gangrene he thought the only

cure we might ever hope to reach would be by the use of serums, in the same way as diphtheria had been shown to be amenable to the anti-toxin form of treatment. Incidentally Dr. Evans referred to success he had had in so treating diphtheria, and the good results which anti-streptococco serum had given in puerperal fever. He thought the practice of amputating after spreading traumatic gangrene had developed three or four days was useless; that it would be better to allow the patient to die without operation. The history of the disease showed that it was useless to operate.

Dr. Struthers, in reply, held that operation did hold out a chance for recovery. Cheyne was his authority for saying that five per cent. recover after amputation.

Dr. J. W. S. McCullough, of Alliston, read the next paper, being the report of a series of cases. (See 39.) He presented the specimens—a tuberculous testicle, two appendices, and a kidney.

Dr. Brown referred to the high mortality in nephrectomy, and congratulated the essayist on the good result. He had assisted at the attempted removal of a kidney for pyonephrosis; but the patient collapsed on the table from the anæsthetic. A *post mortem* revealed the absence of the other kidney.

This being the end of the programme, Dr. Hanly, the Council representative, was called on to make some remarks regarding the last Council meeting and the present status of the college and its interests. He first spoke of the action of members of the legislature stepping in to interfere with the action of the Council regarding the raising of the standard of the matriculation. "I may say," the doctor colloquially went on, "they took us by the throat, and Mr. Ross informed our Committee on Education that we would have to draw in our horns, saying that, with

regard to the matriculation, that there was an Act before the House, and if we didn't cease our efforts the House would step in and take the matter out of our hands. The committee on legislation decided that there was nothing for us to do but to submit. Therefore they promised that the change he asked for would be made in the way of lessening some of the conditions. There was some blame attached to the committee for agreeing to that, but I think the general feeling in the Council was that there was no help for it. The temper of the legislature at that time was such that it would have been dangerous to go before them, for if any Act had gone before them which would take away our privilege, it would have received the sanction of the majority of the members, and we would have lost some of our privileges.

The question of general registration throughout the Dominion was brought up, and a committee was appointed to confer with similar committees from the other provinces at the Canada Medical Association. As regards action, nothing was done. Our members were quite willing to see inter-provincial reciprocity brought about, but they were anxious that the other provinces should get a standard as high as ours. The others, however, were unwilling to do so; and so far as I can see now, there seems to be no prospect of its being effected.

The question of the sale of the building came up, but it seems there has been no offer, and the thing is hanging still. One change was made; we obtained our loan at a less rate of interest, thus saving \$900 a year.

The question of the compulsory collection of the annual fee was brought up. This was opposed; but it was found to be necessary in order to secure money from the bank. So there was nothing else to do.

The question of asking for legislation for the security of costs in malpractice suits was brought up.

But it was opposed on the ground of class legislation. The speaker thought that some act might be brought in by the legal profession only, while in the medical fraternity would not be mentioned at all, so that in actions brought for personal damages, the defendant might apply to the judge before whom the case would be tried, to see if in his judgment reasonable security of costs would be obtained.

The five years' course was likely to be dropped, and four sessions of eight months each substituted. Dr. Hanly then replied to numerous questions asked by the members.

The election of officers resulted as follows:—President, J. W. S. McCullough, Alliston; Vice-Presidents, Drs. Pauling and Ardagh, Barrie; Secretary Treasurer, Dr. James Evans, Stroud. The meeting then adjourned.

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### THE LONDON MEDICAL ASSOCIATION.

The regular monthly meeting of the London Medical Association was held in the Medical College on the evening of December 13, the following members being present: Dr. Wishart, the president, and Drs. Roome, J. B. Campbell, Macarthur, Eccles, Moorhouse, Hodge, Hotson, Ovens, Thompson, Ferguson, Meek, Balfour, Henderson, H. A. Stevenson, W. J. Stevenson, W. S. Macdonald, Kingsmill and English.

Dr. Wishart opened a discussion on the treatment of appendicitis, referring briefly to twenty-one operative cases which had come under his care during the past seventeen months.

In regard to the gynæcological work done during the past two and a half years at the London Asylum, the following resolution was unanimously carried:

"Resolved, that the London Medical Association, recognizing the humane and effective operative work

being done at the London Insane Asylum, for the physical relief of inmates of that institution, and appreciating especially the benefits, mental as well as physical, which have resulted from gynæcological operations among the insane,

"The association hereby solicits the attention of the Provincial Government to the claims of that work, and urges the duty of providing better facilities for its prosecution."

It being the annual meeting, the following officers were elected for the ensuing year: President, Dr. F. R. Eccles; Vice-President, Dr. R. Ferguson; Recording Secretary, Dr. W. M. English; Corresponding Secretary, Dr. W. S. Macdonald; Treasurer, Dr. J. Macarthur.

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### THE HURON MEDICAL ASSOCIATION.

The regular meeting of the Huron Medical Association was held at the House of Refuge, Clinton, on Wednesday, Jan. 26th, Dr. Stansbury, of Bayfield, in the chair.

The question of the formation of a joint medical association in conjunction with Perth medical men, was discussed, but was left in abeyance until the next meeting of the association.

Dr. Taylor read a very interesting paper on "Ulceration of the Stomach," which was followed by a discussion, in which almost all the members took part.

Dr. Kennedy presented a specimen of scirrhous ventriculi showing marked hypertrophy of walls, and fluid capacity of  $\frac{3}{4}$  i.

Dr. Shannon read a very instructive paper on "Chronic Catarrhal Gastritis," which was instanced by several cases presented, and on which general discussion followed. The election of officers for the ensuing year resulted as follows: President, Dr. Stansbury, Bayfield; Vice-President, Dr. McKenzie; Sec.-Treasurer, Dr. Hunter Goderich.

## A MEETING OF THE NURSES.

The American Society of Superintendents of Training Schools for Nurses held its annual meeting in the Normal School, Toronto, February 9th, 10th and 11th.

### OPENING ADDRESS.

The President, Miss Snively, of the Toronto General Hospital, read her address. Reviewing the history of training schools, she said that although Canada was less experienced in the work of training schools for nurses than the States, she yet claimed to have organized a school for nurses prior to the organization in Bellevue Hospital, New York.

Regarding the present work of the convention, Miss Snively said: "We are looking forward with pleasant anticipations, in the hope that those who have large experience, may be ready to aid us in solving such weighty problems as those which relate to diet and cleanliness; and, lastly, we hope to carry away with us some valuable practical hints as to the best method of attaining a measure of uniformity in the practical parts of our work."

An interesting paper was read by Miss Nevins, Garfield Hospital, Washington, on "Hospital Laundries," which was discussed thoroughly by Miss Nouse of Chicago, and Miss Banfield, of Philadelphia Polyclinic Hospital.

A paper was read by Miss Stowe, of Rhode Island Hospital, Providence, on "Practical Diet Kitchens as Part of a Uniform Curriculum," in which many valuable pointers, as to the buying and storing of food, the storage of cooked and uncooked foods, the best sorts of foods in point of wholesomeness and nourishment, were given. Miss Stowe thought that the best person for the head of the food department of a hospital was the one who is well versed in the theoretical values of foods and their economic functions, the same as a person at the

head of a drug department. This paper was discussed by Miss Milne, of the Presbyterian Hospital, New York, and by Miss Loomis, of Williamsport Hospital, their papers being read by Miss Daek, the Secretary of the Society, in their absence. A number of other interesting papers were read.

A reception was tendered to the visitors in the Normal School, which was attended by a goodly number of Toronto medical men and their wives.

## A SCHOLARSHIP IN MEDICINE.

At a meeting of the University Council, held on Feb. 1st, a letter was read from Dr. R. A. Reeve, Dean of the Medical Faculty, offering for the next four years an annual scholarship in medicine of the value of \$250. The holder of the scholarship must devote himself to research in physiology or pathology during the year subsequent to graduation. The thanks of the Council were unanimously tendered to Dean Reeve for this gift. This is not the first occasion on which the University has been indebted to the generosity of Dr. Reeve. During the past two years he has not only made a handsome donation of apparatus to the physical department, but has also contributed liberally to the equipment of the medical faculty's building. His name is also to be found in several of the lists of benefactors published in The Calendar.

## THE AMERICAN MEDICAL ASSOCIATION.

SECTION ON MATERIA MEDICA AND THERAPEUTICS: The following papers and discussions have been promised for the meeting at Denver, Col., June 7-10, 1898:

"Yellow Fever: Its Etiology and Treatment." Discussion by Surgeon-General George M. Sternberg, M.D., of Washington, D.C.; Prof. John

Guitéras, M.D., of Philadelphia; Sol-lace Mitchell, M.D., of Jacksonville, Fla.; T. S. Scales, M.D., of Mobile, Ala.; G. B. Thornton, M.D., of Memphis, Tenn.; H. M. Bracken, M.D., of Minneapolis, Minn.; P. E. Archinard, M.D., of New Orleans, La.

"Aims of Modern Treatment of Tuberculosis." By Prof. Edwin Klebs, M.D., of Chicago. Discussion by Charles Denison, M.D., of Denver, Col.; C. H. Whitman, M.D., of Los Angeles, Cal.

"Serum Therapy of Tuberculosis." By Prof. S. O. L. Potter, M.D., of San Francisco, Cal. Discussion by Prof. James M. Anders, M.D., of Philadelphia.

"The Therapeutics of Pulmonary Phthisis." By Paul Paquin, M.D., of St. Louis, Mo.

"Tuberculin as a Diagnostic and Curative Agent, with Report of 250 Tubercular Cases Treated." By C. H. Whitman, M.D., of Los Angeles, Cal.

"The Practical Value of Artificial Serum in Medical Cases." By P. C. Remondino, M.D., of San Diego, Cal.

"The Use of Remedies in Diseases of the Heart and Blood-vessels." By T. Lauder Brunton, M.D., D.Sc., F.R.S., London, England.

"The Mescal Button." By Prof. D. W. Prentiss, M.D., of Washington, D. C.

"The Modern Intestinal Antiseptics and Astringents." By William Frankhauser, M.D., of New York.

"To What Extent is Typhoid Fever Favorably Modified in Its Course, Duration, Termination or Sequelæ by the Administration of Drugs?" By Frank Woodbury, M.D., of Philadelphia, Pa.

"Strychnine." By J. N. Upshur, M.D., of Richmond, Va.

"Methods of Teaching Materia Medica and Therapeutics." By Prof. G. H. Roché, M.D., of Baltimore.

"The Study of Materia Medica and Therapeutics." By H. M. Bracken, M.D., of Minneapolis, Minn.

"The Great Therapeutic Import-

ance of a Rational Adaptation of Cathartic Remedies to the Physiological Functions of the Gastro-intestinal System." By E. D. McDaniels, M.D., LL.D., of Mobile, Ala.

"Why the Pharmacopœial Preparations Should be Prescribed and Used by the Profession." By Leon L. Solomon, M.D., of Louisville, Ky.

"The Use of Electricity by the General Practitioner." By Caleb Brown, M.D., of Sac City, Ia.

The following have also promised papers, subjects to be announced very soon, together with the day assigned for each discussion and paper:—

Dr. J. E. Atkinson, of Baltimore, Md.; Dr. Henry Beates, of Philadelphia, Pa.; Dr. T. M. Balliet, of Philadelphia, Pa.; Dr. George F. Butler, of Chicago, Ill.; Dr. Dudley W. Buxton, of London, Eng.; Dr. J. Solis-Cohen, of Philadelphia, Pa.; Dr. N. S. Davis, Jr., of Chicago, Ill.; Dr. P. J. Farnsworth, of Clinton, Ia.; Dr. J. E. Moses, of Kansas City, Mo.; Prof. Joseph Remington, of Philadelphia, Pa.; Dr. L. E. Sayre, of Lawrence, Kas.; Dr. H. V. Sweringen, of Fort Wayne, Ind.; Dr. E. L. Stephens, of Fort Worth, Texas.

The chairman will be pleased to receive and place upon the programme subjects for discussion and papers.

JOHN V. SHOEMAKER, M.D.,

*Chairman,*

1519 Walnut Street,

Philadelphia, Pa.

THE necessity of aseptic cushions for the operating table is urged by L. Klemm, of Riga, who recommends for the purpose bags made of stout linen, of the required shape, filled as needed with excelsior (Holzwolle), and sterilized with steam, or the bag and excelsior can be sterilized separately. He has found these cushions convenient, cheap, absolutely aseptic and superior to rubber cushions for several reasons.—*Cbl. f. Chir.*, November 16.

## Special Selections

### PRACTICAL MEASURES IN OBSTETRICAL EMERGENCIES.\*

BY S. MARX, M.D.,  
Attending Surgeon, New York Maternity Hospital.

When I was asked by your president to open the discussion on the subject of Practical Measures in Obstetrical Emergencies, certainly an interesting and worthy one, little did I think of the difficult task I had undertaken. The field to be covered under this caption is a very large one. To take up each and every condition of emergency likely to occur during the parturient act would carry me so far beyond the limits of an ordinary society article that it would be terrible to contemplate the result upon you from such a prolonged *seance*.

To properly cope with this almost endless topic, to treat of it in an exhaustive manner, would take hours and hours of time. Let it therefore be understood from the first that such is farthest from my thoughts. The most common complications as well as the most serious ones, those that demand instant and thoughtful action, will be dealt with to the best of my ability. Those that I shall omit are left out for the reason that in order to deal intelligently with some, I must slight others from lack of time. These can, nevertheless, be brought out to better advantage by those who follow me in the discussion. There is no branch of medicine, and I speak advisedly, in which a cool head and steady hand are of greater importance than in the practice of obstetrics. What chance has a woman and her unborn babe if in the presence of a dangerous complication the accoucheur loses his head completely? Far

better do nothing in such conditions; for will not Dame Nature come to our aid and meet us more than half way? Better this than under the influence of intense mental excitement or physical demoralization do what under other and safe conditions would be criminal. Witness, for instance, the criminality of a physician in the presence of a ruptured uterus cutting off a yard of gut in order to hide the signs of omission and commission; or the luckless medical man who deliberately leaves a woman with the head of a foetus lying undisturbed in the uterus, trusting that either the powers of Nature or some kindly practitioner will help him out of such an awful dilemma!

It is my honest belief that the larger our experience on lines of preservation and conservation grows the fewer will the accidents and emergencies be, as pertains to our own practices. Ordinary care and skill in making out presentation and position is half the battle won. I do not mean the perfunctory examination as undertaken, and I do not exaggerate, by seventy-five per cent of medical practitioners who rest satisfied so long as they feel a hard round body, which they interpret as the head. Deflections, obliquities, malpositions of the vertex are rarely thought of, less often made out—not until a fruitless forceps application or a slipping forceps, with its terribly destructive consequences, recalls to their minds that there is such a thing as a *malposition of a good presentation*. I there be even the suspicion that a presenting part is not clear in our minds it is necessary, nay, the absolute and sacred duty of the medical man, to introduce the hand into the uterus and explore not only the presenting part but the conformation of the maternal pelvis. Pelvimetry is beyond the scope of this paper, but I

\*Read before the Harlem Medical Association, November 1st, 1897.

wish to state again which has been repeatedly said: "*Know your woman's pelvis as you know her face.*" Deal with malposition and malpresentation early; recognize your pelvic contractions in time, and I feel morally certain there will be fewer threatened uterine ruptures, fewer fatally exhausted women, fewer dead children, fewer septic cases and septic deaths, and many more smooth convalescences. Do not operate too early or too late, but in time; that is the secret. Never operate until an indication presents. Just here lies the difficulty. It is far simpler to do an obstetric operation than to place an indication. Far more difficult is it to know *when* to operate than *how* to operate. Indications for operating occur more frequently for maternal than for foetal causes. Any general condition which threatens the life of the mother warrants instant interference, no matter what the condition of the maternal parts or the position of the child in reference to the pelvis. If the cervix is not dilated, a direct manual dilatation or, in extreme cases, the deep incisions of Dührssen. The method of delivery depends upon whether or not the head is engaged. If it is above the brim, version is to be instituted in nearly every case. When the head is engaged and in a normal position, forceps should be the operation of election, except in those cases when the part presenting is in a vicious position—*i.e.*, mento-posterior cases or occipito-posterior cases. Here version should be done. As said above, version is to be the elective measure in all cases where the head is above the brim, but the exception to this rule in my experience is in those cases where there is a tetanic uterus, a threatened or already present uterine rupture. Under these conditions it is thought better to do the high forceps operation, to our minds the most difficult of all obstetric operations, for the fear of causing or increasing the lesion which is threatening or already pre-

sent. But in the great majority of these cases the labor has been so prolonged and tedious that the child is dead or the foetal exhaustion so grave that the life of the child cannot be taken into consideration. Here, then, we must submit to a measure which, while it does not affect the mother, can do the child no possible harm—namely, perforation.

A good rule in midwifery is one which states: "The delivery of a dead child should always be effected by the perforator and cranioclast, unless its position be so low in the pelvis that its delivery cannot possibly materially militate against the condition of the mother." If symptoms of a threatened rupture occur, delivery should be instituted at once as above. Far more grave is the condition where actual rupture occurs. The author has seen a number of these cases, and all have died in spite of every variety of treatment. With the foetus still *in utero*, high forceps or direct perforation is called for. Laparotomy is to be countenanced only in those cases where the foetus or placenta has passed into the abdominal cavity. Those of you who have done or seen a laparotomy under these conditions will for ever remember the boggy, œdematous, succulent state of the organs involved, and the difficulty in properly treating such accidents. Few of these patients come to an operation, for most of them die from shock and hæmorrhage; but from a practical standpoint, a total hysterectomy ought to give the best results. Of a number of cases, I have treated them on tentative lines: passing the hand into the uterus, preventing gut from being nipped, or, after carefully washing intestines, replacing them. A drain in the rent, a firm uterine tamponade, ice bag to the abdomen, and large dose of opium, is all we can do in the hope of saving these patients. There is no more terrible or heartrending accident in the lying-in chamber than that known as a post-partum hæmorrhage. This is *the one*

condition which to cope with successfully is the highest gift in the hands of an accoucheur. It occurs quickly. Its results are dire, but it does not frequently happen in the hands of a careful man. Its prevention is the absolute retraction and contraction of the uterus. After delivery the uterus should be held and kneaded, and not allowed to relax.

Many men speak of frequent post-partum hæmorrhages. These either denote faulty technique on their part, or else they call every bleeding a true post-partum hæmorrhage. I speak of these hæmorrhages as those where in a few moments from perfect health, in good spirits, the woman lies cold, collapsed, gasping for breath, with sighing, yawning, and all those symptoms which we all recognize too well as soul-stirring and marrow-freezing. There may be no external hæmorrhage, but the large, relaxed, boggy uterus tells the story but too well. Quick, precise action is required. No theoretical measures are to be thought of. Means that have stood the test of time must be used, and used at once, to bring on firm and good uterine contraction. I have thrown aside everything but one of two measures. I countenance but one *hot intra-uterine douche*, and if this procedure does not bring about the desired result, I do not use irrelevant and dangerous measures, such as direct compression, ice, persulphate of iron, lemon, vinegar, etc., *ad infinitum*, but proceed to pack the uterus with gauze, towelling, or anything I have on hand. I never go to a case without five yards of gauze being on hand. This is a surgical means of controlling hæmorrhage. The technique of gauze tamponade is simple: one hand over the uterus, while with the other the gauze is shovelled in, as it were, until no more can be introduced.\* So long as this gauze remains, bleeding cannot occur, for it

acts mechanically in controlling the bleeding and actively stimulates the uterus to contraction. The after-treatment is simple: Postural treatment and stimulation by the needle, with large doses of strychnine given at short intervals; infusion of a saline solution, for the heart needs a fluid, not necessarily blood, to act upon. Intravenous transfusion is difficult of application in those cases, for the veins are so small, so collapsed, that to find them is not only difficult, but valuable time is lost. Hypodermoclysis is all right if the needle and Davidson syringe are at hand, when a pint may be injected under each breast. But we have in the colon an avenue which greedily absorbs about all the fluid we can inject. The tube of a fountain syringe is slowly wormed two feet into the bowel and the salt water allowed to run in, at the same time elevating the buttocks to allow the force of gravity to act in getting the fluid higher and higher. It is remarkable how much fluid a colon will absorb under these conditions, and how little is expelled. I well remember one case where one pint was injected every hour for twenty-four hours with most brilliant results. The water should be hot, and it would not be amiss to add to the salt solution strong coffee, or liberal doses of cognac or whisky. Ergot is of little value in these cases when given by mouth, for Hemmeter has shown that it takes at least a quarter of an hour to act. As an adjuvant, ergot or ergotole might be given hypodermically, but deep into the outer side of the thigh.

Hæmorrhage from the cervix, while not so fatal in its immediate action, can in a relatively short time exsanguinate a patient. Its causes and prophylaxis do not enter into discussion in this paper. The diagnosis is simple enough if, in the presence of a well-contracted uterus, hæmorrhage from the vagina and vulva can be excluded. Its treatment is self-evident, but by what means? Power-

\*The packing can be safely removed at the end of twenty-four hours and, if necessary, renewed.

ful traction from below by bullet forceps or pressure from above, both causing an artificial prolapse of the organ, has in my hands, by putting the uterines on the stretch, caused a cessation of the hæmorrhage. Direct pressure for ten minutes, the thumb and index finger of one hand directly grasping the angle of the tear, has answered in others, or, to the same end, clamps inserted well above the angle of the laceration. Further surgical measures would be the firm utero-vaginal tamponade. These are the varieties of treatment when direct suture and needle are not on hand. I can only advocate primary trachelorrhaphy in the presence of hæmorrhage, and not, as many have advocated, in all cases of laceration. The universal application of sutures is condemned for the reason that if the accoucheur has been surgically clean deep tears will in the largest number of cases heal spontaneously. If the rent is sewed up and strict cleanliness is not observed, sepsis will arise and union not occur. I well remember a case where the physician sewed so thoroughly that the entire uterine canal was closed and not a drop of lochia could escape. But in the presence of cervical hæmorrhage we recognize the only condition for the primary operation. In itself the operation is simple. Place the woman on the back, artificially prolapsing the uterus by direct pressure, or pulling down the cervix to and through the vulva—in other words, delivering the cervix into the world—passing as many sutures as are required, and tying them tightly; for, since we are operating upon a uterus which will rapidly involute, in which the parts are congested and swollen, bleeding might occur or the wound gape from ligatures that in this wise become loose from not being tied tightly enough.

Following this technique, it is as easy to sew up a cervix as it is to operate upon the perinæum. Hæmorrhage from the vagina is rare, and re-

quires simple sutures. Spouting from the clitoris, while apparently a simple matter to treat, is one which has puzzled the writer in finding the source of the hæmorrhage. Direct pressure, or a suture passed beneath the bleeding vessel, will readily control the condition.

Hæmatoma of the vagina and vulva is a rare condition. The acute pain, the presence of pressure, and rapidly increasing swelling will direct the attention of the attendant to the source of trouble. No matter how insignificant the matter might be at the beginning, it must be remembered that impossible delivery and a dead fœtus has been the result of procrastination in delivery. The patient ought to be delivered at once, direct pressure instituted, and ice applied locally. In the event of our feeling that the submucous hæmorrhage is not under control, direct incision and firm surgical packing would be called for. Vividly do I recollect a tremendous diffuse hæmatoma of the vulva and vagina in which it was impossible to pass even one finger into the vagina, and the patient in the deepest collapse. The gravest condition which can confront the accoucheur is an "accidental hæmorrhage" during labor. The practice of obstetrics is associated with anxieties at all times, but this becomes many times magnified in the presence of so unforeseen, sudden, and fatal a complication as the one just mentioned. Accidental hæmorrhages do not frequently occur, but yet are not so rare as to rank among scientific curiosities.

The diagnosis of the traumatic cases is readily made. The so-called idiopathic ones are difficult of recognition only because the condition is seldom thought of. Characteristic of such a condition would be previously rigorous pains, feeble and irregular; the change in their character; the pains are typified by their fixity at one point; the increased size and doughy consistence of the uterus. There may or may not be external

evidence of hæmorrhage. The patient is in a condition of unrest; she is irritable. The pulse now becomes rapid and feeble; there are symptoms of an intense hæmorrhage going on, and yet the external flow is entirely out of proportion to the condition the patient is in. Shock is most often the fatal element, which cannot be accounted for by the loss of blood. The death-rate is enormous for both mother and baby. Consequently, the treatment, you can readily imagine, must be of the heroic order. As the placenta and uterus are one or both at fault, there can be only one measure to our minds to stave off the almost inevitable condition. If there ever be a legitimate field for the performance of the deep cervical incision, we have it here. Ergot, rupture of the membranes, Barnes's bag, etc., have here no place. Either rapid manual dilatation or the bloody dilatation can but seldom save either mother or child.

Beyond this our hands are tied. Active stimulation, rapidly emptying the uterus, perforation for baby—for it has already in the largest number of cases been sacrificed—and thorough tamponade of the uterus. We are not to be understood as recommending such rapid operation in all cases, but only in the desperate ones. The milder accidental hæmorrhage cases, as a rule, take care of themselves, and need little if any treatment but rest and general narcotic sedatives. A rare and interesting condition met in the parturient and puerperal woman is uterine inversion; and yet, because of its rarity, it is essential for the practitioner to have the mode of treatment at his fingers' ends, so that reinversion may be commenced; for the longer we wait before active treatment is commenced the greater the spasm of the contraction ring and the more remote the chances for successful treatment. It will not be dogmatic if the statement is made that inversion, as a rule, is caused by faulty technique in the third stage of labor—that is, during

the attempts made to express the placenta. The rationale of the Credé method is not only manual compression, but manual expression, instituted during the height of pain, at some distance from the end of the second stage. Best at that time, whether this be at the end of five minutes or an hour, when the tired uterus has regained its usual vigor of contraction. Faulty position of the hand, as the digging of the fist firmly against the fundus; indentation of that part of the uterus, with or without traction upon the cord, all predispose to inversion. It is far better if one hand fails, to stand in front of the patient and, using both hands—the thumb in front, the fingers behind—grasp the organ firmly and compress and express steadily and forcibly the entire fundus. Inversion in the second stage of labor is, as a rule, due to short cord. It is always incomplete. In cases of inversion in the second stage we should apply the forceps under narcosis, and; while traction is thus made, artificially prolapse the whole uterus by pressure, not against the fundus but against both uterine horns, so as to relieve the tension between the cord and uterus; then we should employ manual removal of the placenta, reinversion of the fundus direct, and firm utero-vaginal tamponade. Grave is the condition of complete inversion during the third stage of labor. The quicker the inversion is attacked the better is the result obtained. Whether or not to remove the placenta is yet a moot point; still, the writer would advocate such a measure, for the placenta can only be an obstacle to successful work. Chloroform narcosis is essential. Pressure is to be made not against the fundus but directly against either one or both horns. The procedure is very tiresome, but the applied force must be kept up until the spasm of the internal ring is overcome. Then, when once yielding, do not give the advantage so obtained, but rapidly follow by complete fun-

dal reinversion. As a rule, this primary operation is simple but tiresome, and will succeed in most cases; after which, in order to stimulate uterine contraction and prevent recurrence, the uterine tampon should follow. But where success does not follow, brute force must not be used, for we would thus invite traumatism, with the inevitable sepsis that ensues. When such a case confronts us we cannot countenance any measure short of attacking the contraction ring by the abdominal route. Hydrostatic bags, gauze vaginal tamponade, are all too uncertain, too risky, to weigh against the ever-increasing danger to the woman. A direct abdominal section, steel dilators, or direct manual dilatation, at the same time that the fundus is teased up from below, is certainly more scientific and rational than the measures mentioned above. Placenta prævia and eclampsia are two conditions which every man would want to shun. Eclampsia is a complication which can be as surely prevented as puerperal sepsis, and this by the systematic examination of the urine.

When, in spite of medical treatment carefully and conscientiously administered, our results fail; when, instead of improving, the condition remains stationary, and especially if it grows worse, surgical interference is called for. The presence of the uræmic state is bad, but an eclampsia seizure is far worse. We cannot understand the last reports from the French school, who even in the presence of an attack of eclampsia still prefer the medical to the surgical treatment. It can only be that either these authors are not correctly reported, or else the French women are built on different lines from the American. During labor in the presence of eclampsia, the fœtus must be removed at once, for the prognosis for the child is bad, at least fifty per cent. dying if not delivered. It is further known that when once the uterus is emptied the attacks of

eclampsia cease in over ninety per cent. of the cases. If the os is fully dilated, forceps when the head is engaged and version when above the brim should be the operation of election. If the os is not dilated sufficiently for the passage of the fœtus, manual dilatation or the deep incisions of *Duhrssen* should be done at once. So far as the uræmic state is concerned, the surest way of mitigating the condition is to cause a return of diuresis. Hot colon irrigations, elevating the hips and turning the patient on the side, continued for hours at a time; hot packs, large draughts of water; hypercatharsis by croton oil, elaterium, etc., is about all we may hope to accomplish this by. When a full, bounding pulse and congested face, a free bleeding from the uterus, until the pulse is soft and feeble, is a distinct indication. *Veratrum viride* acts similarly but not so certainly as uterine phlebotomy. Where heart stimulants are indicated as recognized by the rapid and feeble pulse and the collapsed condition of the patient, large doses of nitroglycerin, a fiftieth to a twenty-fifth of a grain, every half hour to hourly doses, strychnine, caffeine, and camphor must be exhibited. To treat the seizures tentatively, chloroform, morphine, codeine, and chloral are of distinct value as adjuvants, but cannot be recognized as curative measures in the true sense of the word.

The secret of success in treating these cases is rapidly emptying the uterus, under deep but short chloroform narcosis, and employing every measure known to cause a return of diuresis. A woman who is the victim of a vicious insertion of the placenta is one who is suffering from a malignant disease. She is on the verge of a catastrophe, which is imminently threatening her, even though the condition may not manifest itself until the critical hæmorrhage occurs. There is no condition which I so dread as a placenta prævia, and yet it is safe to say that no dangerous

condition can be so readily overcome as this dread complication. Rare is it that the vicious placental state gives trouble primarily during the labor, but we are most frequently compelled to deal with it some months before the end of utero-gestation. Hæmorrhage is inconsistent with normal pregnancy. Every hæmorrhage in the "gravida" must be looked upon with grave suspicion. The complete and partial implantations are readily recognizable, but there are cases where, while no placenta can be felt, a diagnosis of placental implantation, involving the dilating zone of the uterus, can be made pretty accurately by exclusion. Thus, if an abortive menstrual period can be eliminated, and lesions of the cervix, vagina, vulva, and anus can be proved absent, the condition can hardly be anything but a hæmorrhage from the placenta, which is clinically or anatomically prævia. Far better to err on the wrong side and empty the uterus than shield ourselves by inaction because no placenta can be felt, and thus run the woman into the enormous danger from hæmorrhage which may cost the death of two beings. There can be no question in the minds of those who do the best they can by their patients that when a placenta prævia is present, or when there is even a suspicion of its presence, the emptying of the uterus at once by any measure which is consistent with the integrity of the maternal structures is called for. Whatever operation is performed, let it be one that will empty the uterus rapidly, and while so working saving the woman the loss of blood, and at the same time endeavoring to preserve foetal life. In my hands the direct manual dilatation will always remain the operation of election. The placenta must be removed at once, and to save the woman the loss of as little blood as possible the direct gauze uterine tamponade is a measure to be recommended.

Now, before closing this rather dog-

matic article I should like to call as rapidly as possible to your attention a few grave emergencies which pertain to the foetus. The first is funic prolapse. So dangerous is this condition to the child, so imminently fatal in its effect, that in many cases before you can do much the foetus will have perished. Should extraction of a child dead under these conditions prove a difficult measure, or materially dangerous to the mother, it would be wise to deliver by perforation and cranioclast, since it is far easier to deliver by such interference than to extract a child with an unopened skull. But where a foetus is alive it has been a rather dreary experience, speaking from a personal standpoint, after replacing the cord by the usual method, to find that after all careful manipulation a dead child has been extracted. You cannot tell when you have thoroughly replaced the cord, and as likely as not a small knuckle is nipped between the foetal head and the bony pelvis, and in this wise the foetus has been sacrificed. Accordingly, it has been customary, while waiting for assistance, to place the woman either in the Trendelenburg posture or in the knee-chest position to prevent pressure. A combined version has been the operation of election, and, in the presence of a dilated or dilatable os, an immediate extraction. These measures have given us the best results.

There are a number of cases on record where, after the head had been delivered, it was found impossible to extract the shoulders, and so the foetus was lost. This is often due to a failure of the shoulders to rotate; that is the long diameter between the shoulders attempting a passage through the narrowest part of the pelvic outlet—namely, the transverse. Here simple rotation will overcome the difficulty. But yet, where the mechanism is true, the size of the shoulders is so great that the greatest difficulty is encountered in their de-

livery. Pressure from above, breaking up the impaction by the forcible extraction of one arm even at the expense of a fracture, will in many cases do. If spasm of the sphincter ani or the pelvic floor is evident, a unilateral incision through the vulva, running obliquely downward and outward, but making it deep, will dilate the vulva as quickly as will a similar incision in the cervix. If this does not fill the bill, and the foetus is still undelivered, the operation "cleidotomy" should be done at once. By this means we cut directly through either one or both clavicles by the use of a pair of scissors; the chest must of necessity instantly collapse—that is, there is a diminution in the diameter of the shoulders, and delivery is readily accomplished. The last emergency to be dealt with is extension of the after-coming head either after version or extraction. Flexion is as essential in the successful delivery of the after-coming head as it is in the delivery when the vertex presents. In breech delivery, should any obstacle, bony or otherwise, obstruct the passage of the after-coming head, chin and sternum part company, extension of the head ensues, the arms quickly are carried extended above the head, and the greatest difficulty in extraction occurs. The necessity of other than manual (direct) interference in after-coming head extraction means nothing but faulty technique; in other words, when it becomes necessary under existing circumstances to apply forceps, it is almost certain that flexion has not been maintained, and this through the fault of the operator. To properly maintain flexion it is the custom with the writer to exercise less power in pulling on the legs, but to institute from above direct pressure and force upon the after-coming head—that is, follow the head downward as rapidly as extraction is exercised upon the feet. Traction upon the feet and breech must be forever downward and backward as far as possible, and just here lies the common error with

many. Traction directly forward or even upward of the legs and breech is but too commonly practised. The secret of successful after-coming head delivery is traction downward and backward until the shoulders are delivered—more "*vis a tergo*," a materially less "*vis a fronte*;" to guide the head through the pelvic diameter at the inlet, in contracted pelvis, which is the widest, and this is most frequently the transverse; when the head comes to the middle of the pelvis, rotation by a finger in the mouth, so as to conform to the largest diameter of the outlet—namely the antero-posterior. These precautions being taken, the head, well flexed, is found in the pelvic floor, when delivery is readily accomplished by any of the ordinary methods. Should extension occur, what is to be done? Firm pressure from above by the hand or that of an assistant or nurse. The introduction of one or two fingers inserted into the mouth of a child as far as the root of the tongue. This re-enforced by centre pressure against the occiput to assist the other fingers working in the same direction, flexion is forcibly made and thus delivery is readily accomplished. We advise the introduction of the fingers far back into the child's mouth, and not pressure made against point of jaw, since pressure made at this time may fracture the mental process; further, the traction made at this point simply forces open the jaw, but, on account of lack of resistance, does not act in flexing the head. The advisability of making pressure against the malaris is not well thought of, since our degree of purchase is very limited and flexion cannot be as thoroughly promoted as by the means recommended above. In the event of these measures failing, forceps may be used, and the child's life saved. In all probability in this time it has been already sacrificed. When the child is dead there is no measure which so little compromises the welfare or life of the mother as the perforator.

Nothing is so dangerous to the maternal parts as brutal and forcible attempts to extract a dead child, and on more than one occasion I have seen two or three men *at one time* pulling, as if their life depended on it, to extract a child that was dead; and likely as not after one or both legs had been pulled off. Timely use of the perforator is to be recommended the moment no foetal life is present, for the mother's condition would be endangered by the extraction of a non-craniotomized baby.

### TUBERCULOSIS AND VINEGAR.\*

By JOHN ASHBURTON CUTTER,  
B.Sc., M.D., New York City.

The enormous amount of work done in bacteriologic lines as to tuberculin has been of such little avail as to treatment and prevention, that I have no hesitation in bringing before the Section in a few words, a record of work that has been done on other lines and to the glory of medicine in that this work has cured the desperately sick and prevented the pre-tubercular becoming tubercular.

Dr. John Christian read a Latin inaugural thesis at Jena, October 1729, in which reference is made to the coagulation of living blood by vinegar which he says dissolves silica and poisons like viper's venom. He laid down the law, "*Causa coagulationis, sanguinis est acidum.*"

In "The Relation of Alimentation and Disease," Dr. James H. Salisbury recounts investigations made on 1,028 hogs fed with sour foods in 1858. Salisbury in the preface, page iii., says: "I had been a graduate of Albany Medical College, and in 1850

entered upon the practice of medicine. I was immediately and forcibly struck by the almost entire want of medical knowledge in regard to the true causes of disease, and by the consequent uncertainty that must and did exist as to the means of combating and curing pathologic states." Salisbury's first publication relating to foods that ferment into alcohol and vinegar and are thereby causative of consumption of the bowels and lungs was made in 1864 in the Surgeon-General's report of Ohio; this paper and the matter found in "The Relation of Alimentation and Disease" (published 1888) contain enough to show this investigator's work as to the relations of vinegar and tuberculosis; yet I believe that medicine was not wholly the chaos he considered it when he started to practice in 1850; honor to whom honor is due; honor to Salisbury for his colossal experiments in feeding hogs to death with sour foods. (I would that some of the quid nuncs in bacteriology would enlarge their ken and get away from the bacteria and study yeasts, alcoholic and vinegar.) Honor to the Europeans who recognized the souring properties of certain foods before the time of Salisbury's publications.

In the bibliography appended, much of which is from the publications of this Association, I show what has been done by an American writer:

#### BIOLOGICAL.

"The morphology of the blood in health is as follows:

"*Color*.—Bright, fresh, clear, ruddy, strong. Clottings, rapid and firm.

"*Red corpuscles*.—Arrange themselves in nummulations, or are scattered evenly over the field; normal in size; non-adhesive; central depression well marked on both sides; periphery well rounded, clean-cut. Hold coloring matter firmly. Pass readily to and fro through the fibrin filaments. Appear fresh and fair.

\* Presented to the Section on Physiology and Dietetics, at the forty-eighth annual meeting of the American Medical Association held at Philadelphia, Pa., June 1-4, 1897.

" *White corpuscles*.—Normal in size, not enlarged by internal collections of foreign bodies. Amoeboid movements strong or not. Proportion, 1 to 300 of red corpuscles. Consistence good, not sticky. Color a clean white. Freely moving at will.

" *Serum*.—Clear and free at first sight from any form. After fifteen minutes, most delicate semi-transparent fibrin filaments appear, forming a very light network in the field, which offers no obstacle to the passage of the corpuscles."

The morphology of the blood in tuberculosis is as follows:

" *First or incubative stage*.—Red blood corpuscles are less in number,ropy and sticky more or less, but not much changed otherwise.

" *Second stage of transmission*.—1. Red corpuscles: Color pale, non-lustrous; not clear-cut, not ruddy. Consistence, sticky and adhesive. Coating of neurin removed. Not so numerous as in normal blood. Owing to the increased size and strength of the fibrin and the stickiness, they form in ridges, rows, but not so marked as in rheumatic blood. They accumulate in aggregations of confused masses, like droves of frightened sheep. They adhere to each other, and are rotten, as it were in texture. 2. While corpuscles: enlarged and distended by the mycoderma aceti, or spores of vinegar yeast, that are transmitted into the blood stream from the intestines. 3. Serum more or less filled with the spores of mycoderma aceti, or vinegar yeast. These occur singly or in masses of spores, which is the common form in which they are found, wherever vinegar is produced. The fibrin filaments are larger, stronger, more massive, than in health, and form under the microscope a thick network which is larger, stronger and more marked in direct proportion to the severity of the disease or the amount of accumulation. Besides the serum is apt to be of a dirty ash color. The sticky white corpuscles, the massive fibrin fila-

ments in skeins, and the yeast spores alone or combined, form aggregations, masses, collects, thrombi and emboli which block up the blood vessels of the lungs soonest, because exposed to cold air, the most of any viscus; the blood vessels contract and thus arrest the thrombi and form a heterologous deposit, which is called tubercle.

" *The third stage of tubercular deposit*.—These deposits increase so long as vitality subsists in the tubercle and surroundings. When vitality ceases, the tubercle softens or breaks down. Sometimes if the process is very slow and life slightly inheres in it, the proximate tissue undergoes fatty infiltration which preserves it from readily breaking down. The morphology of the blood is the same for the second and third stages of consumption.

" *Fourth stage, interstitial death*.—The red corpuscles are thinner, paler, much lessened in number, increased in adhesiveness, stickiness and poverty; devoid more or less of neurin. The white corpuscles are fewer in number, more enlarged, often ragged and rough. Distended with spores of mycoderma aceti; more adhesive and sticky. *The serum*.—Fibrin filaments are thickened, stronger; more massive, and more skeins of them present. The collects of mycoderma aceti are very much larger and more numerous; in moribund cases, I have seen them so large as almost to fill the field of the microscope."

#### PRE-TUBERCULOSIS.

"The idea that diseases have periods of incubation preceding their full development accords with other facts in animal and plant biology. It is to be expected that tuberculosis of the lungs, for example, has a pre-stage. In fact, pre-tuberculosis exists and clinically means that the morphology of consumptive blood is present to a lesser extent than in tuberculosis, that the essence of pre-tuberculosis is in these vegetations in the blood,

which coming from the fermentations in the alimentary canal, pass the barriers of the intestinal epithelia and float about in the blood stream of consumption any time during one year before the necrosis or sphacelation or breaking down of the lungs, sufficient to be detected by the usual signs, furnished by auscultation and percussion. It is evident that in such spongy bodies as the lungs small deposits may escape physical macroscopic exploration. But the microscope will detect this stage."

#### VINEGAR AND HOG CHOLERA.

"Seven years ago my son and I independently studied hog cholera, on a large stock farm in Western Massachusetts, autopsying animals immediately after death; 1, by the disease, and 2, by slaughter in early and late stages of complaint, the proprietor giving us every opportunity of macroscopic and microscopic examinations of blood and tissues of his animals, as he considered his herd doomed. We found, independently: 1. the blood morphology of the tubercle and embolism; 2, tuberculosis of lungs, bowels, skin; 3, recent fibrin clots in heart; 4, partial paralysis of hind extremities; 5, paralysis of nerve centers.

"*Causation of this epidemic.*—1. Steady feeding of ensilage which is loaded with vinegar and vinegar yeast; 2, swill food brought from outside; 3, cold weather; 1 and 2, predisposing causes; 3, exciting cause."

The hog physically is much like man; man is very much of a hog as to eating food that makes swill, and hence suffers much from tubercle.

#### WORLD-WIDE RELATIONS.

The Esquimau does not die of tuberculosis. He lives on animal food, yet for months of each year he breathes a vitiated atmosphere.

Tuberculosis ravages in the South where little good beef is eaten and instead very much of vegetable food. Some fifteen years ago a resident of

Savannah, Ga., came under treatment in New York. He changed his mode of living and became a beef eater. Since that time all his family have died of tuberculosis; he lives because of his beef-eating habits. The negro dies of tuberculosis. Causes, poor food, the mental strain of trying to reach the white man's level, and syphilis, with its grandchild scrofula, and tubercle.

Tuberculosis has ravaged in New England, especially the rural portion, with its diet of pie three times a day and baked beans, which latter, chemically, are splendid food for cattle, but for man not fit, unless cooked for many hours. Tuberculosis is now diminishing in New England because they are eating more beef and drinking more milk, although there has been very much of foolish opposition to the use of milk.

Cattle are dying in New England and other places of tuberculosis, and so long as the silo with its alcoholic and vinegary products is used, so long will farmers lose their cattle. A man imported a splendid herd from the Island of Jersey some fourteen years ago. He had a silo. He was expostulated with as to the dangers of feeding sour foods to his cattle. He persisted, and all died of either tuberculosis or heart disease.

The easiest way to exterminate the Indian is to give him plenty of white flour and rum. Tuberculosis always follows.

There is no "royal road" to the cure of tuberculosis or its prevention. The various tuberculin treatments are based on the principle of injecting an attenuated dose of poison into the human system—and this poison, like strychnia and many other drugs, stimulates nature and in some lines by inflammation to cure the diseased lungs and joints. One that has been afflicted with cough, weakness, emaciation, pain and dread of impending death, would only too eagerly accept such a treatment, yet in its very best it only effects results,

it does not touch causes, and when one sees men like Robert Koch wrestling on this line, while lives go out because they persist in ignoring the causative relations of vinegar and vinegar yeast to tuberculosis it makes one wonder at this neglect of general principles. So long as the cause is being put in the system, so long will tuberculosis continue, and it is strange that these followers of Koch also ignore the positive relations of syphilis and scrofula to consumption. As far as I can learn the majority of medical men are using, as a basis of their treatment, animal food, but why should they gravitate to the other side and give the causes of the disease, to-wit, fermented milk foods, such as kumyss, etc., pastry, starches, sugars, vegetable foods of many kinds, that cannot digest, because of the weakness of the bowels, salads that soon make swill, jellies and colloids, to name no more. These same men also neglect the value of the study of the morphologies of the blood, sputum, fæces and urine, as laid down by American observers.

At whose door shall be laid the blame of the ignoring of the incalculable value of the diagnosis of the pre-tubercular state, which diagnosis can be made before the lungs are affected, and before there is any sputum to find bacilli in or diseased spots in the lungs for tuberculin to react on? This knowledge of the pre-tubercular state is of the greatest value to humanity of anything in the practice of medicine.

The Dr. Cyrus Edson treatment was based on so-called logical grounds as to certain relations of carbolic acid to the human body in tuberculosis, yet he adds pilocarpine to his remedy to stimulate white blood corpuscle activity. He, therefore, indirectly recognizes the presence of vinegar yeast in the blood and that anything which helps the action of white blood corpuscles will help the patient for a time. Why not put the ax to the root of the tree, and stop the formation of this vinegar yeast in the blood?

Some Europeans are now using raw beef. Why they do not give patients broiled beef, I cannot understand. Raw beef is unpalatable, it promotes tape worm. The use of beef is the bottom principle in the treatment of tuberculosis, but it should be employed in the form of steaks or roasts, or the first-class top of the round freed from connective tissues by machine or knife and chopping bowl, as the connective tissues are of a colloid nature, and ferment, and tend to the production of vinegar yeast. The lean muscle pulp is then molded into a cake, an inch and a half deep, several inches wide, not too tightly pressed together and in all of its preparation care should be taken to touch as little as possible the meat direct by the hands as the human animal heat will change the character of the muscle pulp; broil this over a bed of good live coals, a gas stove, or even kerosene flame, turning often, and the resultant should be of a dark brown color on the outside and of a reddish but not raw appearance inside. It is best served on a hot water plate, and if a little underdone, it will cook on the plate when the meat cake is opened. If a hot water plate cannot be obtained, one can be extemporized by the use of a soup plate filled with hot water on which is placed another plate with the meat. There cannot be too much care used in the buying of the beef or its preparation, and if proper caution is taken, the patient will generally eat it with a relish. It should be seasoned with pepper, salt, butter, Worcestershire sauce, horse-radish, lemon juice, as the patient desires.

Lamb, mutton, the dark meat of fowl and game; broiled cod-fish can be used, as changes; the whites of eggs dropped in boiling water and slightly cooked, may be taken freely if the patient is not eating enough of solid food. Some patients will take the whites of from one dozen to two dozen eggs in a day when weak and not able to take other food.

Don't do as one woman did ; she gave her husband the whites of eggs dropped in boiling water with plenty of vinegar. The masses of vinegar yeast in the blood were so large and frequent under the microscope that amazement was expressed. The woman protested that she was doing everything absolutely according to order for her husband. As all of his symptoms were worse and because of this blood morphology of the masses of vinegar yeast, it was insisted on that some error was being made and it was ascertained what she had done.

Vegetable food may be added as follows: Some patients can bear one of the following foods at a meal—cracked wheat, rice, hominy, toasted entire wheat flour bread, baked potato. It is a hardship at the best to confine patients to close diet and physicians should give them as much variety as possible, but there is more danger of error on the one side of too broad a diet than one of too narrow. The use of distilled water or some good spring water that has not more than five to ten grains of salt to the gallon, should be persisted in, drank (after boiling) at a temperature of from 100 to 120 degrees Fahr. one hour before each meal and on going to bed.

Medicines should be employed in the treatment of tuberculosis on principles, and the main one is give no medicine which can ferment into alcohol and vinegar in the alimentary tract. This principle forbids the prescribing of many cough syrups and other preparations now largely used.

The skin in tuberculosis is more or less loaded with the vegetations of vinegar yeast. There should be employed daily sponge baths. The water to be hot or cold according to the patient's desire. Ammonia and water in the proportion of two teaspoonfuls to a pint or the aromatic sulphuric acid one teaspoonful to a pint or even the nitro-muriatic acid, one-half teaspoonful to a pint, can be used with great advantage ; rubbing with a saturated solution of spirits

and salicin is a good means of toning up the skin and the whole body.

Bacteria or bacilli are babies of vegetations which have become animalized by contact with the human body and human secretions. Robert Koch demonstrated their presence in the sputum of tubercular cases, for which he should receive due credit, but the work which antedates his in time and importance as showing the real cause of tuberculosis must not be ignored. The vinegar yeast found in the blood is the second stage of the bacteria, and is found there in the spore form, and sometimes in tubercular cavities we get the third stage of development in the aerial filaments of the vinegar yeast.

Physicians could learn more as to relation of sour foods to tuberculosis in a few months' time by experimenting on hogs (not guinea pigs or rabbits), by feeding a certain number with sour and a certain number with sweet foods, having all in the same building so that they breathe the same air. The beauty of this kind of work is that one can kill the animals any time one pleases and know just what is going on.

The agricultural experiment stations of the different States are fully equipped to make these investigations on hogs. It is necessary, however, that the microscopist who follows the experiments, should have a fair working knowledge of the methods of the American observers who have been studying this subject for nearly thirty years on their patients and with animals. If it is right to rush abroad to Berlin to study cured cases of tuberculosis, some of whom die the day after they are pronounced cured, there can be no harm in studying in America, all the work which made cured cases twenty-five years ago, for such cases are living now.

#### 'ROGNOSIS.

Granted a recognition of the relation of vinegar to tuberculosis, the prognosis can be more definitely

made out, for if one is stopping a cause then one has some hope to base his belief of cure on. If one is simply treating results according to tuberculin methods, and is still putting in the food which will undergo vinegary fermentation, the prognosis must necessarily be doubtful.

What is the experience of those who recognize the relation of vinegar and tuberculosis? Temperament here comes in. Some of the most appalling cases with many hæmorrhages, with the evidence of cavities in both lungs unquestioned, as determined by physical examination of the chest and by the detection of the elastic and inelastic lung fibres in the sputum, have progressed most favorably under proper treatment. Others, who apparently had little disease, went down to death. The rule has had to be laid down that all cases except the moribund should have a chance for treatment. It is a most wonderful thing how nature endows these cases with hope. Some patients fight indomitably, and contrary to expectations they get well. It is not pleasant to look back and consider the amount of opposition which was placed in the way of those who twenty-five years ago were endeavoring to help these distressed patients.

But what will you do with cavities? The post-mortem evidences of many morgues and dissecting rooms show unquestionably that cavities do heal over and patients live. I die of another complaint. My own wife showed three small cavities healed in the top of the left lung and two in the right. There was some fatty and calcareous degeneration going on in the base of the left lung; liver somewhat enlarged but normal in structure; no tuberculosis of stomach or bowels; heart normal in size and as to structure; yet all her symptoms for three years had been of heart exhaustion, needing the greatest of care and attention. Seven years before her death an eminent medical man stated that she had but three months to

live; if her appetite for beef foods, and in fact for practically all other foods, had not failed three years before her death, she would probably have lived to old age. Of great courage, good judgment, she in her weakness for many months travelled close to the verge of the grave. Of strong affections, her love for her dear ones kept her alive a long time; yet something in her nervous system broke down as to appetite, and her time eventually came.

It is cruel to take away from the very sick hope. There are many doctors of eminence and influence who literally are executioners because of their brutally taking away all hope. The passionate, anxious, eager holding on to life of the very sick is a matter of divine origin, and I do not propose to stand in the way of that divine gift of the desire for life.

Some patients die from money troubles. Others die from the long-continued opposition of their friends, relatives and medical men to treatment. It can be thankfully said that this opposition is dying out. Others die because they are associated in herds at the various resorts in the mountains of the South and West, and in sanatoria, seeing and hearing the consumptives all about them. Such suffer for the privileges of home. They have many comforts taken from them and are liable in going South, of getting into a blizzard and have to live in a shelter which is improperly made.

I wish to emphasize that the treatment of tuberculosis must depend upon the family physician. It should commence in infancy; the children should be properly fed and taught to avoid sweets and the vegetable foods which do not agree with them, and those who are so unfortunate as to break down with the disease must still be kept at home, or such change of air and climate made as can do good and no harm. There is no question that good air is a wonderful thing, yet we can buy oxygen and

force the air alimentation if necessary, in our cities.—*Jour. of Amer. Med. Assn.*

## A PLEA FOR THE MORE FREQUENT RESORT TO ANALYSIS OF THE STOMACH-CONTENTS FOR DIAGNOSTIC PURPOSES.

By BOARDMAN REED, M.D., of Philadelphia.

There are evidences on every hand of a recent awakening in the medical profession as to the importance of the newer and more exact methods in the diagnosis and treatment of the diseases of the gastro-intestinal tract. Yet these methods are still practically ignored by many physicians who would not think of neglecting to make chemical and microscopic examinations of the urine in obscure cases of chronic diseases, or to examine the sputum for the bacilli of tuberculosis in cases of stubborn cough.

Floating kidneys and dilated or displaced stomachs, which are easily discoverable now-a-days by expert diagnosticians without even the help of a tube,\* are still in innumerable cases the unsuspected cause of serious and prolonged ill-health; unrecognized aberrations of gastric secretion develop into chronic catarrhal inflammation of the stomach and intestines; and numbers of persons in every community go on suffering year after year with their so-called nervous dyspepsias or gastric and intestinal indigestions until the liver and kidneys finally break down under the enormously increased work imposed upon them in striving to rid the system of morbid products of fermentation and putrefaction.

\*"The Diagnosis of Changes in the Size, Position and Motility of the Stomach," etc., by Boardman Reed, M.D. *The Medical News*, January 18, 1895.

The exact nature, extent and tendency of abnormal functioning of the gastric glands can be detected at once by means of an analysis of the gastric contents after a test-meal, and when recognized early, the cure is usually prompt and certain. When the modern methods of precision are not called into requisition until at a late stage of the malady, the diagnosis only thus attainable may come too late to save the patient; or, if the disease be still curable, the treatment must often be prolonged over many months and sometimes years, when a few weeks would have sufficed in the beginning.

Of all the multifarious new appliances and procedures for the diagnosis and treatment of gastric and intestinal disorders, none is applicable to so large a number of diseased conditions, so generally helpful in diagnosis, so useful for guidance in treatment, and in short so indispensable to the conscientious physician as the test-meal, followed by a thorough examination of the gastric contents, chemically and microscopically.

The following are the most noteworthy of the gastric diseases and derangements the diagnosis of which is greatly aided (and often positively decided) by an analysis of the stomach-contents:

1. Deficient secretion of hydrochloric acid and the gastric ferments.
2. Excessive secretion of the same.
3. Deficiency or insufficiency in the motility or muscular power of the stomach.
4. Excess of the same.
5. Inflammation of the gastric mucous membrane.
6. Presence and degree of infection of the stomach by fermentation-exciting bacteria.
7. Atrophy of the gastric glands.
8. Carcinoma.
9. Ulcer.

1. One of the most frequent and practical uses of stomach-analysis is to decide as to the proper treatment in any case of obstinate dyspepsia or

obscure nervous derangement dependent, as such maladies so often are, upon impaired digestion and nutrition. When there is deficient secretion of hydrochloric acid, with or without deficiency in the secretion of the gastric ferments (hypopepsia of the French), the administration of hydrochloric acid as a medicine, even in small or quite moderate doses, usually prove highly beneficial. The gastric digestion is thus greatly improved, and, whether indirectly through the gain in nutrition or by a direct stimulation of the peptic glands, there is in the majority of such cases a gradual and often a rapid restoration of the secretion to the normal. In these conditions the usual medicinal tonics may serve as valuable adjuvants. There is evidence that at least many of them directly stimulate the gastric glands.

Another powerful auxiliary is massage of the abdomen. In a recent paper I have reported a number of cases showing the stimulant action of abdominal massage upon the gastric glands.\*

2. In the cases with the excessive secretion (hyperpepsia, hyperchlorhydria) all the remedies mentioned—hydrochloric acid administered internally, many tonics, and even abdominal massage unless extremely gentle, tend to aggravate the condition. Here an entirely different treatment, including alkalies in full doses and a very bland diet, is necessary.†

3 and 4. The relative muscular power of the stomach may be estimated from the amount of the test-breakfast remaining in the organ at the end of the hour, or in case of a

test-dinner, at the end of three hours. Lavage five or six hours after a mixed meal is also capable of giving much valuable information upon this point.

When there is motor insufficiency, intragastric faradization has proved one of the most valuable of the new therapeutic resources.

5, 6 and 7. The results of the chemical analysis, taken in connection with the macroscopic appearances and microscopic findings, are entirely conclusive as to the presence of inflammatory processes, microbial infection, and atrophy of the glands.

8. The opinion formerly held that the absence of free hydrochloric acid pointed to carcinoma, has long since been exploded, and we now know that in a majority of cases of chronic gastric catarrh at an advanced stage, free hydrochloric acid cannot be demonstrated in the stomach-contents at any time. Even the more recent claim of Boas that the presence of a notable proportion of lactic acid after a test-meal, from which bread and other milk-containing foods are excluded, is an absolute proof of carcinoma, has had to be modified. It is true, however, that whenever in addition to the symptoms usually referable to carcinoma of the stomach, there is a persistent absence of free hydrochloric acid and the persistent presence of a considerable quantity of lactic acid demonstrated under the careful conditions prescribed by Boas, we may with a reasonable degree of certainty diagnosticate that disease even before a tumor can be felt.

9. There is a prevalent impression that the mere suspicion of gastric ulcer should prevent the introduction of even the soft flexible tube for any purpose; but in the clinics of Ewald and Boas the tube is used continually in all ulcer-cases except those in which there has been a recent hæmorrhage, and no harm or inconvenience seems to result. It would be almost impossible to diagnosticate ulcer certainly without an analysis of

\* Important Indications and Contra-indications for Massage of the Abdomen, with Report of Cases Showing its Effect upon the Secretion of Hydrochloric Acid. *International Medical Magazine*, January, 1898.

† The Excessive Secretion of Hydrochloric Acid by the Stomach and its Possible Serious Consequences. *International Clinics*, vol. i, Seventh Series.

the stomach-contents, except in a case in which there is the characteristic pain accompanied by repeated free hæmorrhages in a person evidently well nourished and not at all cachectic. There are few things more constant in the science of medicine than a high percentage of hydrochloric acid as an accompaniment of gastric ulcer, though exceptions have been observed in cases of very long standing. Hence by means of gastric analysis we can always clear up at once any possible doubt as to the differential diagnosis between carcinoma and ulcer. There are not a few cases in which carcinoma develop in the site of a former ulcer, but even in these the history of a previous excess of hydrochloric acid, with its subsequent disappearance and the appearance of lactic acid, should usually be conclusive in connection with the other symptoms.

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#### THOUGHTS ON THE APPENDIX.\*

BY S. T. HARDISON, M.D.,  
Lewisburg, Tenn.

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For the last decade the mind of the medical world has been turned to the region of the appendix, and possibly no part of the body has been so often before the profession for attention, both medical and surgical. The professional gentleman who has not had numerous cases of appendicitis to treat has either been careless in his diagnoses and investigations, or has had a clientele that is far behind in medical fads and fancies. The increased frequency of troubles that involve the appendix, either primarily or secondarily, has caused much thought and many theories in regard to its treatment, both medical and surgical, conservative and radical.

Many learned men of wide experience have espoused the conservative course, but possibly a greater number favor prompt surgical interference. Quite a degree of success has been attained, and many are almost entitled to be called experts in its management and if failure to bring relief is the result, it is almost always attributable to the lateness of the operation. Indeed, some have advocated the removal of the appendix as a superfluous organ, a menace to health and comfort. Doubtless, this is a wise conclusion if it has no function to perform. When I mention the use of function of the appendix, I am aware of the fact that I am approaching a subject that not only has not been investigated, but one so unimportant and prospectively so barren and uninviting as to forbid investigation. Years have come and gone, medical students with scalpel in hand have carefully studied the anatomy of the appendix, and have often asked the question, What purpose do you serve in the mysterious make-up and mechanism of this creature so fearfully and wonderfully made? Up to the present moment no satisfactory answer has been returned. Some have suggested that it is a rudimentary appendage, and that possibly man in his early existence had different viscera from what he now has, and as his condition changed, his anatomic make-up changed to keep in harmony with his environments. Another theory is that the troublesome appendix is an accidental formation which never had any mission. I think that both these theories are unsatisfactory and humiliating, and without intent are a reflection on the wisdom, power and goodness of Him who not only doeth all things well, but who doeth all things perfectly. No imperfections can be attributed to Him. No accident can happen to mar His work. And man, the last, most wonderful and most exalted of all His creatures, could not come from His hands with

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\* Read at the meeting of the Middle Tennessee Medical Society, November 18, 1897.

defects and imperfections that are unknown to the make-up of His inferior creatures. Therefore, I must be permitted to emphasize the statement that the appendix is not a useless appendage, occupying its place without use or function; and while I may not be able to explain to you its function clearly and satisfactorily and demonstrate it beyond doubt or cavil, I do hope to encourage you to examine the matter, and not cast it aside as did the builders of the temple that stone that was to become the head of the corner, because we already know that the appendage often becomes an important tail on the corner.

Let us look for a moment at the anatomy of the parts. First, we have the valve at the termination of the ileum that prevents almost completely the regurgitation of the contents of the bowels. We have the cecum as a kind of receptacle or depot, and the ascending colon is indeed an elevator whose power to remove the accumulations in the cecum, opposed by gravitation when in the upright position, smaller diameter, depends alone upon peristaltic action, and the least failure on its part to do the work produces stoppage and accumulation in the cecum. Now we want more power. The colon, the elevator, is ready but no power to put it in motion. The accumulation increases so gradually that the cecum distends slowly until the imperfect valve of the appendix is open, and the contents of the cecum press in. Irritation and stimulation is the result producing contraction and expulsion. This irritation and stimulation is communicated to the cecum, and by its contraction the contents are forced up through the colon or elevator, and the depot is emptied and the appendix closes (if no grape seed or any other hard substance becomes entangled in its valve) and remains quiet and in a restful state, until there shall be a similar demand made on it, to assist in re-

moving undue accumulations in the cecum in a similar way. This would not be necessary if man did not maintain the upright position, hence no animals have an appendix except those that maintain an upright position, viz., the wombat, orang-outang and man. This is a strong circumstance in favor of the position taken. The appendix, like any other organ, has a limit to its capacity. If overworked and badly treated, it will break down and fail, and instead of performing its functions it will allow the contents to remain in it, producing inflammation resulting in gangrene, not only being destroyed itself but inviting destruction upon the whole body, upon the principle that a little leaven leaveneth the whole lump. This sacred adage has never been more forcibly illustrated than in the diffusibleness of a poison germ originating in or developing in the abdominal viscera.

Another potent factor that neutralizes the function of the appendix, is slow bowels or constipation exercising its influence by the damming-back process closing up the elevator or colon, increasing the demand on the appendix beyond its capacity until appendicitis is the result, and once developed it is almost sure to return. And as slow bowels have so alarmingly increased until constipation to a degree is almost the rule or natural condition of a majority of the people, this is an easy explanation as to why appendicitis has grown from a very rare affection to one of remarkable frequency. Therefore, it is not true that it has always existed to the extent that it does now, and was overlooked by our illustrious predecessors, for in all other things they proved themselves the equals of the present day of great and glorious workers in medical and scientific research. Man's habits have changed. In fact, the man himself has changed. He once had a large foot and a small head. He used a number ten shoe and a number six hat. He now wants a number

seven shoe and a number eight hat. There is less physical exercise and labor for him. There is more mental worry and work for him. He does not go to bed and sleep all night as did his fathers. He does not live on coarse laxative food that required much mastication, developed his teeth and strengthened all his digestive powers. Hence indigestion, constipation and appendicitis were unknown to our ancestors, and would be unknown to us if we had proper food rightly prepared, taken at proper intervals in necessary quantities, without hurtful stimulants and narcotics and all other things that have a tendency to retard digestion. Then let us not remove the appendix, but let it remain to perform its God-given function.

Let us relieve it and protect it. Take time to eat and time to sleep, and to do everything that is necessary to preserve and protect the body, and so far as this life is concerned all will be well.—*The Journal*.

#### PHTHISIS AND INSANITY.

The close relations of tuberculosis to insanity have been matters of observation and comment since the days of Esquirol and Georget and the other early alienists of the modern period. The fact that the mental symptoms of phthisis were notably characteristic had also been still longer a matter of common observation and naturally assisted in calling attention to these relations and suggested a direct connection between the two. When more recent clinical studies had shown that tuberculosis was not only exceedingly common in the insane, but that a hereditary tendency to the one was often associated or alternated with that to the other disorder the relations of the two became still more striking and suggestive.

In former times, not so very remote, the mortality from tuberculosis

among the insane exceeded that for almost any other complication; a distinguished French authority reckoned that at least one-third of the deaths were to be attributed to lung affections and usually to this one. Within very recent times, Clouston, who is certainly a good authority on this subject, estimates that while the mortality from this cause has been greatly reduced under the best conditions, the proportion of the insane in asylums who die from tubercular lung troubles is still three times as great as that of the average population outside. How much of this discrepancy is due to the general lowering of resistance to the disorder, to trophic debility from the as yet imperfectly understood brain abnormalities of the mental disorder and how much to the enforced sedentary life and to the congregation of the inmates, many of whom must be necessarily infected, is uncertain, but that both of these factors are in play is more than merely probable. Asylums or hospitals for the insane are almost inevitably overcrowded, at least that is true of the public ones; their inmates are notoriously neglectful of sanitary rules and even the utmost care by physicians and attendants can only partially compensate for these unavoidable drawbacks. Under such conditions it is only remarkable that in times past, before the infectious and contagious nature of phthisis was recognized, all our asylums were not perfect hotbeds of the disease, and that any other affections had a chance to figure to any extent in their mortality statistics. It is only within late years that special infirmary wards have been the rule or at least common in asylums; the consumptives are not yet commonly isolated; the prevention of the spread of the infection is seriously embarrassed by the mental conditions and habits of the patients, and yet ordinary attention enlightened by a better knowledge of the nature of the dis-

case, has probably reduced the mortality due to this cause by one-third or one-half. That in the former times of our ignorance the tuberculous death rate was no greater than it was and that even remarkable recoveries took place and post-mortems revealed in old chronic cases the cicatrices of cured tuberculosis, goes far to make one believe in a general comparative immunity or the non-malignancy of the infection. It has been proposed by some zealous sanitarian alienists to build isolation wards for consumptives apart from the ordinary wards of the infirmaries, and thus to stamp out or absolutely prevent the spread of the disease. Apart, however, from the reluctance of authorities to appropriate funds for what does not appear to them imperatively necessary, there is some question whether such provisions would be as effective as anticipated. Tuberculous disease is not as readily discoverable in the insane as in the sane; many of the characteristic symptoms are apt to be wanting, and the condition may be far advanced before recognition, even by a careful physician. Inasmuch as post-mortems show that one person in every four or five has been affected with tuberculosis at some time or other, it seems probable that such isolation wards would only receive the well-marked cases, while less obvious cases would be constantly received and circulating amongst the other patients. The possibility of infection may thus be still almost as great as ever, and probably even greater, from the false security preventing the watchful care on the part of those in immediate care of the patients not thus isolated. However desirable such accommodations may be, they are not an absolute security, and much can be done without them by the use of the ordinary sanitary precautions especially applicable to this disease.

Whether there is a special form of insanity caused by tuberculosis may

be questioned by some, but it appears to be the experience of alienists that a certain type of suspicious melancholia is most frequently associated with this disorder. In paretics also, with whom the delusions are so generally of an expansive nature, they are apt to take on a melancholic type when associated with consumption. The exact relations of the insanity and the tuberculosis are not altogether clear; the mental disorder usually, according to Clouston, antedates the other, but the latter can be often foretold by the character of the insanity. The prognosis of the mental disorder in these cases is not as good as when uncomplicated by phthisis, while the restoration of mental soundness is sometimes apparently facilitated by the lung disorder in cases of the expensive type of insanity. It would appear that this special depressive type of mental disease either particularly favored the outbreak of phthisis or that it itself was often an early symptom of latent tuberculosis. Whichever of these views is accepted, the fact of their apparent relations is interesting and suggestive, and the designation of phthisical insanity appears to be warranted in the classifications.

The fact of the so frequent common heredity of phthisis and insanity, already referred to, affords another ground for suspicion of their close relations. Clouston indeed believes that a combined heredity of the two is more perilous as regards the probability of either disease than the same of either one singly. That is, he holds that a person with one parent tuberculous and the other insane is more liable to both insanity and consumption than one who has both parents suffering from one of these two disorders.

As an evidence of the improvement that has taken place of late years in the asylum mortality from pulmonary tuberculosis, the statistics of seven American hospitals taken without special selection for a period of ten

years, from 1888 to 1897 inclusive, gave a mortality of 22 per cent. Taking out one of these with the highest mortality from this cause the percentage was 17. Six American hospitals similarly taken, of which only the figures for 1897 were available, gave a percentage of 13.7, while withdrawing one of these with the exceptional percentage of 57.69, the mortality from phthisis of the remaining five was only 9.4 per cent. of the total deaths. It seems entirely beyond question that tuberculosis, even under the comparatively unfavorable conditions afforded by the insane in hospitals as at present managed and equipped, is to a large extent a controllable disease—*Editorial of The Journal of The American Medical Association.*

### THE MODERN NOVELIST AND MEDICAL SUBJECTS.

Erroneous statements on medical subjects are very frequent in the modern novel, and appear to be becoming more so. Impossible and contradictory descriptions of the symptoms and course of a disease, together with a display of ignorance of medical matters in general, are a feature of up-to-date fiction. One would imagine in this age of realism that writers would try to be fairly accurate, or at least not make glaring mistakes. The latest literary production emanating from the fertile and imaginative brain of Mr. Hall Caine is a startling example of this slipshod tendency on the part of modern romancists. "The Christian" has raised a storm of criticism on all sides. Its accuracy as to details has been severely questioned, both from a lay and from a medical standpoint, and certainly the misstatements to be found in the work in respect to matters medical are extraordinary and amusing. The word pictures of hospital life and of a nurse's duties as portrayed in the description of Nurse

Glory, while exhibiting the author's powers of imagination in a favorable light, also tend to show that his real knowledge of the subject is very little. To one who is acquainted from practical experience with the internal management of large hospitals, the accounts of the doings therein set forth in "The Christian" will appear wonderfully funny. The entire book, indeed, is full of amusing perversions of medical knowledge, of which perhaps the most comical is Mr. Caine's definition of a stillborn child as one that has breathed but never cried.

The writer of fiction of the present day does not appear to advantage with many of the novelists of the past generation in his acquaintance and handling of medical subjects, although it must be confessed that even among the dead giants of romance there were but few whose description of a disease was absolutely correct. George Eliot is without doubt entitled to the first place on this list; her sketches of doctors and her statements in regard to the diseases of which she treats are drawn with a masterly hand, and are as accurate as if written for a medical text-book. Charles Kingsley, again, in "Two Years Ago," traces the history of a cholera epidemic with the utmost attention to technical minutiae. Thackeray also described the course of a malady as correctly as he did the treatment pursued by the physicians of his time. Of modern novelists, Besant, in the "Ivory Gate," gives an interesting study of an obscure brain disease, and as he informs us in the preface that he procured his medical information from a competent doctor, it may be taken for granted that his statements are correct. Putting on one side, however, the comparatively few instances in which the disease dealt with by novelists are to be depended upon as being correctly described, the majority of the medical statements in fiction can be divided into two classes: those in which the accounts of diseases given are false in every respect, and

those in which the author, not being *au fait* with his subject, is careful not to commit himself, and therefore wisely confines himself to vague generalities.

Another point worthy of notice is the small number of diseases brought into the service of the novelist. At one time brain fever was the universal favorite, with typhoid a good second, and although within recent years neurosis has, to a certain extent, banished brain fever from its proud position, yet the latter disease still holds its own in fiction. That nervous prostration is much more likely to attack the hero or heroine suffering from the storm and stress of life as depicted in the ordinary modern novel, than is brain fever cannot be denied. Nevertheless, there are occasions when an author, in order to extricate himself from a complicated situation, is compelled to fall back upon a disease of an acute nature; and in such a predicament what so suitable as brain fever, or what so convenient as its delirious ravings? The fact has been more than once pointed out that there is a disease which has been strangely overlooked, and which certainly deserves to find more favor in the eyes of the novelists than has hitherto been the case. This complaint is pneumonia, for while it fulfils all the conditions required by the novelist, and to a fuller extent than brain fever, it has none of the disagreeable associations connected with typhoid. Pneumonia may be termed an aristocratic disease, while typhoid, though no respecter of persons, still has a certain plebeian flavor savoring of foul-smelling drains and tainted water. In novels acute diseases invariably end suddenly. Pneumonia terminates by crisis; the onset of the attack is sudden, the temperature is always high; delirium, stupor, or complete unconsciousness is a feature in its progress. Thus in this disease there is a choice of dramatic climax found in no other malady. A wicked man can be cut off in the midst of his

sins, or a good one can be made to provide an edifying death-bed scene. Pneumonia may be recommended to authors as a disease whose merits as an aid to fiction have not as yet received the appreciation from them which is undoubtedly its due. Consumption is a disease of such a nature that most novelists fight shy of it and are very chary of relating its tedious course. William D. Howells, in his latest work, has been bold enough to introduce a family all of whose members but one are afflicted with phthisis; and Gilbert Parker, in an interesting book he has lately written, has succeeded in rendering his consumptive hero a most fascinating and attractive personality. In connection with consumption in fiction it is instructive under the present circumstances to note that Smollett, more than one hundred and fifty years ago, draws attention in "The Expedition of Humphry Clinker" to the prevailing opinion then existing that consumption was contagious. Heart disease is naturally a favorite with writers of romance when a character gets rather too obtrusive and it is deemed advisable to remove her or him from the scene. Marion Crawford, in a "Rose of Yesterday," has drawn a graphic picture of the life and death of a fast man; but the most powerful sketch of the stages of syphilis was that of Samuel Warren, entitled "Man about Town," included in his "Diary of a Late Physician." In present and past fiction too many examples have been afforded of the manner in which eminent writers can err when they enter upon descriptions of technical matters without taking the trouble to verify their statements. It cannot be expected of a novelist, however talented he may be, that he should be conversant with a disease by mere intuition, and if he trusts to his imagination and to some superficial observation he will surely fall into grievous errors. When an author is distrustful of his medical knowledge, he should follow in the foot-

steps of the great masters of his craft, and either, like Dickens, touch upon such matters vaguely, or, better still, like Thackeray or George Eliot, obtain his information at first hand.—*N. Y. Med. Record.*

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### THE MEDICAL INSPECTION OF SCHOOL CHILDREN.

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In the *Med. Review* appears a report on a proposed medical examination of school children of this city; also a paper by a well-known hygienist and originator of this movement, Dr. George Homan. The report consists of resolutions which were introduced by the undersigned committee at the annual meeting of the City Hospital Medical Society, held December 16, 1897. The resolutions, which were adopted by the society, owe their origin to the propositions embodied in Dr. Homan's paper. There can not be the slightest doubt in the mind of anybody that is familiar with hygienic matters, that the idea upon which Dr. Homan's paper and the resolutions, adopted by the Society, are based, is a most excellent and practical one. Moreover, what is proposed in the resolutions has been subjected to a practical test with most gratifying results in the city of Boston. It is an unquestionable fact that it often happens that children are sent to school when they are ailing and when they should be at home and under medical supervision. But it is not only for the best interests of sick children, but also for the protection of their healthy comrades at school and everybody with whom they directly or indirectly come in contact while they go to and come from school, that a medical inspection of such children as are pointed out by their teachers as ailing and requiring a medical examination, is of the utmost practical importance.

The isolation of sick school children, which is proposed by Dr. Homan and

approved by the City Hospital Medical Society and, we might say, will be endorsed by the entire St. Louis medical profession, is a preventive measure of the greatest practical utility. While the great importance of medical inspection of school children as a preventive measure against the spread of disease would seem self-evident, the figures quoted in Dr. Homan's paper from statistics that were gathered in Boston, as well as the example which he cites from his own practice, must in themselves convince everybody of the great effectiveness of such inspection as regards the prevention of disease. If introduced into the public school system of this city and also in parochial schools, it will undoubtedly considerably help to prevent the dissemination of contagious diseases, and will also have the advantage that sick children who are in the earlier stages of a disease may receive prompter medical treatment, whereby, for instance, in the case of diphtheria, many a life would be saved which otherwise would be lost on account of the relatively advanced stage of the disease. To treat a disease from its beginning is also much more satisfactory to the medical attendants, for more cases will recover under their direction, and, as far as the general public is concerned, the medical inspection of school children, as proposed by Dr. Homan, will be a most excellent and necessary innovation in the school hygiene of this city. Whatever view may be taken of the matter, it is evident that it can only redound to the benefit of all concerned.—*Med. Rev. (St. Louis).*

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### HOW TO GET BOYS.

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The world, scientific and domestic, is a good deal excited over the boy and girl question, and waiting with intense interest the formula of Dr. Schenck, the great Vienna scientist, how the thing can be done. It seems

the question is really solved, but the distinguished scientist hesitates about putting the public in full possession of the facts, but lets them into the secret so far as to assure them that he himself is the father of six boys, all in a row, and that a distinguished archduke of Austria, who had been trying as only an archduke can try for nineteen years, to become the father of a boy, awoke one morning bright and early to find—with the help of the great scientist, whose instruction the archduchess had carefully followed—the boy had arrived. We are not yet in possession of how the thing was done, but we are led to believe that carefully selected nutrition was a most important factor.

Is it possible Dr. Schenck has found out the secret by which the queen bee controls the sex of the offspring? When she wishes to develop a male brood she lays unfertilized eggs. The eggs of a virgin queen and also of workers—which sometimes mysteriously possess the power of egg laying—always develop into males, or drones, as they are called. The fertile queen simply refrains from fertilizing an egg when she wishes to produce a drone.

This new idea of Dr. Schenck may not be more tenable than one which was launched upon the world during the second French Empire, and the following out of which, it is said, gave to France the Prince Imperial. A large stock-grower in Switzerland noticed that cows who went to the bull early in the heat, were seen to have heifers, while those which went to the bull late in the heat had bull calves. To test the matter he selected twenty cows, and sent them to the bull in the first stage of the heat and the result was twenty heifers. He also selected two cows and sent them to the bull near the termination of the heat and two bull calves was the result. From these facts he formulated the theory that a male could only come from a fully ripened ovum, say after the fifth or sixth day from the termination of

the menses, while previous to that time, and for two or three days before the menses, the result would be a female. In many years' observation we have noticed while there were very many exceptions to this rule, still it seemed that a correct solution of the mystery was somewhere along this line. Male and female children being born at the same birth would upset either theory as a whole, unless it could show that each conception was at a different date. The whole question seems to be but of slight importance, and if solved might be productive of more harm than good.—*The Medical Times.*

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#### ETHER AS AN ANÆSTHETIC IN LABOR.

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At the Sixth Congress of Russian Physicians, Dr. Bakoemsky related his experience with fifty-three women, in normal labor, to whom he administered anæsthetics. To forty-five he gave ether, and to eight chloroform. The investigations carried on partly by the aid of the tokodynamometer, and partly by other instruments of precision, showed that during the administration of ether the pulse and the respiration remained almost the same, and the contractile force of the uterus was increased; the duration of labor was shorter; in no instance was there albumin in the urine; the involution of the uterus seemed to progress more rapidly; in the newborn icterus was more rare; they lost less in weight during the first week. The experience with chloroform was not quite so favorable, as it somewhat slows the progress of labor. In conclusion, the author says that in ether we possess an ideal remedy to abolish the suffering in labor, and we should employ it much more frequently than we do. He is surprised that this agent is making such slow headway among physicians.—*The Medical Times.*

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No. 2

### THE RUSH FOR THE MEDICAL KLONDIKE.

That the medical profession should be overcrowded in the neighboring Republic is not to be wondered at, for degrees can be purchased at a trifling cost by the unscrupulous, and formal registration is only required in a few States. Even the *bona fide* medical man is only required to put in about twelve months' study—six months one winter and six months the next; and the examinations are then star chamber matters. For example, in one of the seaboard states each professor used to have, and I am told has still, a private class which costs those entering a matter of ten dollars; the advantage of entering into these private classes, besides the regular lectures by the same lecturers, being the guarantee (verbal) of the professor, who was also the examiner, that the student would pass in his particular subject. With a few exceptions most of the medical colleges of that country are managed upon this satisfactory and expansive money-making plan.

They manage these things differently in Ontario, fortunately, yet we suffer here quite as much, nevertheless, from overcrowding of the pro-

feSSION as they appear to in less favored localities where there are no barriers at all. The Medical Council has endeavored to make provisions against this overcrowding by raising new barriers, which incidentally tend to raise the standard of the profession. The true corrective is not to repel from the medical profession, but to attract to other walks of life, for it stands to reason that the higher the standard of the profession is raised, so much greater will be the honor of belonging to it; and the higher the honor of belonging to it is, the more will there be who will wish to enter it, for in these days, the difficulties with which any honorable calling is hedged about are so great that increasing time of study, or raising the percentage of examinations in one, are a very small matter to a man who amounts to anything, and we predict that while the Province continues to maintain its healthy tone, the higher the medical profession is raised the greater will the number of applicants become.

This will be very unfortunate. There are already about three times numerically as many physicians in

the Province as there is any necessity for. This one profession seems to hold out a certain undefinable attraction lacking in all others; and in spite of the fact, too, that the profession of medicine is not officially recognized at all. Indeed, it is an object of deliberate and constant insult in the army and navy of the Mother Country. In semi-official publications there are complete lists of the clergy and of the members of the law society, but the profession of medicine is entirely ignored, just as the barbers of the Province are. The highest honors of the church and the bar, moreover, are very impressive. There are no public honors for the medical profession. In the two professions mentioned, gradation rises above gradation, and culminates in a lordship in either case—the Lord Bishop or his Lordship the Judge. The medical profession has no visible or recognized gradations, and only those invisible ones which genius makes. But in spite of all these outward considerations there appears to be still a glamor about the medical profession which attracts to it the flower of the youthful intellect of the country. A possible remedy would be to render the legal profession more honorable or the ecclesiastical calling more dignified. Commerce and agriculture also lose constantly in much the same ratio as medicine gains, and the loss on the one hand is to be equally deplored with the gain on the other.

#### PROPOSED ACADEMY OF MEDICINE.

The establishment of an Academy of Medicine is again being talked of by the medical men of Toronto. The subject was up for discussion two or three years ago, committees appointed, meetings called, but the scheme was turned down. Since that time some of our men, on invitation, have visited Buffalo's Academy of Medicine, and are loud in its praises,

and ask, Why cannot there be such an academy in Toronto. The advocates of the academy idea say, why the need of so many separate societies, with so many sets of officers, so many different places and times of meeting, and so many different fees? (For some of us belong to all.) Why not federate the various existing societies, have one set of officers, one place of meeting, one set of by-laws, and one fee?

Now, this would appear easy, but there will be some difficulty in carrying it out, owing to the existence of certain opposition of a factionary or personal nature. Until this dies out (it is dying out) we fear any effort to unite the various societies into one will not result in that much-desired result.

#### THE COUNCIL.

We publish in another column "Mentor's" letter. Notwithstanding the mistakes of the Council since its inauguration, and no one will deny that there have been mistakes made, yet we believe firmly in the great good the Medical Council has done since its establishment. In no place in the world are there so few quacks. No country has a more honorable body of practitioners. None (with few exceptions) but good and worthy men are allowed into the profession. The desire of any medical college to let men "slide through" unqualified for the sake of fees is reduced to a minimum. The territorial representation has been better adjusted than formerly. The affairs of the profession in relation to the State are being well attended to, and the interests of the profession, in most respects, well guarded. We think every man, therefore, should not object to the small mite of two dollars towards the maintenance of an institution the existence of which every level-headed man in the profession approves, and the demolition of which would usher in

such a reign of unprofessionalism, fakirism, overcrowding, and other deplorable evils. Let us have the Council. Let its members be judicious in its management. Let us keep our fees paid up.

### EDITORIAL NOTES.

THE American Medical Association meets in Denver, June 6th and 7th. A number of Canadian medical men are already planning to go.

AT the last meeting of the Lambton Medical Association, Dr. John Dunfield, of Petrolia, was elected president for the coming society year.

DR. H. D. FRASER, of Orangeville, died suddenly, on February 16th, of heart failure. He was in good health up to the time of his death, but had been overworked for some weeks. He lay down to rest before supper, and when they went to call him he was dead. He was forty years of age, and leaves a widow and three children.

DR. JOHN CRONYN, one of Buffalo's best known physicians, died on February 11th. He was born in Ireland in 1825 and emigrated to Toronto in 1837. He took up the study of medicine and in 1852 obtained the degree of M.D. from Toronto University. He moved to Buffalo in 1859. At the time of his death Dr. Cronyn was an honorary member of the Ontario Medical Association.

THE Executive Board of the International Association of Railway Surgeons met in Chicago on January 24th, with Dr. A. I. Bouffleur, of Chicago, chairman, presiding. Dr. Bruce L. Riordan proposed that the dates for the next meeting, which is to be held in Toronto, be July 6, 7 and 8 this year. This was adopted. The prospects are that the meeting will be one of the largest in the history of this important association,

which has a large membership in United States, Canada and Mexico.

THE Ontario Medical Association meets in Toronto, on the first two days of June this year, under the presidency of Dr. William Britton. The following committee on Papers and Business has been chosen: A. McPhedran, Albert A. Macdonald, T. F. MacMahon, L. M. Sweetnam, J. L. Davison, of Toronto; John L. Bray, Chatham; J. W. S. McCullough, Alliston; E. E. Kitchen, St. George; R. W. Garratt, Kingston; John Philp, Hamilton. This committee has already begun work. A good meeting is assured.

PROPOSED ACADEMY OF MEDICINE.—A number of prominent city physicians are taking steps to bring about the formation of an academy of medicine, similar to those existing in New York and Buffalo. The organization, when completed, will consist of the amalgamated medical societies of Toronto. Those societies interested in this movement are Toronto Medical Society, Toronto Clinical Society, Toronto Pathological Society and Toronto Medical Library Association. Committees are being formed and the details are being awaited by the professional men with much interest.

HAMILTON citizens, who so generously provided the furnishings of the seventeen private wards of the Jubilee wing of the City Hospital, were tendered a reception on the afternoon of February 21st by the governors. There was a large gathering of ladies present. The visitors were received by Chairman Roach, the Mayor, Ald. Carscallen and Dr. Edgar and the staff. Among medical men noticed were: Drs. McGillivray, Olmstead, O'Reilly, Metherele, Rosebrugh, Cockburn, etc. The guests, who were taken over the building, were delighted with the bright and comfortable appearance of the rooms. Supt. Edgar claims the wing to be equal to any in Canada or the United States.

## Obituary

### THE LATE GEORGE McNAIRN SHAW.

On Sunday the sixteenth of January, the medical fraternity suffered a severe loss by the death of the late George McNairn Shaw, one of the best known and most highly respected physicians in the city of Hamilton.

Death resulted from pneumonia after an illness of only three days. The physicians in attendance were Drs. Mullin and Malloch, Hamilton, with Dr. James Thorburn, of Toronto, called in consultation.

It may be truly said that the doctor sacrificed himself to his profession, as he contracted the disease which so quickly caused his death whilst responding to a call to attend a suffering woman,

whose family physician could not be secured at two o'clock on the Tuesday morning previous to his death. He was not feeling well at the time and was urged not to go, but he went, feeling that it was his duty. Upon his return he was seized with a chill, and took to his bed from which he never arose.

The deceased was only 47 years of age. He was born at Woodburn, in the County of Wentworth. After passing through the high school he went to the Toronto School of Medicine, from which he graduated with

honors, winning the silver medal. He then took his degrees in the University of Toronto and commenced practising in Queenston about the year 1875. In three years he worked up a large practice; but, preferring city life, he came to Hamilton where he practised successfully for the past twenty years.

Amongst the many positions held by the late doctor might be mentioned that of representative of the Hamilton District on the Council of the College of Physicians and Surgeons of Ontario, Physician to the Boys' Home, which post he held from the time he came to Hamilton; a member of the Collegiate Institute Board, representing the City Council thereon; Consulting Physician to several large insurance



THE LATE GEORGE McNAIRN SHAW

companies, and at one time a member of the staff of the Hamilton City Hospital.

Shortly after coming to Hamilton, the deceased married Isabel Thorburn, the eldest daughter of Mr. John Symons, of Toronto, and she and four children survive him.

The deceased was of a quiet and retiring disposition, and was devoted to his family and profession. Among his patients the doctor was looked upon not only as a learned and skillful physician but as a friend, and with them he was exceedingly popular.

The funeral took place on the Wednesday following the death and was very largely attended not only by the medical fraternity of Hamilton and Toronto, but by citizens generally.

The pall-bearers were, Drs. Graham, Toronto; White, Mackelcan, Woolverton, Russell and David Thompson, Hamilton. The remains were taken to the Church of the Ascension where a service was conducted by the Rev. W. H. Wade and Rev. F. E. Howitt, and afterwards to the place of interment in the Hamilton Cemetery.

Amongst the medical men present from Toronto were: Dr. Thorburn, President College Physicians and Surgeons of Ontario; Dr. R. A. Pyne, Registrar of same. Dr. Reeve, Dean of University of Toronto, Medical Department; Dr. Graham, Prof. University of Toronto; Dr. B. L. Riordan, Surg. G. T. R.; Dr. J. D. Thorburn, Dr. C. O'Reilly, Pres. Toronto General Hospital; Dr. Adam Wright, Toronto University; Dr. Britton, Member Toronto University Medical Council; Dr. Herner Mullen, Staff of General Hospital; and also Dr. W. W. Thompson, of Niagara Falls South.

#### DR. JAS. H. BURNS.

It is a matter of personal regret for us to write, as it was for our readers to hear, of the sudden death of Dr. Burns at his home in the city of Toronto. Dr. Burns was a model physician. With

a high degree of skill and good judgment he combined so much geniality and sympathy that he was not only trusted but loved by his patients and friends.

Dr. Burns' native place was Oshawa, where his early years were spent. He was a student at Upper Canada College; later he studied medicine at the University of Toronto, where he received his degree at the age of 21. This was about the time of the Fenian trouble, and deceased gentleman acted

as assistant surgeon to Colonel Denison's provisional regiment. He was the attendant of many a wounded man at Ridgeway.

After the raid was over he went to Collingwood, where splendid success attended him during some ten years. His next move was to Toronto in 1876, where he remained until called away. He served for several years on the Medical Council, and in 1888 was its president. At

the recent contest for the Western Territorial Division of Toronto, he was elected to serve again; but two hours after, he was dead.

After an attack of La Grippe some years ago, Dr. Burns had, we understand, certain cardiac seizures resembling angina pectoris. There were some signs of cardio vascular changes, but no marked objective signs were noted.

He was on the staffs of the General and St. John's Hospitals, was a member of Toronto Clinical Society and Ontario Medical Association.



THE LATE DR. JAS. H. BURNS

## The Physician Himself.

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DR. J. H. ELLIOTT, of Toronto, has been appointed physician at the Gravenhurst Sanitarium.

WE regret to announce the death of Dr. Fraser, of Orangeville, which occurred so suddenly last week.

Ye Editor, DR. BEATTIE NESBITT, has returned to the Johns Hopkins Hospital for a couple of months.

DR. THOS. WHITELAW, B.A., of Guelph, is turning to the wild and woolly west. He will hang out his shingle at Edmonton.

DR. J. W. S. McCULLOUGH, of Alliston, was appointed President of the Simcoe Medical Association for the coming year at the last meeting. Under his live direction we hope to see the northern society prosper.

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## Correspondence.

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To the Editor of DOMINION MEDICAL MONTHLY:

SIR,—Surely the reluctance seen in some quarters to pay the annual dues expected by the Ontario Medical Council is hardly reasonable. The dues are much higher in the Ontario Law Society, and the privileges are quite identical. The Law Society has a building, so has the Medical Council. The Law Society has a very extensive and valuable library, open to all its members, and in constant use by the majority of them; so has the Council. The Law Society protects the legal profession; even so the Medical Council protects the medical profession.

The buildings of the Medical Council are, to say the least, a triumph of financial acumen. The medical profession, especially outside the city, could hardly exist without these buildings, so urgent and constant a need do they fulfil. These buildings are also a copious source of profit to the College, thanks to the unselfish prudence of the Council representatives who planned their construction and put the matter through. The profession owe a great deal to their Council, and it hardly needs pointing out that the Council richly deserve this profound debt—of gratitude.

These unselfish representatives,

with a purity of soul never observed outside the medical profession, do not make their Council membership a means to their own personal advantage, but with an altruism most exalted give up their time and energies eagerly to the correction of abuses in the profession.

We said abuses carelessly. There were abuses. For example, there was once a back door entrance to the College. Now no one can possibly register, no matter who he may be, without a special examination. There is not a single exception to this rule—mentioned. Advertising, of the modern æsthetic variety, that partakes rather of the nature of literary biography, has also been suppressed—in the dailies—by the editors of the same. Neither are there any quacks now, robbing the worthy venereal specialist of his just prey. The question of Lodge practice has been very properly left entirely to the delicacy of the individual members of the profession. Indeed, some medical practitioners are most exceedingly delicate (and sensitive) upon all ethical points—which affect others. The ophthalmologist is now undisturbed by unlicensed doctors of refraction, who, if allowed to survive, would prove even a greater peril to the public than to the profession. In these halcyon

days, too, the blatant professional rogues have been ably handled by the Medical Council. Hypnotic fakirs, also, and other charlatans have been brought to condign punishment.

In American cities where they have no license law at all, and where the profession is not under the virile protection of a Medical Council such as ours, such abuses as these which we have just mentioned exist, but there

are none of these evils in Ontario. The Medical Council's excuse for being in existence is that it should protect the public, as well as the profession, from imposture and abuse, and to the extent that it has compassed this it is deserving of its revenues. We have seen what the Council has done. Magnificently, Possibly it will do more.

Yours, etc.,

MENTOR.

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## Physician's Library.

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*Transactions of the British Orthopaedic Society.* Vol. II. Session, 1896. London: John Bale, Sons & Dainelsson. 1897.

*Saw Palmetto.* Its history, botany, chemistry, pharmacology, provings, clinical experience and therapeutical applications. By E. M. HALE. Philadelphia: Bœricke & Tafel.

*A Modern Pathological and Therapeutical Study of Rheumatism, Gout, Rheumatoid Arthritis and Allied Affections.* By E. L. GROS, M.D. Morrison print, New York, 1897.

*Outlines of Rural Hygiene.* For physicians, students and sanitarians. By HARVEY B. BASHORE, M.D., Inspector for the State Board of Health of Pennsylvania. With an appendix on "The Normal Distribution of Chlorine," by PROF. HERBERT E. SMITH, of Yale University. Illustrated with twenty engravings. 5½ x 8 inches. Pages vi-84. Extra cloth, 75 cents net. The F. A. Davis Co., publishers, 1914-16 Cherry Street, Philadelphia; 117 W. Forty-second Street, New York City; 9 Lakeside Building, 218-220 S. Clark Street, Chicago, Ill.

The country practitioner, especially the M. H. O., will find the book useful. This little book calls attention to a neglected subject, hence it is worthy of distribution. It deals

with cisterns, rivers, lakes, springs the examination of wells and well-water, excreta, slops, garbage and the various soils. There are some especially good points on, and illustrations of, various privy closets.

*The International Medical Annual, 1898.* A work of reference for medical practitioners. New York: E. B. Treat & Co., publishers, 241-243 W. 23rd St.

The *Annual* for 1898 will contain many special articles of great interest—in addition to the regular summaries of the year's work in medicine and surgery, by thirty-eight editors, each contributing to the department with which he is specially identified. Among the special articles will be found one on "The Chief Pathogenic Bacteria in the Human Subject," with descriptions of their morphology and methods of microscopical examination, by S. G. Shattock, F.R.C.S., the Pathological Curator of the Museum of the Royal College of Surgeons, London, illustrated by a series of ten finely colored plates; two contributions by Drs. Robert Jones, F.R.C.S., and A. H. Turby, M.S., on "The Obliteration of the Deformity in Pott's Disease," and on "Congenital Dislocation of the Hip," showing the technique in each case; both are freely illustrated, chiefly by reproductions from photographs.

*Elements of Latin.* For students of medicine and pharmacy. By GEO. D. CROTHERS, A.M., M.D., teacher of Latin and Greek in the St. Joseph (Mo.) High School; formerly Professor of Latin and Greek in the University of Omaha, and Hiram H. Bice, A.M., instructor in Latin and Greek in the Boys' High School of New York City. 5¼ x 7½ inches. Pages xii-242. Flexible cloth, \$1.25 net. The F. A. Davis Co., publishers, 1914-16 Cherry Street, Philadelphia; 117 W. Forty-second Street, New York City; 9 Lakeside Building, 218-220 S. Clark Street, Chicago, Ill.

The authors quote: "Half the difficulty of anatomy is inherent, the other half wordiness. The trouble with the student is more in the names of things than in the things themselves. He mistakes the one for the other, his head swims, and then he founders in a Latin storm at sea." They begin with the declension of tinctura, and before long the embryonic medico is construing *laminae spongiosae sunt in fossa nasi*. A list of Latin subscriptions is given and notes explanatory of the various technical terms used in the work.

*Orthopedic Surgery.* By JAMES E. MOORE, M.D. With 177 illustrations; 354 pages. Philadelphia: W. B. Saunders, 925 Walnut Street. Toronto: J. A. Carveth & Co. Price \$2.50.

This text-book gives a clear, concise and practical exposition of orthopedics. Besides the direct emphasis on the essential features of the subject, there are numerous pictures which gives the reader a fine idea of the appearance of the deformity, and of the gymnastic attitudes, or of the applied apparatus, etc., as the case may be. We have read with especial pleasure his discussion on scoliosis, talipes, Pott's and hip disease, and like the level-headed view he generally takes. Two features of the work are noteworthy: the simplicity of the

various measures the author adopts in the way of treatment, such as the general practitioner may carry out quite readily; and the aim he has had in view of maintaining that desirable middle ground, as he confesses in the prefatory note, between the surgeon who operates too frequently and the orthopedist who seldom operates, believing that in this branch of surgery, as in everything else, the best is not to be found in the extremes.

THE Problems of City Populations in *Appletons' Popular Science Monthly* for March, is the title of the concluding chapter of Professor RIPLEY'S papers on the Racial Geography of Europe. The long series of articles which this brings to a close forms probably the most important contribution to general ethnology which has appeared during recent years. They were the Lowell Institute lectures of 1896, and are promised to the public in book form in the near future.

#### NEW BOOKS FOR 1898.

"Pozzi System of Gynæcology." Third edition. Revised by Dr. John D. Hartley.

The following books are in press and will soon be issued by the publishers, J. B. Flint & Co., 104 Fulton Street, New York.

"Flint's Encyclopædia of Medicine and Surgery." Second (1898) edition, 1555 pages, revised with the assistance of fifty-six contributors and thoroughly in line with recent advances in medical science. Cloth \$5, leather or half mor. \$6.

"Hartley-Auvard System of Obstetrics." Third (1898) edition, 436 pages, 543 illustrations. Revised by Dr. John D. Hartley. This work is essentially Auvard, and embodies the author's personal experience, the text is clearly pictured by hundreds of original drawings to be found in no other book. Cloth \$4, leather or half mor. \$5.