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THE  
**Maritime Medical News**

A MONTHLY JOURNAL OF  
**MEDICINE AND SURGERY.**

Vol. XIII.

HALIFAX, NOVA SCOTIA, MARCH, 1901.

No. 3

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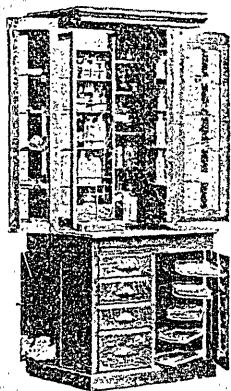
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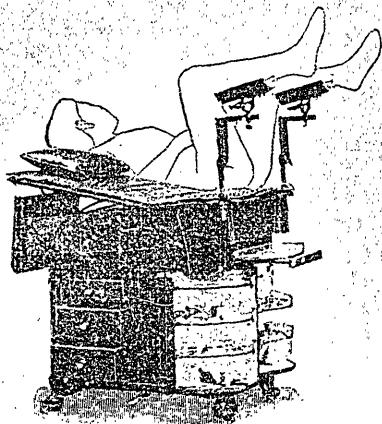


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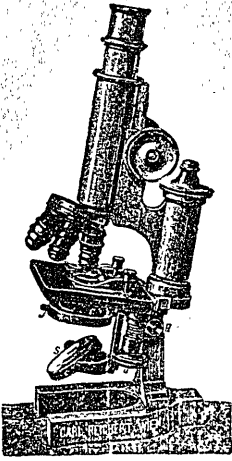
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A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

EDITORS.

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CONTENTS FOR MARCH, 1901.

ORIGINAL COMMUNICATIONS.

Troubles of the Cornea.— J. Robertson  
McIntosh..... 73

CLINICAL REPORTS.

Abdominal Hysterectomy for Fibroid  
Uterus.—A. Laphorn Smith ..... 80  
Diphtheria—William D. Finn..... 82

RETROSPECT DEPARTMENT.

Treatment of Simple Fractures..... 84

EDITORIAL.

Spinal Anesthesia ..... 89  
Report of Sanatorium Commission .... 91  
Editorial Notes..... 94

SOCIETY MEETINGS.

Tuberculosis Conference ..... 96  
St. John Medical Society..... 99  
Nova Scotia Branch British Medical Association..... 101

OBITUARY.

Dr. James R. DeWolf ..... 104  
Hon. W. J. Almon, M. D. .... 105  
Dr. Thomas E. Chase..... 109

BOOK REVIEWS..... 110

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VOL. XIII.

HALIFAX, N. S., MARCH, 1901.

No. 3

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**Original Communications.**

**TROUBLES OF THE CORNEA.\***

By J. ROBERTSON McINTOSH, M. D., St. John, N. B.

(After some general introductory remarks the author proceeded to consider the cornea—and more particularly its commoner diseases, in a general way—saying.) The cornea is part of the eye, and might be thought to belong to the oculist, but he is not the only one who makes good or bad attempts to rectify its troubles or cure its diseases.

Most of you know or have heard of the virtues of the picker and his sharp pointed knife in stone works and machine shops—and I am willing to admit that much that he does is well done—unfortunately, however, at times he does not know when to stop, and goes digging away to remove a certain amount of iron rust stain which it would be much better for the sufferer if he were to leave alone. It is, however, at home that we see the more efficient injuries to corneas produced. Here the head of the house, generally the wife, is all powerful with her poultice to get the inflammation out, and the fact that matter commences to come is, I suppose, proof to her scientific mind that she has succeeded in her efforts.

The great majority of people now, however, are beginning to recognize that they might not be successful in treating their own or their neighbours' eyes, and seek medical advice as soon as their eyes inflame or their sight begins to deteriorate; and I thought that in the consider-

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\*Read before the St. John Medical Society, December 5th, 1900.

ation of the cornea we would have a subject in which we all took a more than ordinary interest as cases implicating it are constantly coming under the observation of each one of us.

In examining a cornea it is necessary to have a good light, a good condensing lens, and for fine work a magnifying glass as well, as frequently the fine particles that may blow into the eye on a windy day and become ground into the cornea may so nearly resemble the back ground of the iris in color as to reveal their presence only to the sufferer, unless we have a glass to magnify and distinctly focus them. The majority, however, of such foreign bodies as gain entrance in this way are sufficiently distinct to be readily recognized, and having got fixed under the upper lid are readily removed by a camel's hair brush or some other soft pointed article. But when the foreign body strikes with more force it is apt to become embedded in the cornea where it strikes, or even to pass through its entire substance into the interior of the eye. If it is on the surface, it can as a rule, be fairly easily removed by patience, even if it is a friable substance like gunpowder. The main point is to stop at the right time and not go picking on in our endeavours to get out what is simply a stain of iron rust or burnt charcoal, and in so doing dig either so deeply or widely as to leave what is practically a large ulcer to heal as best it may, and have a correspondingly large white opacity to obscure vision for time to come. After removing foreign bodies we should always wash out the eye with a mild antiseptic, like boric acid. Put in a little vaseline or something of that nature to keep the eyelid from rubbing over the roughened surface, tie the eye up, and by the next morning it will be found comfortable and free of all likely chance of becoming infected.

*Burns* from caustic or molten metal are serious on all occasions—not only from the destruction they cause at the time to the cornea, but from the subsequent disorganization of tissue that often follows at a remote period, while the cicatrization that follows is quite as disfiguring here as elsewhere if not more so. What is chiefly soothing to the patient is a soft bed on which the lids may rest to keep them from rubbing on the injured cornea, and sterilized vaseline to which atropine and a little cocaine has been added is the best means I know of to attain that result.

If there is one thing the eye of a child is liable to, it is a *little ulcer*. If there is one thing that that ulcer tends to do it is to get worse—not better—it wants to spread all over the cornea and make what

looks like miniature macadamized roads, all of which tend from the periphery to the centre of the cornea, where they end. They never grow outward towards the periphery. These little phlyctenules, as they are called, generally begin just outside the corneal margin, in the conjunctiva—beginning as a small papule they may be for a time pustular but soon they grow somewhat smaller and seem to move toward the cornea which they invade, and as they advance inwards leave a leash of vessels behind them and later a whitened streak, which is simply an opaque scar and nothing more, not only rendering the vision imperfect through that part of the cornea but also destroying the corneal surface for some distance on either side and in this way further impairing the sight. It is needless for me to tell you what we can all read in books—that such patients are generally of the debilitated class—are often getting over measles when these things first make their appearance, that they often have a nasal catarrh, that the ulcers are influenced by climate, being especially bad in warm and moist weather it is said. What is more to the point is that such patients suffer pain, tears are continually running down their cheeks, they have a great—a remarkable intolerance of light, and keep their eyelids firmly closed the whole time, so much so that we can only with difficulty get a look at the eye under compulsion and forcibly separating the lids by retractors.

This series of symptoms, however, occurring in a young child is almost enough to guide us even if it were not necessary to see the eyeball, but we have to get at them somehow to treat them, and it is best to have our remedies at hand so that after seeing we are right we can apply such treatment at the time as we think fit. Bad cases one has to handle as he would a baby with ophthalmia; with a towel on the surgeon's knees you get the mother to lay the child on its back so that the head rests on the towel and the mother holds the body and hands of the child, and so with the help of a retractor you can soon get a glimpse of the eyeball. What I would desire to impress however, is that this disease should never be allowed to get to this climax. It is a fact that it rarely causes such complete blindness, is only apt to follow small-pox or ophthalmia neonatorum, but, on the other hand, it is the cause of a considerable amount of defective vision by the scarring of the cornea, the whitish opaque patches, the irregularities on the surface of the cornea and the consequent astigmatism for which glasses do little if any good.

The disease in its early stages is most amenable to treatment, and the treatment is simple—all the more reason then that it should be attended to. If the cornea has not been involved, a little yellow ointment put on twice a day will soon cure the trouble—it will be well in a week; it is then the mistake is likely to be made. The disease is the most prone to relapse of any I know of, therefore keep up your yellow ointment—keep it up for three months or more putting a little on every night at bed time and you will have no more trouble. That is the basis of the whole treatment locally, that and fresh air—out all day long with no bandages over the eyes. If the patient is anæmic or has tubercular or other tendencies, appropriate internal medicine may also be given, of course to suit his case.

If the ulcer has spread and involved the cornea it is more troublesome, it is then we get the pain, photophobia, lachrymation and blepharospasm, all due, so it is said, to the direct irritation or exposure of the corneal nerves in the ulcer and the greater amount of infiltration which follows their course. Here what are we to do? The same treatment, plus atropine to soothe the irritated and inflamed cornea, and a pair of goggles as a shade to keep off the light. The good result will come like magic. You will wonder at it how a tissue without a blood-vessel in it will naturally change for the better so quickly, but it does—of course the scarring will be left behind just in proportion as the disease has advanced. The constant use of the simple yellow ointment alone used over a considerable period along with a limited amount of friction or massage after the inflammatory symptoms have subsided is of material use in removing the slighter forms of opacity, especially in younger persons. In adults however more particularly if the scarring is at all bad, little or no result is to be attained.

There are other forms of ulcers and diseases which trouble the cornea in childhood, but this is the all important one. Let us now step to adult life. Here we see two classes of ulcer, one coming as the result of some local or systemic disease as a general thing, the other the traumatic—the result of violence from without. The former class of ulcer of adult life may occur anywhere on the surface of the cornea; it does not tend to spread towards the centre particularly; it may if given a decent chance tend to get better of its own account; it may be sluggish and indolent and neither increase or decrease in size, *but it is most likely to increase*, and it does so in any direction, superficially or

deeply or making a tour around the margin of the cornea, as it often does in the aged and debilitated, forming a deep groove whereby the nutrition of the cornea is greatly impaired and its entire destruction likely to follow.

All of these different kinds of ulcers which have distinctive names applied to them have certain general features and symptoms in common:

1st.—They cause temporary, and may be, permanent impairment of vision in relation to their size, situation and amount of fibrous opacity they leave behind them.

2nd.—There is pain of a greater or less extent in all cases.

3rd.—There is pericorneal injection in all cases—greatest near the site of the ulcer.

4th.—More or less photophobia and tearing, according as the patient or the ulcer may tend to be nervous or irritable.

5th.—In severe cases a tendency for the spreading of the inflammatory trouble to the iris or ciliary region.

6th.—In all cases a certain varying amount of discharge from the conjunctival sac and ulcer itself.

Such are the indications we have in most cases to meet and treat. In most cases there is a tendency to irritability—to pain and congestion which we must soothe and not aggravate. This we do by regular cleansing of the conjunctival sac, the application of hot fomentations, and the use of atropine. In doing this we do much more than what we aimed at, for under such conditions absorption is promoted, healthy healing of the ulcer is excited and the eye is put at complete rest by mydriasis produced. These with fresh air and a pair of dark glasses is often all that is wanted to insure a happy result. Sometimes we find an ulcer is indolent—wants stirring up. That is a time when our yellow oxide of mercury may be added to the atropine, and so with something like the following :

Hyd. Ox Flav. gr. iv.  
Atrop. Sulph. gr. ii.  
Vaselini Alb.  $\frac{5}{8}$  i

the great majority of our remaining cases are brought to a happy termination.

Even yet however there may be stubborn cases—cases which get a little better and then relapse again.

If we have omitted before to notice that the patient has granular lids or ingrown eyelashes, or has a marked anæmia, or strong rheumatic tendencies, or keeps on working—may be under unfavor-



able circumstances of air, or light or dust abroad, and an indigestible or deficient diet at home—or carries out your line of treatment according to his own light or his own ideas, then it is time to have the matter rectified if possible in the hope of a more favorable termination than is apparent at present.

But there still remains a distinct class—a remainder we may call it, but a serious one. These ulcers may become infected from some source. You may notice the eye begins to be undermined by a yellowish looking material—discharge and pain increase rapidly. The pain spreads all over that side of the head and a sleepless night follows. The dreaded hypopyon is at hand and soon we can see the thick gelatinous lymph beginning to accumulate in the lower part of the anterior chamber. What has caused it? Possibly a purulent conjunctivitis; may be an obstructed tear duct has caused accumulation of pus in the lachrymal sac; may be the infection has come up through a quite patent tear-duct from a fetid nose. Did you ever think how careless the patient is after putting the ointment in his eye with a camel's hair brush to lay it down on the dusty mantle-shelf or other convenient place equally dirty? Of course we should anticipate such troubles when we can, but this is not always possible.

Supposing such a case to come to us—I do not intend to take you through the whole category of treatments and cures that are advocated—what are the essentials? Cleanliness of conjunctival sac or lachrymal duct and keep them continuously free of discharge by frequent use of washes. Iritis is present sure—use atropin. Now for your ulcer. Scrape out the infected area with a small sharp spoon and wash it well afterwards using iodoform or aristol or whatever else you like to keep it sweet if possible. If you don't like to do that, put a small drop of carbolic acid on it, or tincture of iodine (though this is apt to be very painful.) Or again, cauterize the spreading infiltrated area with Paquelin's or the galvano-cautery if you choose. Whatever you do your object is to stop the progress of and render sterile a septic ulcer. Convert it into a healing ulcer.

Next, you have septic material—a thick yellow lymph in the anterior chamber. Apply the general principles of surgery and let it out. The letting out of this septic lymph is important of itself, but the relief of tension within the eyeball will do as much to change your ulcer to a healing one as any of the aforementioned processes and therefore I always practice it. You may get your lymph absorbed without doing

so, but you may not get your ulcer to heal without that relief of tension which is necessary for a proper circulation of the fluids necessary to nourish the affected area.

Had we had to deal with a *traumatic* ulcer of the cornea the general line of treatment would have been the same. Possibly the danger of iritis would have been greater simply from the blow—certainly the proportion of cases liable to become septic is greater in the traumatic group, especially amongst stone cutters and harvesters, but otherwise the condition is such as would be met by the line of treatment described above.

In making these very general remarks I have been forced to omit several other conditions which affect the cornea—notably interstitial keratitis, mycotic and nervous diseases, but they are comparatively rare.

In a general way I need only add a word of caution in regard to cocaine. There is great temptation to use it freely for painful conditions about the eye, but where there is an abraded condition of any sort, especially in an adult, avoid it if you can. You can make your solution of it aseptic and all that, but you cannot stop its tendency to loosen up and undermine the ulcerated area; if you have to use it at all make it up in the form of an ointment with vaseline and not as a watery solution—as in that form it seems to do much less harm.

Some one will be sure to say, you have not mentioned eserine—I purposely avoided it. It can be and is used with advantage at times *e.g.*, where there is threatened perforation of an ulcer at the periphery of the cornea. It is also advocated for septic cases, on the ground that it stops the migration of white blood corpuscles, promotes absorption through dilatation of the ciliary vessels and so stops the sloughing process. It is however equally good when there is no sloughing and you might be surprised to know that if not used in too strong a solution it is as useful in phlyctenular keratitis as atropine itself.

## Clinical Reports.

### CASE OF ABDOMINAL HYSTERECTOMY FOR FIBROID UTERUS.—RECOVERY.

By A. LAPHORN SMITH, M. D., Surgeon-in-Chief of the Samaritan Hospital for Women, Montreal.

This fibroid uterus was removed on the 17th December, 1900, from Mrs. L., age fifty-one and a half years, who gave the following history: She began to menstruate at the age of fourteen and continued to do so normally until her marriage at the age of twenty-three. She has had twelve children who are all living and her labors were all normal without the aid of instruments. She never had any miscarriages. Her last child is now ten years old. Since three years she has been flowing almost constantly. During all that time she has been taking medicine to stop the flowing but without any benefit. Two years ago her heart was examined and she was told that she had heart disease. At last she had to keep to her bed she was so exhausted, and then she called two of my friends to a consultation, who at once and for the first time diagnosed a fibroid tumor and advised her to come to me to have it removed, advice which she at once accepted. Her complexion was of a dark waxy color, very suggestive of cancer, and she had a very marked cardiac murmur heard at the apex and also conducted upwards from the base, which I considered largely due to anæmia but with a slight organic cause. As her condition was serious and imperatively demanded that something should be done quickly, the heart murmurs were practically ignored in the presence of the severe hemorrhages and I decided to operate within a few days. I chose abdominal hysterectomy, but left the question an open one whether to remove the cervix as well as the body of the uterus. If I should find the omentum shrivelled as I generally find it in cancer of the uterus and ovaries, I would remove the cervix. It was important that no blood should be lost, so the two ovarians and the two round ligaments were first tied and the sides of the uterus were clamped before a single cut was made in the broad ligament and the bladder was separated by a single slight cut across. The broad ligaments were pushed off

the sides of the uterus until the large uterine arteries could be seen and felt beating, when they were tied so that when the uterus was cut across at the internal so there was not a dram of blood lost. The omentum was found long and pale and easily drawn down to the pubis so I knew that there was no cancer about it. The broad ligament was closed with a running suture of catgut after the cervix had been first carefully closed and made dry. The abdomen was closed with through and through silk worm gut. Only two and a quarter ounces of A. C. E. mixture were used, the operation occupying twenty-five minutes from the first incision to the last stitch. This patient made a perfect recovery going home in three weeks and is rapidly gaining color and weight.

There are two or three points of interest in this case to which I would like to call your attention: first, the great reduction in the mortality owing to the improved method of operating. This was my fourteenth consecutive case of abdominal hysterectomy for fibroid uterus, seven cases in 1899 and seven in 1900, all of whom recovered and as far as I know they are all in good health. Second, the age of the patient; our experience during the last ten years has shown us that elderly women bear operations just as well as younger ones, so that I would have no hesitation in performing this operation on a woman of seventy if the symptoms required it. These patients with cardiac murmurs, especially if they are only blood murmurs; but even if they are moderate organic ones, bear an hour's anæsthesia with the A. C. E. mixture very well. At the Samaritan the average quantity used is only two and a half ounces and with this the patient is partly anæsthetized while being removed to the operating room and being scrubbed and shaved, making the duration of anæsthesia nearly an hour altogether. I have often claimed in previous papers that shock is another word for depression of the vital powers from hæmorrhage, prolonged anæsthesia and cooling; and as we take great care to prevent these three causes, it is very rare for us to have any shock at all. I think I can say that there was no shock in any of these fourteen cases.

## DIPHTHERIA.

By WILLIAM D. FINN, M. D., Halifax, N. S.

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On Feby. 5th I was called to see a baby one year and nine months old. It had been ill for five days with a cold—as parents put it. The child was suffering from diphtheria—the disease had invaded deep into the larynx and trachea; the general condition of the patient was bad. I saw I could do nothing to save it as death was fast approaching. It died during the night. Next morning I made a visit and found two other children ill, but up and playing about. Did not complain of anything except a pain in swallowing. Their ages were 6 years and  $7\frac{1}{2}$  years. On examining the throats I found tonsils, soft palate, uvula and side of pharynx coated with extensive thick gray-colored membrane—diphtheria. I immediately put patients to bed and quarantined the premises. To the elder child I administered 500 units of the antidiphtheritic serum, and the same to the younger one. Ordered a solution for spraying throat and nose, consisting of equal parts of enzymol and bovine to be used every half-hour. I ordered the parents to get a can of pineapple and give as much to the patients as they wanted. I gave calomel, grs.  $\frac{1}{16}$  every hour till bowels moved well. I kept a kettle boiling, containing a solution of enzymol and acid carbolie—about 1-20 to saturate the atmosphere. Also gave as much milk as patients would take, containing a tablespoonful of brandy and bovine to each cupful. At my visit next day I found the throat of the elder boy looking better—he said it felt better and he could swallow with greater ease. The younger one was not doing so well, voice was husky and croupy—throat covered with foul smelling membrane. I injected 1500 units more of the serum, and continued the same general treatment. That evening at my visit the elder boy was markedly better and the younger child had improved and was asking for nourishment. My visit next day was at noon; the throat of the elder child had cleared almost altogether while that of the younger was much improved, and the mother told me that he had coughed up large pieces of “foul flesh.” On examining the throat I

was surprised to find that all the membrane had come away, except a very small piece on the uvula—this I detached with forceps. I continued the milk, brandy, bovine spray and pine apple. At my next visit the improvement was marked. The child had called for food and had eaten an egg and some toast. At the end of a week all traces had left the throat. I then gave syr. ferri iodidi and syr. ferri phos. co. At present children are all right. I still enjoin rest in bed for a fortnight. During the disease the pulse in both cases was good, never above 110, and temperature varied between  $100\frac{1}{2}^{\circ}$  and  $102^{\circ}$ . The children were of a tubercular nature, many glands being enlarged about the neck.

I mention these cases to show the benefit derived from early recognition of this dread disease, and prompt treatment. The antitoxin acted like a charm. The enzymol and bovine undoubtedly dissolved the membrane. It is the second time that I have used the pineapple juice, and I think with beneficial results. I saw some remarks upon its efficacy in diphtheria in one of the medical journals some years ago—the writer, a physician, reported many cases in which it had yielded good results. It is a simple remedy, and it is worth while to give it a trial.

# RETROSPECT DEPARTMENT.

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## Surgery.

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UNDER THE CHARGE OF

MURRAY MACLAREN, M. D., M. R. C. S., St. John.

JOHN STEWART, M. B., C. M., Halifax.

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### TREATMENT OF SIMPLE FRACTURES.

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We may have imagined that whatever changes the nineteenth century had introduced, our long established practice in such every-day surgery as the treatment of simple fractures was not likely to be challenged. But ere the new century had dawned we find the principles of our science and traditions of our art called in question even here. Voices more or less authoritative have been raised here and there in criticism of existing methods; news has come from great surgical centres of radical, even revolutionary changes; and the sorely tried practitioner, treating an awkward fracture, and with visions of a suit for malpraxis haunting him, scarcely knows what to do, or how to choose.

The animated discussion which followed the reading of Major Peeke's paper on "The Treatment of Fractures," (see the MARITIME MEDICAL NEWS for January,) at the Nova Scotia branch of the British Medical Association, showed the interest which the subject has aroused among us. Major Peeke is an exponent of the views of Bennett, of St. George's Hospital, the most prominent advocate in England of the new method of treatment.

It would be more correct to say, with regard to Mr. Bennett's advocacy that it pleads for modification in existing methods rather than for revolution. The true revolutionary is the Parisian surgeon Justin Lucas-Championniere, who has for some years advocated the treatment of fractures entirely by massage, discarding splints of any kind. His paper on the treatment of fractures of the upper extremity

# WYETH'S

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**DIRECTIONS.**—The Elixir being free from irritant qualities may be given before or after meals. It has, indeed, the properties of a stomachic tonic, and will promote, rather than impair, appetite and digestion. The dose for ordinary purposes is a dessert-spoonful three times a day. When the symptoms are acute, or pain is present, it may be taken every three or four hours. In cases of dysmenorrhœa, neuralgic or congestive, the administration should begin a few days before the onset of the expected period. In irritable states of the uterus, in threatened abortion, in menorrhagia, etc., it should be given frequently conjoined with rest and other suitable measures. For the various reflex nervous affections, due to uterine irritation, in which it is indicated, it should be persistently administered three times a day. When the pains are severe or symptoms acute the above dose, a dessert-spoonful, may be increased to a tablespoonful at the discretion of the patient, or advice of the attending physicians.

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of the humerus by massage appeared in 1894. In the same year Landerer, a German surgeon wrote "On a New Method of Treating Fractures," advocating massage and passive movement at an early date, together with the use of removable splints. These ideas spread very slowly in England; Bennett's first paper was in the *Lancet* in 1898. About a year earlier, Woolsey, of New York, read a paper on the subject at the New York Academy of Medicine.

The received treatment of simple fracture is to reduce the deformity and then to immobilise the limb, and to keep it carefully immobilised for a definite time, this period varying with the seat of fracture, and being fixed upon by experience as sufficient for the repair of the bone involved. In a large majority of cases this treatment has been highly satisfactory. But in the experience of every surgeon there have been failures and disappointments. Not infrequently the real troubles of patient and surgeon begin when the fracture has united. The splints are removed and the limb is found crippled, the joints stiff, the muscles wasted, or adherent to each other and to the bone, and there is much pain in efforts at motion. Too often, alas! the fracture may be firmly united but the limb is permanently disabled.

It is asserted that these mishaps are due, not to defective immobilisation, but to the very fact that immobilisation has been so complete. Extremes meet, and the same period which has seen the rigid plaster-of-Paris bandage advocated as the best application to a fractured limb, just because it is so rigid, has seen the rise and spread of the dogma that an immovable apparatus is a bad one, and that a fracture will heal more quickly and the use of the limb be restored at an earlier date if passive motion and massage are begun early.

Among the Hottentots of South Africa the regular treatment of fractures is massage. This is interesting but not necessarily instructive. Experiment has shown that in the case of dogs, fractures heal better when left to nature than when treated by splints and bandages. No bone in the human body heals better, or more surely than a rib, and yet it can never be immobilised.

The advocates of the new method hold that in cases of disability after simple fracture the difficulty is much more frequently due to lesions of the soft parts than to imperfect union of bone. They have shown pretty conclusively that these disastrous results are due to atrophy and degeneration of muscles, to adhesions of tendons in their sheaths, and to ankylosis of joints. And they maintain that these

pathological changes are due to the immobility and long continued inaction of the parts, and that by the judicious use of massage and passive exercise they would be prevented.

The most valuable recent contribution to this question is the paper read by Mr. Bennett at the meeting of the British Medical Association at Ipswich, last summer.

In addition to the results of his own experience, Mr. Bennett gives a summary of the opinions of three hundred surgeons in all parts of Britain, to whom he had submitted certain questions bearing on the treatment of simple fractures. The great majority of those to whom he applied for information were members of the senior staff of hospitals having at least one hundred beds, but some were men having large experience in colliery practice, and among quarry-men, a practice which yields a large proportion of fractures.

One of the questions was "do you use massage or passive movements? If so, at what period after the receipt of the injury do you adopt either or both of these?" Of those replying, twelve per cent. use neither, twenty-five per cent use both, and sixty-three per cent. use passive movement without massage. As to the period of commencing passive movement, the reply indicated that in the chief centres of medical teaching passive movement is begun considerably earlier than in the country generally. Eighty per cent. of surgeons using movements, etc., reserve the treatment for cases in which joints are involved.

The next question was as to the average time elapsing after the receipt of injury before the patient is allowed to resume work. The replies are interesting, showing considerable variety, but the striking fact is brought out by an examination of the replies to these two questions "that the quickest recoveries followed in cases in which movements active or passive, are earliest used."

The last inquiry in the series was, "Have you had experience of the treatment of fractures by the immediate use of massage and passive movement; if so, what is your opinion of the method?" Only forty of those replying expressed an opinion upon the method. Of these nine were adverse to it. But of these nine, seven had never tried it. Thirty-one were in favor of the treatment, and all of these spoke from personal experience.

The discussion which followed the reading of Mr. Bennett's paper turned mainly upon other questions of the series, chiefly on operative measures in simple fractures, but the majority of those who spoke on

massage agreed in the main with his views. In closing the discussion Mr. Bennett disclaimed his being an enthusiast on the point of massage, but "believed there was sufficient good in the method to deserve more trial at the hands of surgeons. . . . In young children he did not use it."

The following are the conclusions at which Mr. Bennett has arrived from a study of the answers to his enquiries, as well as from his own personal experience:

1. The treatment of simple fractures at present, although less stereotyped than hitherto, is conducted generally too much upon lines which are traditional rather than rational.

2. The use of splints for long periods is disadvantageous, especially in the form of irremovable appliances such as plaster-of-Paris and the like.

3. Speaking generally, the earlier movements of the joints above and below the fracture in a long bone are used the shorter is the time occupied in recovery.

4. The legitimate scope of the operative treatment of simple fracture is limited and should be confined to (a) cases which are otherwise unmanageable, (b) special cases, such for example, as certain spiral and oblique fractures, mainly of the tibia, and (c) certain fractures near joints in adults, notably of the humerus at the elbow.

5. The operative treatment of recent fractures of the patella is by no means so generally satisfactory or so free from risk as published cases would tend to show; and further, in cases in which the separation of the fragments does not exceed half or even three-quarters of an inch, as good results for practical purposes are usually obtainable without operation although less rapidly.

6. The use of massage and passive movements immediately in simple fracture when the circumstances of the patient and of the practitioner admit of it either in its entirety or with modifications is, in the majority of cases, the best means of effecting a rapid and useful recovery.

7. The tendency of late has been to exaggerate the degree of disability and diminution in wage-earning capacity following upon simple fractures.

8. Although no pains should be spared in obtaining perfect position of the fracture ends, moderate displacement, provided that it is not rotatory, is not necessarily followed by any disability if care

be taken by the use of early movements to prevent any matting of the parts around the fracture; in other words the disability which follows in certain cases in which the position of the united fragments is not ideal is due, not to the bony deformity, but to the adhesion of the soft parts around, which is easily preventable.

9. Having regard to the unavoidable modifications which must be dictated by the circumstances, social and otherwise, of the patient, and by the facilities possessed by the practitioner, no one method of treatment for simple fractures can be insisted upon for routine use even in cases in which the local conditions are precisely alike.

REFERENCES.—*British Medical Journal*, 1900, vol. ii, p. 1005 for the paper and discussion at B. M. A. meeting at Ipswich. *Lancet*, 1900, i, p. 1569 and 1640 for lectures by Bennett, describing his methods. *Lancet*, 1900, ii, p. 1399, article by Tubby on "Sprains and Fractures." *Annals of Surgery*, 1900, ii, p. 351, Woolsey. *Maritime Medical News*, 1901, January, Peeke. *Fracturen and Luxationen*, Helferich, 4th edit., p. 46. *Manual of Surgical Treatment*, Cheyne and Burghard, vol. iii, p. 28-31.

J. S.



# THE MARITIME MEDICAL NEWS,

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

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Vol. XIII.

HALIFAX, N. S., MARCH, 1901.

No. 3

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## Editorial.

### SPINAL ANÆSTHESIA.

The new method of anæsthesia by injection of cocaine within the spinal meninges has attracted considerable attention during the past year. It has been fairly tried in the gravest surgical procedures with considerable success and its use has been extended to obstetric practice. At the International Medical Congress held at Paris last year, Tuffier, a celebrated French surgeon, repeatedly demonstrated the procedure in the presence of surgeons from all parts of the world thus giving an impetus to the practice which it had not previously received. Since then many American surgeons have given the method a trial with somewhat varying results, and from their reports we glean the following points. The technique of the procedure is about as follows: The instrument used for introducing the solution is a hypodermic syringe admitting of sterilization having a needle about three inches in length, ending in a short bevel. The needle must not be too large and preferably made of platinum. A two per cent. solution of cocaine is used, about fifteen minims being injected. The solution must be sterile and recently prepared.

The site selected should be the lumbar region below the termination of the cord, so that no injury shall be done to the cord itself especially its lumbar enlargement. The level at which the injection is made is the level of the crest of the ilium just above or below the fourth lumbar vertebra. In order to widen the lumbar interspaces the patient is usually directed to assume the "scorching" position. The field of injection is thoroughly sterilized.

The needle is passed slowly through the tissues until the subar-

achnoid space is reached. As soon as the needle is in the spinal canal it meets no resistance and from it escapes a clear yellow fluid which is often blood tinged. The cocaine should not be injected until the escape of the cerebro-spinal fluid is observed. This having occurred the syringe is attached and the solution slowly injected. The injection ended, the needle is rapidly removed and the puncture sealed with sterilized collodion. From four to ten minutes after the injection anæsthesia is usually complete. Usually it extends to the thorax, in many cases it may reach as high as the axilla. The duration of pain varies from a half to three or four hours. Tactile sensation is usually retained.

The after effects of the injection are epigastric pain, nausea, vomiting—sometimes persisting for hours, cardiac weakness, rise of temperature, profuse sweats, severe headache and now and then involuntary defecation and urination during the operation. Altogether the after effects seem somewhat more serious than those following general anæsthesia. Most of these occurrences are probably the result of cocaine poisoning. Other dangers may arise from imperfect asepsis and withdrawal of too much cerebro-spinal fluid. No directly fatal result has been reported, but rumor of such happenings are current.

One writer has remarked: "Only a few years ago to have heard such reports and been told that a hip-joint amputation or a hysterectomy or nephrectomy could be performed and an interesting conversation carried on at the same time with the patient would have sounded like a fairy tale, or one worthy to rival those of Baron Munchausen." The demonstration is certainly a most striking one, but it does not seem likely that the new method is likely to supplant anæsthesia by chloroform or ether except in cases where the use of these agents is objectionable. The retention of consciousness is not generally desirable in serious operations, the strain on the nervous system being too great for the ordinary run of individuals. Keen very justly observes that "the ideal anæsthetic is not an anæsthetic which abolishes sensation leaving consciousness intact but an anæsthetic which will abolish consciousness and therefore sensation *without the slightest danger to life*."

It appears that the credit of first observing the main features of spinal anæsthesia by injection of cocaine belongs to an American physician, Dr. J. Leonard Corning, of New York, who published his first research in the *New York Medical Journal*, in 1885.

## REPORT OF SANATORIUM COMMISSION.

On the 4th inst the Premier, Hon. Geo. H. Murray, brought before the House of Assembly the report of the Sanatorium Commission. It will be noted that though there are some differences of opinion in the minds of the members who constitute the commission, it is fortunate that such are practically confined to location. The report reads as follows:

(The government had addressed certain questions to this commission, which were answered in the following report:)

Halifax, N. S. Feb.—, 1901.

Hon. G. H. Murray, Premier and Provincial Secretary.

Sir,—The commission appointed to answer certain questions referring to the establishment, organization and conduct of sanatoria for the care of persons suffering from tubercular disease of the lungs, begs to report as follows:

Question No. 1.—Should there be a single sanatorium for the province or more than one; in either case what location should be selected?

Answer.—We recommend at the beginning a single sanatorium, and think that a suitable location, all things considered, could be found at Dutch Village, near Halifax, or on the shore of Bedford Basin, at or near the village of Bedford.

Question No. 2.—Would it be best to erect buildings on the congregate or segregate (cottage) plan?

Answer.—The commission recommends that the congregate plan of building be adopted for a small number of patients, and for a larger number, the cottage plan.

Question No. 3.—What number of patients had best be provided for in the beginning?

Answer.—The number of patients to be provided for (taking into consideration the amount of money available by the act) should be twenty.

Question No. 4.—What plan of organization as regards resident and visiting medical staff, and what strength of nursing staff would be best?



for the needs of the institution?

Answer.—We recommend that the institution be modelled on the plan of the Craigmyle hospital, conducted by Dr. Phillips, near Edinburgh, having no resident medical man, but instead, a competent and especially trained female superintendent with a proper number of qualified nurses and other employees.

Question No. 5.—In what way could the purely medical treatment of the patients be best carried out?

Answer.—By having not more than two visiting medical men, who should pay a certain number of regular visits every week, and additional visits when summoned by telephone or message.

The nursing staff should be full strength, resident and specially trained for the work.

The above answers have been framed after mature deliberation, ample discussion and a full examination into the special conditions existing in this province, considered from a hygienic, geographical and financial point of view.

Many causes have combined to delay the presentation of this report. The members of the commission, being as a rule actively engaged in their professional duties, have found it very difficult to absent themselves from the field of their practice to visit and report upon the possible locations and sites suitable for sanatorium purposes, to be found in various parts of the province.

At first they were not fully agreed among themselves as to what constituted an ideal locality. Indeed, the profession as a body has not settled this question and holds many different views.

The entire subject of sanatorium care for consumptives is comparatively new and is in process of development. All authorities are, however, in unison in thinking that in its essentials it means an open air life, plenty of nourishing, well prepared food, and a discipline which ensures these two things at least. Drug treatment is secondary if not incidental and unessential.

With possibly a single exception, the members of the commission subscribe to the opinion "that the treatment of consumption, to be of practical value must be carried out in juxtaposition to centres of habitation. Patients must be cured in the locality where necessity compels them to live."

Eminent authorities think that climate, elevation and atmospheric pressure are unessential, and that patients do as well at sea levels as

anywhere else or at high altitudes.

Dr. Adami, of Montreal, asserts that the good results anywhere obtained are due solely to the rigorous carrying out of a systematic hygienic regimen.

As you are aware this whole matter is shortly to be discussed at a conference called for the purpose, and to meet at Ottawa on the 14th of February. His Excellency the Governor-General is to preside, and an effort will be made to obtain concerted action in all the provinces of the Dominion.

The illness, which resulted in the death of our chairman, began just at a time when a meeting of the commission was to be called to draw up this report. His death has, of course, seriously disarranged the work of the commission.

The commission respectfully suggests that the sanatorium act of this province would be improved, if it was so amended as to permit the government to give financial aid to towns or municipalities desirous of erecting local sanatoria. In the province of Ontario such a provision is contained in their act.

The members of the commission signing this report have spent much time and given much thought to the consideration of the questions propounded to them. They believe that the answers returned will receive the endorsement of the majority of the medical practitioners of the province. We are,

Your obedient servants,

D. A. CAMPBELL,  
C. DICKIE MURRAY,  
JOHN STEWART,  
GEO. L. SINCLAIR,

Secretary.

I would endorse the report except the answer to question No. 1. The Atlantic coast is undesirable, unless better can be had, as is the case with the city of Halifax, where I think the system outlined in answer to question No. 4 and question No. 1 would be better than nothing but not what is desirable in an institution designed to be a model, and this the more as Nova Scotia has an abundance of most desirable locations.

The answers to questions No. 4 and No. 5 appear to me to be quite inconsistent with paragraphs 1—2, on page 3 of the report.

A resident responsible and skilled superintendent is necessary to

give patients the opportunity of recovery. Dr. Phillips is successful because capable and practically filling the place of a resident superintendent.

A. P. REID.

We, the undersigned members of the commission, heartily endorse the foregoing report with the exception of part of answer to question No. 1. We will not recommend the site at Dutch Village, believing that a better site could be found in or near the Annapolis Valley

W. HUNTLEY MACDONALD.

J. W. MCKAY.

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### EDITORIAL NOTES.

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OUR NEW EDITOR.—Dr. Roderick Macneill, of Charlottetown, has been appointed to fill the vacancy on the editorial staff of the NEWS caused by the death of Dr. James Macleod. It was with considerable hesitation that Dr. Macneill accepted the appointment, but we are sure that his confreres in Prince Edward Island will feel that he will do justice to that province.

DR. GOULD AND THE PHILADELPHIA MEDICAL JOURNAL.—Many of our exchanges have devoted some space to Dr. G. M. Gould's dismissal from the editorship of the Philadelphia Medical Journal. Though not wishing to judge—not being cognizant of the details from both sides, still the peremptory manner in which Dr. Gould was handled, to say the least, was not a very dignified action on the part of the Board of Trustees. Dr. Gould will shortly start another medical journal called *American Medicine*, and we believe with his extensive experience in this line, the new venture will prove a veritable success.

MARITIME MEDICAL ASSOCIATION.—The energetic President of the Maritime Medical Association, Dr. W. S. Muir, has already secured several noted gentlemen to take part at the meeting to be held in Halifax the first week of July. Dr. Alex. Primrose (a former Pictonian), Professor of Anatomy, University of Toronto, will read the address in surgery, and Prof H. A. Lafleur, of McGill University, will read the address in medicine. Dr. George H. Fox, of New York, the well-known dermatologist, will give a lantern exhibition of skin diseases. The coming meeting promises therefore to be one of more than ordinary interest and should have a record attendance from each province.

CORRECTIONS.—We regret that a number of serious errors occurred in our last issue. In Dr. Melvin's paper on page 38, fourteenth line from the bottom after the word *date*, it should read "*and if not always respectable of origin, are yet invariably so of age.*" About the middle of page 40, "*amicable*" should be *amenable* and on page 43, tenth line from the bottom "*physiological*" should be *psychological*. On page 50—Dr. Muir's paper, "*James Gerdart Bartlett*" should read *Jenner, Gerhart, Bartlett*. On the thirdline of page 53, "*nine*" should be *three* and on the last line of page 58, "*big*" should be *leg*.



## Society Meetings.

### TUBERCULOSIS CONFERENCE.

OTTAWA, Feb'y 14th and 15th, 1901.

At the last meeting of the Canadian Medical Association, an "Association for the Prevention of Tuberculosis," was organized and this conference was called at the request of his Excellency the Governor-General to establish on a permanent basis the association then formed, and to discuss the best means for promoting the object of such an association.

Delegates were present from British Columbia to Nova Scotia, and there was a free interchange of ideas. Nothing new was brought out except a very general consonance of opinion of the laity as well as the profession on the subjects I will enumerate, and the unanimous conclusion, that if the public were thoroughly educated as to what tuberculosis really is (as far as we at present know) there is more than the probability that it can be controlled to as great an extent as the small pox is now controlled, and that it is desirable that each province shall take efficient means for distributing and circulating this knowledge. Especially to impress on the people the following points:

1st.—That Consumption or Tuberculosis is not hereditary.

2nd.—That Consumption or Tuberculosis is preventable.

3rd.—Why not prevent it?

4th.—That Tuberculosis is curable in the early stages and under proper care can be much alleviated in later stages.

5th.—That it is but little amenable to treatment by *drugs or medicines*.

6th.—That it is contagious and is propagated by contagion.

7th.—That it may affect any or every tissue in the body.

8th.—That from one-eighth to one-fifth of deaths from all causes is due to tuberculosis in some form.

9th.—That in post-mortem examinations of thousands of cases, in deaths from causes other than tuberculosis, in over 90 per cent. were found tubercular lesions that had been cured without the patients

ever having been aware of the fact that they suffered from tuberculosis.

10th.—That domestic animals, and particularly the *bovine race*, were very subject to this disease in many forms, and were often the cause of its propagation by the use of the flesh and milk of diseased animals.

11th.—That it was chiefly propagated by careless distribution of the sputum of diseased persons, who, in the advanced stages, would expel from 30,000,000 to 70,000,000 of these disease germs, the *tubercle bacilli*, in twenty-four hours.

12th.—That sunlight in a few hours renders them innocuous.

13th.—That when dried up and in dark places their vitality is greatly prolonged. Just how long is not known. It may be days, weeks or months, owing to the conditions in which they may be placed.

14th.—That a temperature (moist) of 150° Fah. destroys their vitality, but it is not influenced by a low temperature, even that of liquid air.

15th.—That Sanitaria so far furnish the only practicable means of treatment.

16th.—That the affected be treated in the *climate in which they intend to live*, that *relapses may not occur*.

17th.—That the sanitarium is the best educator, not only curing the patient, but teaching him practically how to prevent *auto-infection* as well as how to avoid affecting others. He will also become a missionary in spreading knowledge among his acquaintances.

From a careful consideration of the general experience, up-to-date, I think it safe to assume, in reference to sanitaria :

(a) That though they may be successful in any climate, it is most desirable that they be situated in the purest available atmosphere, distant from *fog, dust, smoke*, and *air impurities* as well as *cold raw winds*. The vicinity of large cities or the sea coast is undesirable. Sunlight, pure air, good hygienic surroundings and skilled medical supervision furnish the key-notes of probable successful treatment

(b) It is not desirable to be too far distant from means of communication.

(c) A dry sandy or gravelly soil is preferable to one of clay. Also, good water and drainage are necessary.

(d) That patients should be constantly under skilled medical care, as every case must be treated on its own merits, and the method, even

in the same case may vary from day to day. The strictest discipline is necessary.

(e) Three classes of sanitarium are needed. 1st.—For the cure of recent cases. 2nd.—For relief of the far advanced. 3rd.—For the care of the afflicted in large cities and towns who are unable to take advantage of the means indicated above. For such, a location near at hand, though not most desirable, may yet give relief to a great number, especially of the poor. Such an institution is even more valuable than the Poor's Asylum and should, under government supervision, be supported by the town or city as are other charities.

(f) The sanitarium bill gives government aid to such an institution, and the City of Halifax should take advantage of this assistance.

(g) The Government or Nova Scotia Sanitarium should be a model institution under the best management and in the best locality in the province.

A. P. REID.



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Sodium Phosphate is Unexcelled:

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1. Sodium Phosphate is a mild but certain hepatic stimulant, and relaxes the bowels both by promoting an excretion of bile and by acting directly upon the mucous membrane of the intestines. It does not cause "gripping," nor does it derange the stomach or excite nausea; unlike many other purgatives, it has a beneficial effect upon the appetite and digestion, stimulating the flow of gastric juice and increasing assimilation.

2. As a Treatment for Diabetes.

2. Diabetes is treated with decided advantage by means of the Sodium Phosphate. Not only are its cholagogue properties beneficial in this malady, but also its well-known power of arresting the secretion of sugar in the liver.

3. As a "Nervetone" in cases characterized by Debility, Spermatorrhœa, etc.

3. Phosphorus is a fundamental constituent of nervous matter, the substance of brain, spinal cord and nerves. Hence, the usage of the present compound in diseases characterised by a deficiency of "tone" of the nervous system in Debility, Spermatorrhœa, Impotence, Locomotor Ataxia, Neurasthenia, etc., is strongly to be recommended. In Asthma and the debility of the advanced stages of Phthisis it is serviceable. In such cases it acts as a restorative and respiratory stimulant.

4. As a Purgative in cases of Exanthematous Fevers.

4. In grave, exanthematous fevers, where a purgative, to be safe, must be simple and efficient, the Sodium Phosphate can be relied on. In such cases its cooling, saline qualities render it grateful and refreshing to the patient.

5. As a cure for Biliousness, Constipation, Jaundice, Diarrhœa, Dysentery, etc., especially in children.

5. Sodium Phosphate, causing a marked outflow of bile, whose consistency it renders thinner, is an incomparable remedy for Biliousness, constipation, and, above all, for Jaundice, especially in children, on account of its absence of taste, and its efficient but unobjectionable properties. Diarrhœa and Dysentery in children are effectively controlled very often by the action of this salt in cleansing the mucous membrane of the lower bowel, and evacuating in a complete and unirritating manner the rectum and large intestine.

**DOSE.**—For children, to relieve diarrhœa, constipation, etc., a small dose only is necessary,  $\frac{1}{2}$  to 1 teaspoonful according to age and effect desired. As a purgative in adults, one or two dessertspoonfuls. As an alterative in gout, obesity, hepatic derangement, etc., one dessertspoonful morning and night. As an excellent substitute for Carlsbad water (which depends largely for its beneficial effect upon the presence of this salt) may be obtained by adding a dose to a tumbler of water and taking it gradually on getting up in the morning. The glass cap on our Effervescing Salt bottle, when filled, is equivalent to one dessertspoonful, and also embodies a time device adjustable to any hour at which the next dose is to be taken.

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## ST. JOHN MEDICAL SOCIETY.

Jan. 16th. The President, Dr. J. R. McIntosh, in the chair.

Dr. Stewart Skinner read a paper on "Tubercle." (It will appear in the NEWS.) In the discussion which followed, the President insisted upon the duty of the physician in early informing his patient of the true nature of his disease.

Dr. James Christie said that tuberculosis can only be stamped out by means of sanatoria. Isolation, among the poor, is impossible. All idea of heredity must be abandoned. He mentioned nine cases of tuberculosis in one family as an evidence of contagion.

Dr. Wetmore agreed that absence of fever was often the case in tuberculosis. Tachycardia is generally an accompaniment of acute cases. He considered that in addition to sanatoria, much could be accomplished in limiting the disease by educating the people as to proper methods. Infected buildings and utensils should be destroyed. Reference was made to a case infected through the use of books previously handled by a tubercular subject. The same pains which are taken in typhoid, diphtheria and other infectious diseases, should be taken in phthisis. He used bichloride of mercury as a wash for walls and woodwork; it prevents infection as well as reinfection of the patients. Sweeping should be prohibited and the use of damp cloths substituted. Sanitary leaflets should be continually distributed.

Dr. G. A. B. Addy said that in nodes or infected foci not near the mucous membrane of bronchi, tubercle bacilli will be long locked up and not found in sputum. Suppuration need not always be looked for in phthisis. Clear sputum is often loaded with tubercle bacilli. He uses large slides instead of cover glasses in examining for tubercle bacilli—this gives larger fields for observation and greater variety of sputum to choose from. Isolation, for rich and poor, is practically only by sanatoria. Sunlight is fatal to most germs, including tubercle bacilli.

Dr. Crawford said that sunlight, after all, is the great disinfectant. The life of tubercle bacilli, according to a high authority, under the

most favourable circumstances is limited to a little over a year.

Dr. Melvin was surprised that phthisis was frequent among the Esquimaux. It has been stated that the atmosphere of Arctic regions is practically aseptic. Climate plays an important part in tuberculosis; in phthisis sudden changes in temperature was most favorable to the disease. An instance was given of a section of Albert county where phthisis was most rife. The ideal spot for phthisical patients was where the temperature all the year round was constant, but little moisture and freedom from storms. He feared that skilful physical exploration of the chest might become a lost art, with such stress being paid to microscopical results.

Dr. Skinner, in closing the discussion, said he considered the destruction of infected houses necessary:

Jan. 23rd. The meeting was called to order at the usual hour and out of respect for the memory of her late most gracious Majesty Queen Victoria, the society adjourned.

## NOVA SCOTIA BRANCH BRITISH MEDICAL ASSOCIATION.

January 16th, 1901. The President, Dr. G. C. Jones, in the chair. Meeting held at 8.30 p.m., at the Halifax Hotel.

Dr. Murphy presented a case of sarcoma of upper jaw which had been operated on by him, to which he referred at a previous meeting.

Dr. W. S. Muir enquired about the use of Coley's fluid at the Victoria General Hospital.

Dr. Chisholm mentioned a case of sarcoma of the leg and multiple sarcomata of other parts for which Coley's fluid had been suggested. The patient, however, was operated on and contracted erysipelas on his own account.

Dr. Muir suggested the remedy should be tried. He congratulated Dr. Murphy on the result of his operation.

Dr. Murphy stated that Coley's fluid was most successful in soft sarcoma.

The President then presented the resolution of condolence in reference to the late Dr. Farrell which had been prepared by the committee appointed. After some felicitous remarks upon Dr. Farrell's position and character particularly in relation to medical societies, he presented the resolution which was moved by Dr. Goodwin, seconded by Dr. Cunningham and unanimously adopted and a copy ordered to be sent to the family. (Resolution was published in last issue.) Dr. Muir and others added their tribute to Dr. Farrell's memory.

The President suggested that a member of the branch be added to the entertaining committee of the Maritime Medical Association which will meet in Halifax next summer.

On motion of Dr. Curry seconded by Dr. Kirkpatrick, Dr. Jones was added to the committee.

The President then called upon Dr. W. S. Muir, of Truro, who read a most interesting paper on "Typhoid Fever." (Published in last issue of the NEWS.)

Dr. Chisholm mentioned the obligation due to Dr. Muir by the branch for his scientific paper containing as it did the account of much close clinical observation. He agreed with all of Dr. Muir's

remarks. Referring to aborting typhoid—his cases used to have four or five weeks of severe illness but since treating with chloroform and carbolic acid the period has been shortened to two or three weeks and the severity of the disease has been lessened. He considered diagnosis of some cases difficult, probably from mixed infections, and described his own recent illness.

Dr. Curry mentioned the branch's indebtedness to Dr. Muir. It was his custom to give calomel early in the disease and urotropine and intestinal antiseptics to keep the bacillus in check. He did not believe the disease could be aborted, though complications might be limited.

Dr. Murphy referred to the effect of cold on the typhoid bacillus. He generally gave a rather full diet in typhoid patients. A case of typhoid complicated by mania was referred to.

Dr. Murray referred to his cases of typhoid from the steamer "Montezuma," which he considered originated in South Africa. He used the same treatment as advocated by Dr. Chisholm, combined with cold sponging when temperature reached 103° or over. He considered good nursing a most important element in treatment. He gave statistics of recovery of perforation cases operated on and not operated on as 2 and 5 per cent. respectively.

The President considered the typhoid cases on the "Montezuma" originated in New Orleans.

Dr. Mader mentioned a case complicated by valvular disease of the heart in which the temperature in the axilla was 100° and under the tongue was  $\frac{1}{2}$  less. He favored a milk diet and lemonade enemata. He referred to malarial complication and also to the advantage of properly applied massage to the extremities after a long time in bed. He also believed the disease was often aborted.

Dr. Goodwin mentioned a case in which he diagnosed typhoid and the disease aborted. In one case he amputated the leg for gangrene following phlebitis. He asked Dr. Muir what was the old-fashioned "slow fever."

Dr. Almon referred to the antiseptic properties of chloroform and also spoke of its use in tape-worm.

Dr. Rose mentioned that he had used chloroform in tape-worm, twenty drops repeated three times, two hours apart, followed by castor oil.

Dr. Curry thought chloroform might reach tape-worm but hardly the typhoid bacillus.

Dr. G. M. Campbell expressed his high appreciation of Dr. Muir's paper. He referred to the epidemic in the region of Oxford street, considering it due to well water. He mentioned a case in which blood was passed very early, on the second day of observation. He also used carbolic acid and chloroform. He did not believe the disease could be aborted if once established.

The President tendered Dr. Muir the thanks of the branch for his excellent paper. He stated that the results of the inoculation of the Canadian contingents were not to hand. He said Major Clements regarded turpentine as a sheet-anchor in typhoid. He (Dr. Jones) objected to milk as a diet thinking it a fine culture medium for the bacillus. He criticised Dr. Mader's line of treatment. Reference was also made to the large number of cases of phlebitis in the returning soldiers from South Africa.

Dr. Chisholm, in reply to enquiries concerning the mode of action of chloroform, explained it as acting through the chylopoietic circulation through the liver and through the bile into the intestinal tract.

Dr. Muir, in reply, thanked the branch for their appreciation of his paper. He said no two cases of typhoid could be treated alike. He objected to a mixed or generous diet. The action of chloroform and carbolic acid he considered acted as a concentrated hydrocarbon. He advised the use of salol which should always be given in powder form. Reference was made to presence of the typhoid bacillus in the bile-ducts as mentioned by Dr. W. F. Hamilton in the *Montreal Medical Journal*. The action of chloroform in the common bile-duct was referred to and the suggestion that the chloroform acted on the bacilli in the gall-bladder.

He could not see what advantage lemonade could have over pure water enemata. The President's remarks concerning a milk diet were also criticised. He certainly did not think typhoid could be aborted and considered "slow fever" an obsolete term for typhoid.

## Obituary.

DR. JAMES R. DEWOLF.—In the death of the late Dr. James R. DeWolf the medical profession loses one of its most honored and respected members. Educated at Edinburgh, he began the practice of medicine in Halifax in 1845, but twelve years later he was entrusted with the superintendence of the Nova Scotia Hospital for the Insane, at that time just being erected. It was as superintendent of this large and important provincial charity that Dr. DeWolf spent the best years of his life and accomplished a work which should ever have a prominent place in the history of medical and charitable advance in Nova Scotia. He entered upon his duties then with energy and enthusiasm, and imbued with the then-developing idea that kindness, tact, appeal to the patient's sense of honor and of the æsthetic counted for much in promoting recovery, he at once instituted at Mount Hope a system of treatment which was free from the trammeling influence of tradition, free from the restraint, seclusion and abuse which was even at that time still common in the institutions for the insane, and established for our Nova Scotia hospital the reputation of being one of the most advanced institutions for the treatment of the insane in the world. There still live in Nova Scotia many of Dr. DeWolf's former patients, long since happily restored to sanity, who will ever have grateful remembrance of his kind and gentle manner, his sunny and hopeful disposition, and of his unremitting endeavour to bring about recovery of the reason of the unfortunate people committed to his care. He devoted himself to his calling with a rare degree of unselfishness, and conscientiously laboured, in season and out, for what he considered would lead to the betterment of the condition of the insane.

After many years of active work among the insane, he retired to private life, but he never lost interest in the cause of the unfortunate people for whom he did so much, and up till the very last continued to post himself in the literature upon insanity, and to follow closely the work of the hospital with whose history his name is so closely associated. His death occurred on the 5th of March, at the age of 82.

A well merited eulogy in the columns of the *Acadian Recorder*

concludes as follows :

“Of Dr. DeWolf’s personal qualities it is not necessary now to speak at length. His amiability of character ; his solicitude for the welfare of those who came within the circle of his acquaintance—in a word, his sterling attributes of heart and hand are known of all men. For years he has lived in comparative retirement, but none the less, as he went unobtrusively in and out among his fellow citizens, he carried with him the respectful esteem of all, because it was felt that his was a life that had been unselfishly devoted to the alleviation of the afflicted—of a class that naturally inspired more than ordinary sympathy. Part of a country’s wealth, it has been well said, consists in her better minds : her statesmen, her philosophers, her christians, her poets. Dr. DeWolf’s mission was undoubtedly the care of the insane, and the memory of his faithful labors will not perish.

The deceased leaves one daughter, Mrs. C. Harrington, and a sister, the wife of Rev. Benjamin Hills, Yarmouth Co. He also leaves a grandchild, in England, daughter of his diseased son, Dr. George DeWolf.”

HON. W. J. ALMON, M. D.—The late Senator William Johnston Almon commenced his educational career at King’s College, Windsor. On leaving that institution he crossed the Atlantic, and attended lectures in the medical and surgical departments of the Universities of Edinburgh and Glasgow, graduating at the latter school in 1838.

In the autumn of that year he returned to Nova Scotia and commenced the practice of his profession in his native city—Halifax. He was physically active and strong, in stature tall, and of good figure—a handsome, manly-looking man. His first residence was north of the Ordnance, opposite Creighton & Grassie’s, now Cronan’s wharf. Here, as was frequently the case in those days, young men combined the drug business with their professional work for a time, or until the professional foundation was surely laid, and they could with safety rely on their practice alone.

The subject of these remarks, Dr. Almon the third, had but a short time to wait before he was called upon, in consequence of a very sad and distressing family event, to relinquish the business above referred to and give his undivided attention to the practice of medicine and surgery. His father, Dr. William Bruce Almon, a member of the Legislative Council, greatly esteemed as a citizen and



a physician, who at this period occupied the most prominent position in the profession of the provincial capital, was surgeon to the Poors' Asylum; and there being no general or marine hospital either in the city or province, this institution was largely used, in its early history, for the treatment of both medical and surgical cases among the poorer classes of citizens, and sailors from all parts of the world. Here, also, the poor and the dangerous insane belonging to Halifax and the out counties of the province were *confined* and *housed*.

The same gentleman, Dr. Almon the second, was also health officer of the port. At that period in the history of the United States and Canada there was a large amount of emigration business carried on between Europe and America, and ships, crowded with passengers of the poorer classes, would occasionally put into Halifax with numbers of men, women and children sick and dying from typhus, or ship fever—as it was then called. A ship thus laden arrived at this port in the early summer of 1840. In the performance of his official duties, Dr. Almon was daily brought in close and prolonged contact with these diseased people on board a ship literally saturated with the elements of disease, and as a consequence very shortly sickened, and died in July, 1840, at the age of 52 years. On the day of his death a noble specimen of a man and a physician was taken from our midst, and the community long mourned his loss. It was this distressing circumstance which caused the then young Dr. Almon to terminate the business to which reference was just made. The son almost immediately succeeded to a very large portion of his father's practice. Not long after the decease of his father, a very important and happy event occurred in the young man's life, on the occasion of his marriage. He selected Hollis street as the site of his office and residence, and for long years occupied and owned the property in which Mr. J. C. Mackintosh now conducts his business.

It is always a desirable thing for a young medical man, when possible, to be in touch with hospital life and work. Indeed, there is no period or age when a professional man may not be benefited by such contact, even should the institution be small and inferior.

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Beef, Milk and Wine Peptonised with Creosote,

Liquid Peptonoids with Creosote is a preparation whereby the therapeutic effects of creosote can be obtained, together with the nutritive and reconstituent virtues of Liquid Peptonoids. Creosote is extensively used as a remedy to check obstinate vomiting. What better vehicle could there be than Liquid Peptonoids, which is both peptonized and peptogenic? It is also indicated in Typhoid Fever, as it furnishes both antiseptic and highly nutritive food, and an efficient antiseptic medicament in an easily digestible and assimilable form.

In the gastro-intestinal diseases of children, it also supplies both the food and the remedy, thereby fulfilling the same indications which exist in Typhoid Fever.

Each tablespoonful contains two minims of pure Beechwood Creosote and one minim of Guaiacol.

Dose.—One to two tablespoonfuls from three to six times a day.

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ABBEY'S EFFERVESCENT SALT is without doubt the most elegant, palatable, and efficient saline laxative and antacid within your reach.

It possesses every requisite that such a salt should have; the slight granulation enables the patient to obtain the fullest benefit of the slower development of the carbonic acid gas; its action upon the bowels is gentle, but positive, and its valuable antacid properties render its use particularly beneficial in many cases where a harsher aperient might prove deleterious.

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The preparation is manufactured in the most perfectly appointed laboratory in America, under the supervision of expert chemists, and is in every way guaranteed to meet the many requirements for which its properties render it useful.

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Disinfectant, Antiseptic, and Germicide

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Creolin-Pearson is prepared from coal-tar oil after the complete removal of carbolic acid, by the addition of resin and caustic soda. It is a dark brown, syrupy, tarlike fluid with a smoky odor similar to that of tar, and has an aromatic, subsequently burning taste. Dropped into water, it at first forms whitish clouds, which soon coalesce into a milky, uniform emulsion, slightly alkaline in reaction.

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Creolin-Pearson is an antiseptic and disinfectant of the first rank. According to the bacteriological investigations of von Esmarch, it acts decidedly more powerfully than carbolic acid on pus-micrococci, on typhus-bacilli, and on cholera bacilli. A 1 : 1000 solution kills the cholera bacilli in 10 minutes ; a 5 : 1000 solution in 1 minute ; whereas it takes a 1 : 1000 solution of carbolic acid 4 days to do the same. The typhus bacilli are distinctly checked in their formation by a 1 : 1000 solution of Creolin-Pearson, and are powerfully affected in 24 hours ; a 1 : 1000 solution of carbolic acid exerts no restricting influence on their formation even after 22 *days*. Pus-bacilli are distinctly hindered in their growth in 1 hour, and are killed in 4 days ; carbolic acid fails completely to produce any effect in 4 days.

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Creolin-Pearson is easy to carry : 1 to 1½ fl. oz. suffice to prepare from 7 to 11 pints of good disinfecting fluid. It readily mixes with water and distributes itself uniformly. It does not stain the clothes, nor injure the hands or instruments. Creolin-Pearson presents an obvious and decided advantage over carbolic acid in its comparative non-toxicity.

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For Disinfection where Contagious or Infectious Diseases are prevailing (such as Consumption, Pneumonia, Grippe, Whooping-Cough, Measles, Typhoid, Cholera, Small-Pox, Scarlet Fever, and Diphtheria), closets, sinks, and chamber pots should, after every using, be treated to liberal supplies of Creolin-Pearson. 4 table-spoons to one gallon of water. Before a sick-room is again occupied, it should be thoroughly cleaned with the same solution.

As a Gargle in Sore Throat, Colds, etc. . . .  $\frac{1}{2}$  to  $\frac{1}{4}$  Teaspoon.

To Heal Wounds and Sores and to stop Bleeding use solution with lint and oiled silk . . . 1 }  
 To keep Air Pure in Houses, School-Rooms, Hospitals, etc. . . 1 }  
 To Sprinkle freely . . . 1 }  
 In Skin Diseases, as Barber's Itch, Ring-worm, Scabies . . . 1 }  
 parts with water.

For Preserving the Teeth and Purifying the Breath, rinse Mouth with 3 to 6 drops in tumbler of water.

In Mosquito and other Bites rub pure Creolin-Pearson well into the wound.

MIX WITH WATER BEFORE USING.

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## DIRECTIONS

To Destroy Insects and all Parasites, to keep off flies wash the animals (especially head and neck) with . . . Parts 1 in 50

As a Radical Cure for Mange (in Dogs, Sheep, etc.) A few Drops suffice: The hair will grow again. . . . Parts 1 in 20

For Horses, as a Preventive and Cure for Mange the coat of animal should be well saturated with solution of . . . Parts 1 in 50

Mop the Stables daily with a similar solution. Will keep animals in perfect safety from Infection. For Broken Knees, Quittor, Grease, Cracked Heels, etc., rub well with . . . Parts 1 in 30

For Worms in Horses give internally, on empty stomach, a quart solution of . . . Parts 1 in 20

Throat-worms in Lambs, Diptheria in Poultry, all Internal Parasites eradicated by giving solution of . . . Parts 1 in 30

If the above Directions are not perfectly clear, please request the Druggist to explain the same.

N.B.—BEFORE USING A SOLUTION, SHAKE WELL

FOR NEARLY A QUARTER OF A CENTURY USED CONSTANTLY IN ALMOST EVERY HOSPITAL IN THE WORLD.

when contrasted with the larger and well-equipped hospitals of older and richer countries and cities.

That Dr. Almon should have been appointed to the medical charge of the Halifax Poors' Asylum was probably, for him, a fortunate circumstance. Although the building of that day had none of the characteristics of a modern hospital (either within or without,) there was constantly found within its walls and among its two or three hundred occupants much interesting material, both medical and surgical, to attract the attention of an intelligent observer who was fond of his profession, as Dr. Almon was. And he had here exceptional opportunities of adding to his store of practical knowledge, and with and in these surroundings it might almost be said that he was in continuous attendance on "a post-graduate course," and thus became the better fitted for the treatment of disease elsewhere and in other circles. Before the Victoria General Hospital had an existence, both the Almons—father and son—had to deal with numerous and varied cases in operative surgery, some of which were very important and serious. These were operated on and treated in a manner to reflect marked credit on the gentlemen in charge.

In the days when William J. Almon commenced his career in Halifax—between sixty and seventy years ago, the relations existing between the family physician and his patients differed from those of the present time. It was a closer tie, and the doctor was considered almost as a member of the family, and was not infrequently looked up to as their confidential friend and adviser in times of trial and perplexity. It was this condition of things existing between Dr. William Bruce Almon and his patients that probably influenced the latter in such very large numbers to *adopt* the son at the beginning of his professional life. Their action in this relation was not regretted, for they found him to be "a worthy son of a worthy sire," and that not in name alone.

Senator Almon was warm-hearted, kind and generous. The poor, when sick and suffering, had always in him a sympathizing friend. In the ordinary intercourse of professional and every day life he was gentlemanly and courteous, and at all times and under all circumstances was an upholder of integrity and fair play. His convictions on certain subjects were decided and

strong; especially those relating to the "crown, empire and flag." Our own Dominion had no warmer friend and upholder than he of whom we write, who has so recently relinquished by death the elevated position he filled in the legislature for a period of years; and had it not been for the sad accident which caused his death, he would have taken his seat again during the present session, notwithstanding the fact that he had passed his 85th year. It is almost forgotten that before being called to the Senate he represented Halifax County in the House of Commons for a full term. Passing events connected with the "body politic" interested him even in early manhood, and he never could remain neutral and inactive when the polls were opened, or were about to be opened, to decide the fate of parties contending for the governmental control of either Province or Dominion, or of both.

Dr. Almon was a pleasant and interesting conversationalist, full of anecdote, and in discussion apt and ready in repartee. His mind was well stored with history and historic facts, more especially with such as related to public men and public events connected with colonial life before the War of Independence; and his retentive memory had stored up much that was valuable and of moment relating to our Canada of the past. When quite a young child, it might almost have been said of him, that he was a student of the Bible—the Old Testament, a pictorial edition, the illustrations doubtless helping to fix the biblical events and acts on his young mind, so that much thus learned could be recalled and quoted in after years. Antiquarian science and objects always interested him, and the probability is that he has left to his family many things related to this subject which would be well worthy of a place in an appropriate museum.

Quite recently, and in some of the cases, unexpectedly, four members of the medical profession resident in the city of Halifax, two of them (Almon and DeWolfe) had lived beyond four score years; the other two (Slayter and Farrell) had reached that matured period in their professional lives which, humanly speaking, suggests the thought that a longer period of life here would have been both important and desirable in the interests of the profession and the public. The two first named had retired from the practice of medi-

cine, while those last named, in a professional sense, were in their prime, if we may so express it. But it must ever be remembered that He who holds in His hand the issues of life and death makes no mistakes. Human eyes will no longer see their familiar forms or ears hear their voices. Still, figuratively speaking, through recollections of the departed, there may reach the minds of professional brethren and friends a still small voice saying to us: "Be ye also ready, for in such an hour as ye think not, the Son of Man cometh."

DR. THOMAS E. CHASE. The death of Dr. Thomas E. Chase took place at St. Margaret's Bay N. S., on the 7th inst. He was born in 1848, graduated from the University of New York in 1873, and practiced his profession at St. Margaret's Bay for upwards of twenty-five years. He had been ill since last November, his death being caused by some affection of the heart. Dr. Chase was well known throughout the province and his funeral was attended by a large gathering, many driving down from Halifax.





## Book Reviews.

A. TEXT-BOOK ON PRACTICAL OBSTETRICS.—By Egbert H. Grandin, M. D., and George W. Jarman, M. D. Third edition, revised and enlarged, illustrated with fifty-two full page photographic plates and one hundred and five illustrations in the text. Published by the F. A. Davis Company, Philadelphia, New York and Chicago.

The reputation of Grandin and Jarman's text-book is so well established that it is not surprising that a third edition has been necessary to supply the demand for it, although scarcely five years have passed since the publication of the first edition. The new edition retains all the good features of the former editions, the conciseness, the wealth of illustration, and the eminent practicability which have won the work so much favour. In addition it contains a chapter dealing with the anatomy of the female organs of generation and with embryology. It is needless to say that the new edition is thoroughly modern, and that it embraces all of the recent teachings which have been proved to be correct. The book is well printed, and many of the illustrations, especially those showing the various phases of the second stage of labour, possess that accuracy which characterize reproductions of actual photographs.

PHYSICAL DIAGNOSIS IN OBSTETRICS.—A Guide in Antepartum, Partum and Postpartum Examinations, for the use of physicians and undergraduates. By Edward Ayers, M. D., Illustrated. Price \$2.00. Published by E. B. Treat & Co., 241-243 West Twenty-third St., New York.

This work is, in arrangement and conception, entirely different from anything on the subject which had previously come to our notice. Its aim is to represent on paper, and with more careful expansion of statement than could be given in daily verbal instruction by the side of the patient, the clinical study of obstetrics as the author has been accustomed to pursue it with his classes in hospital and dispensary work. The author is to be congratulated upon having produced a work which will undoubtedly prove of very material value, especially to those who have little opportunity for "brushing up" at the post-graduate schools. An idea of the scope of this work can be obtained

by a glance at the table of contents, which shews that the various topics are discussed in the following order:—Obstetrical History Chart; Scope of Antepartum Examination; Present Impregnation; Antepartum Examinations; Uterotomy, Pelvimetry and Abdominal Palpation; Vaginal Examination; Urinary Organs; History of Labour; The Breasts; The Child's History; Maternal Postpartum History; Final Examination.

**SEXUAL DEBILITY IN MAN.**—By Frederic R. Sturgis, M. D. Formerly Clinical Professor of Venereal Diseases, Medical Department University of the City of New York; Ex-Visiting Surgeon of the City Hospital, Blackwell's Island; Author of "A Manual of Venereal Diseases;" one of the Authors of "A System of Legal Medicine," etc., etc. Price \$3. Published by E. B. Treat & Co., New York.

The author's preface states:—"The principal reason for writing this book is to introduce to the reading medical public sundry opinions the writer holds upon sexual weaknesses in men, which, although they may be at variance with ideas generally received in this country, he is convinced from experience are correct."

This work comprising some 380 pages is one of more than ordinary interest, and is a very complete volume on a subject so little considered and so entirely ignored by the great majority of medical practitioners. The supposed relationship of masturbation to many diseases is carefully dealt with and many peculiar opinions of some former writers are strongly criticised. For example, Smith's views as to the relationship of phthisis to masturbation which Howe not only concurs with but goes so far as to state that "not only does the masturbator become phthisical but he transmits phthisis to his children as a consequence of his vicious habit," are not according to Dr. Sturgis' belief. Evidently the author considers such ideas rather far-fetched, in which he will be upheld by those whose minds are not easily influenced by exaggerated notions. Sexual impotence is dealt with most exhaustively, considerable attention being devoted to the effect of alcohol and other agents on the sexual organs. So far as the question of impotence is concerned the author states:—"I am perfectly satisfied that a chronic alcoholic is eight times in ten, sexually speaking, a eunuch." This point ought to prove of decided benefit to any who are daily moving towards that goal unconsciously and which class is unfortunately far from uncommon in every sphere of life. Tobacco does not play a prominent part in the way of sexual impotence—according to the author's views, concerning which there naturally exists considerable diversity of opinion.

The large experience of Dr. Sturgis in treating exclusively, for many years, venereal and genito-urinary diseases, enables him to speak authoritatively on the subjects dealt with in his book, and we can heartily commend it as being most readable and instructive.

INTERNATIONAL CLINICS.—A quarterly of clinical lectures and especially prepared articles on Medicine, Neurology, Surgery, Therapeutics, etc. By leading members of the profession throughout the world. Volume IV, Tenth Series, 1901. Published by J. B. Lippincott Company, Philadelphia.

In perusing the latest volume we are made aware of the changes on the editorial staff. "New blood" will accomplish much at times and already such has manifested itself in the excellent condition of the current volume.

The Symposium on Genito-Urinary Diseases is completed in this number and contains much to interest readers. "The Treatment of Urethritis in the Male," by James Pedersen, is written by an authority whose experience counts for much. Guyon, Fournier and Ohmann-Dumesnil are names familiar to all and their articles respectively on "The Use of the Fixed Catheter in the Treatment of Urinary Infection and of Prostatic and Urethral Hemorrhage," "Treatment of the Complications of Syphilitic Chancre," "The Use of Mercury in the Systematic Treatment of Syphilis," are instructive and profitable. In his abstracts from clinical lectures delivered at the German Hospital, Philadelphia, Dr Deaver supplements his remarks by giving a concise description of the technique employed when preparing for operation. "The Role of the Blastomycetes or Ferments in the Etiology of Cancer," by Prof. D. Roncali, deals with this subject in an interesting manner, his conclusions being logical and convincing. The monograph on "The Etiology and Morbid Anatomy of Various Diseases," by Henry W. Cattell occupies over one hundred pages. Naturally the descriptions are brief—but well explained. Other chapters are of considerable merit but space prevents any allusion to them. The plates and figures are up to their usual high standard as might be expected from the class of work always done by the publishers.

### Notes.

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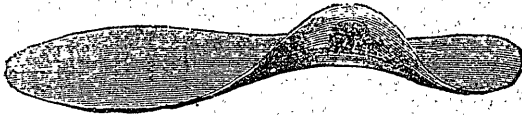
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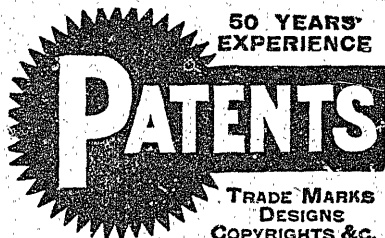
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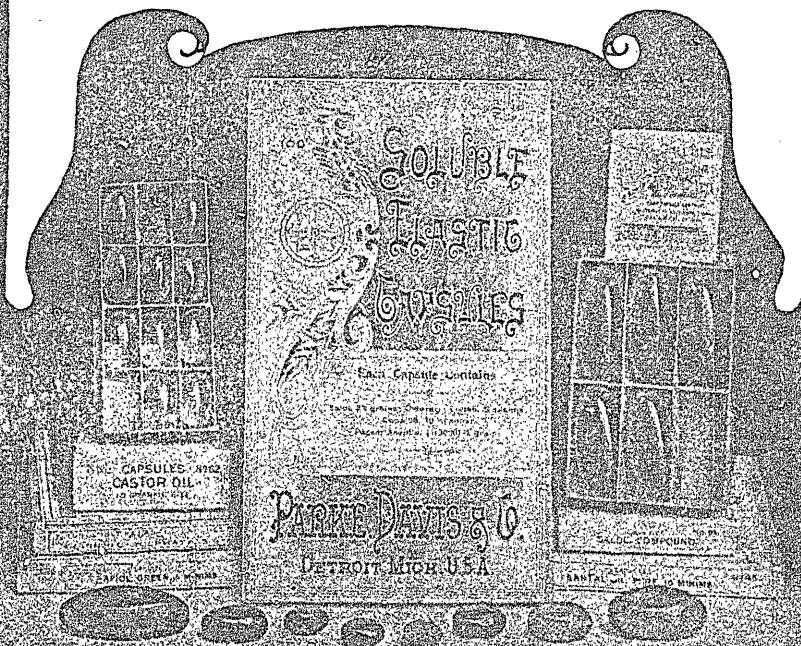
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