

Pages Missing

The Canada Lancet

VOL. LIII

TORONTO, AUGUST, 1920

No. 12

EDITORIAL

"LONDON DOCTORS ESTABLISH RECORD"

The press despatches brought the following item of news from London.

"One of the most extraordinary undertakings in London's medical annals was successfully carried out to-day at the Orphanage of the Sisters of St. Joseph, Mount Hope, when one hundred and three of the children were operated upon for the removal of tonsils and adenoids by volunteer surgeons assisted by volunteer anaesthetists, nurses and nuns. All operations, other than emergency cases at St. Joseph's Hospital were postponed for the day and operating tables and equipment were removed to the orphanage. Drs. Septimus Thomson and W. J. Stevenson, were in charge of the proceeding, with a dozen other doctors assisting. The work was concluded in the one hundred and three cases by 12 noon. Dr. Thomson having established what is believed to be a record by removing tonsils and adenoids from sixty-three children in three hours averaging one operation every three minutes for the entire period. To-night all of the children are reported as in a satisfactory condition and they enjoyed their first food, a small ration of ice cream, at midnight."

It is a matter of deep regret that all the foregoing details should appear in the daily lay press. It would have been infinitely better if the London doctors had removed these tonsils in the usual quiet way. It was not at all necessary to notify the newspapers to have reporters at the institution, or to prepare a "reader" for the press. This sort of thing cannot be too severely condemned.

MIRACLE CURES.

In our July issue we referred to the visit of Mr. James Moore Hickson to Toronto, and the attention given to the numerous cripples, etc., who appeared before him. We suggested that a representative committee be appointed without delay to investigate the present condition

of all these invalids and to report to the public. There should be no attempt at evasion. If Mr. Moore's visit was a failure, so far as the sick and disabled are concerned, the fact cannot be too soon made known. It is very wrong to build up false hopes in the breasts of chronic sufferers. It is also very wrong that Mr. Moore should continue such exhibitions if no good or very little good come of them.

We have watched the papers for the reports of cases cured, and have found the following:

"CURED BY FAITH IN CHRIST

"Mrs. Lewis Watts, crippled, claims to be fully healed, 5th May.

"Cured by faith, of rheumatism which had left her crippled, Mrs. Ruby Lewis-Watts, 43 Patricia Road, is now as hale as before her incapacity to walk in November, 1917. She attributes her cure to her belief in Jesus Christ and faith instilled into her by the laying on of hands by J. M. Hickson, the Church of England healer, who conducted a one-day mission in St. James' Cathedral.

"Rev. W. L. Baynes-Reed, D.S.O., when informed of the cure, said: 'It is simply marvellous.' He has a notation in his diary, dated some years ago, which reads: 'On account of knee trouble, Mrs. Lewis-Watts has to stand to be communicated.'

The woman herself says she can hardly credit it, and recites how, in February this year, she discarded crutches for a stick which she used until attending Mr. Hickson's mission."

This case looks much like a case of an hysterical knee. Medical men know well how a neurotic joint may act. The women will go on crutches for years, and quite suddenly get well. Organic diseases do not behave in this way.

Now let us give another case from another source:

"NEW MIRACLES.

"Quebec, July 26.—Three new miracles are reported at St. Anne de Beaupre. In one case, a young boy, crippled since early youth, came from St. Johns, Nfld., accompanied by his family to implore the saint. After Mass this morning it is reported that he was able to walk unattended and without the help of crutches."

It would be curious to know if Mr. Hickson would regard this case as on the same foundation as that of Mrs. Lewis-Watts. It is only reasonable that an answer should be given to this question. These theologians should be prepared to discuss this matter frankly. We are dealing with disease and its cure, and there must be no mysticism. We only desire the truth.

Again we make the request that those responsible for the advent of Mr. Hickson should lose no time in having a Committee appointed to investigate fully and fearlessly all these cases. We should think that

all concerned in this matter would hasten to turn on the searchlight. What a satisfying thing it would be if Mr. Hickson's visit had to its credit the cure of a case of cancer, or infantile paralysis, or locomotor ataxia, or cataract. We have been anxiously waiting for such an example.

DR. GLOVER'S CANCER TREATMENT.

So far the medical profession has little before it but lay newspaper statements. We claim that it is time something in the way of a scientific report appeared from some authoritative source. It is to be hoped that there will be no delay in giving out some definite word soon. It should now be possible to say something by way of a progress account on the number of cases treated, the number of deaths, the number not improved, the number improved, the extent of the improvement, and the location of the cancers.

All this information is urgently needed, and could be made available for the medical profession. In asking this we are not asking for anything that would be difficult to furnish, and it would be very interesting to the medical profession. We take it that this is the only true way to proceed in a matter of this sort. Great medical discoveries should be made known in the medical press or before some medical body, and not through the lay press. We hope this treatment will speedily be got into proper channels in this regard.

HISTORICAL BRIEFS.

The first general anesthetic was recorded in Genesis Chapter 11 verse 21, "And the Lord caused a deep Sleep to fall on Adam, and he slept, and he took one of his ribs and closed the flesh thereof."

Cocaine was first used by Carl Koller in 1884.

Eucaïne was first used by Merling in 1896.

Novocaine was used by Alfred Einhorn in 1905.

Ether.—Though not authentically recorded, Dr. Crawford Williamson Long of Danielville, Ga., probably performed the first operation with ether as an anesthetic. In March, 1842, Dr. Long removed a cyst from the neck of a patient, using ether as a general anesthetic.

Nitrous Oxide.—Horace Wells, a dentist of Hartford, Conn., began the use of nitrous oxide in his dental practice. The death of a patient from an over dose of the anesthetic caused him to give up his practice and later to commit suicide.

—THE LEUCOCYTE.

ORIGINAL CONTRIBUTIONS

TUBERCULOSIS—A SOCIAL DISEASE

EXTRACTS FROM AN ARTICLE BY DR. OCTAVE MONOD OF THE LEAGUE
OF RED CROSS SOCIETIES.

OF all the great scourges with which humanity is afflicted, there is none today more terrible than tuberculosis. This disease, already known to Hippocrates, had always been considered throughout the ages as a diathetic and constitutional affection, engendered in the organism by manifold and various causes. We must pass over the long darkness of the middle ages and come to quite modern times, before we find any change in this point of view. It was due to the genius of Villemin that the inoculability and contagiousness of tuberculosis were both asserted and proved. When, some years later, Koch discovered the bacillus which today bears his name, the last remaining doubts on this question were dispelled, and a new horizon, rich with promise, was disclosed.

No longer have we to contend with a hidden and mysterious foe; we know our enemy, we know where he is generated, the causes which favor or retard his development are perceptible to us. The first measures to be taken aim above all at the destruction of the microbe by disinfecting the sputum, clothes, and bedding of those afflicted with the disease, as well as by sterilizing milk and meat which may contain tubercular bacilli of animal origin.

Unfortunately, however sound these ideas may be in theory, their practical application presents great difficulties, for it soon became apparent that on account of the prevalence of tuberculosis, and its great diffusion, the isolation of the carriers of contagion is one of the most intricate of economic and social problems, and which so far it has been impossible to solve.

Since the work accomplished by Villemin and Koch, continuous research has gradually modified our conceptions and thrown a new light on the means of combating tuberculosis. For one thing, the long admitted and uncontested theory that the disease is hereditary has had to be abandoned. The child of tuberculous parents (except possibly in some very rare instances) is not born with the disease, but only contracts it afterwards. This is a comforting fact, inasmuch as it suffices to remove the new-born infant and surround it with proper care in order to save it from the disease which has attacked its parents. It has also been ascertained that tuberculosis is far more widespread than had at first been supposed.

Whether or not you become infected with tuberculosis depends on numberless circumstances, on whether the life you lead is given to excessive indulgences or overburdened by work, whether luxury and idleness or poverty and privations fall to your lot. It depends on the calling you have chosen, on the food you eat, on the house you live in, the neighbors you frequent, the diseases you contract. It depends more or less on the hygienic conditions of your existence, on the cleanliness and width of your street, on the number of squares and gardens which adorn your street, on the number of squares and gardens which adorn your town. It is dependent on the price of bread, on the rate of exchange, on whether there is war or peace.

After reading these lines, we are perhaps tempted to ask whether it is worth while engaging in the fight, whether it is in our power to change the conditions of our daily round of life, or whether it would not be wiser to resign ourselves to our fate? . . . I have before me large posters bearing in heavy lettering the words: "Fight tuberculosis, tuberculosis can and must be overcome." But what can I, poor mortal, do to combat this universal scourge? The few precautionary measures I might take would be no more than a drop in the ocean. It is indeed obvious that in this case individual action is not enough; combined social, governmental—I might even say international action is necessary.

We should no doubt not lose sight of the fact that, as members of the vast social body, we are inevitably interdependent one on another, and that the effect of associated individual action is incalculable. Let us keep before us the principles inculcated by modern hygiene: live in the open air, sleep with the windows open, adhere to the rules of cleanliness, develop the physique by sport and exercise. In sickness, two considerations must be taken into account, the microbe on one hand, and the soil on which it operates on the other. It is to a certain extent in our power so to prepare the soil that only healthy grain can take root, by increasingly and with unwavering attention uprooting and destroying the weeds that are ever ready to spring up. Never forget that if, during certain periods of our lives the protection against infection is of supreme importance, at others, on the contrary, it is even more indispensable that the organism should be prepared for resistance to infection. A superstitious dread of this disease is apt to have consequences as disastrous as those due to ignorant carelessness. Let us therefore everywhere endeavor to create healthy minds in sound bodies. Individual effort must, however, be supported by legislation. Governments must realize that, from the economic standpoint, prevention is better than cure, and that national expenditure can never be too great when applied to improvement of housing condi-

tions, construction of hygienic dwellings for large families, application of sanitary regulations in factories, improvement of labor conditions, general sanitation of towns and country dwellings, and to helping persons affected with tuberculosis to obtain proper care by providing them and their families with the requisite means for so long as shall be necessary. Similarly childhood must be protected, and the child removed from infected environment. To this end, the creation of dispensaries, sanatoria and special hospitals must be undertaken. Encourage sport, which strengthens and develops the weakly, and fight tuberculosis by every direct and indirect means within our power. The Belgian Minister of Hygiene recently stated that "hygiene in the twentieth century cannot be limited to the methods employed during the nineteenth, which were chiefly negative in character, such as avoiding microbes, dust and contamination. Modern hygiene demands active methods. Its object is sound health by means of air, exercise, rest and good feeding"—to which may be added co-ordinated and legally regulated work.

The effort required is no doubt immense. The object in view is, however, worthy of the most supreme endeavor, and its attainment calls for the united action of all individuals in every nation.—The Red Cross Bulletin.

A NOTE ON HYPERPIESIA.

By G. D. Maynard, read to Witwatersrand Branch S.A.M.A.

BEFORE discussing the condition known as hyperpiesia, I may perhaps be allowed to make a few general remarks on blood pressure, the methods of estimation, and the significance of variations from the normal.

That instrumental determination of pressures is essential to scientific work will, of course, be admitted, but a practitioner who has not systematically checked his digital estimation of pressures by the sphygmomanometer may not realise the great difficulty, if not impossibility, in obtaining even a relatively reliable guide to pressure by this means. Having by experience demonstrated to myself, by manometer control, how faulty my digital estimate of pressure often was, it was a satisfaction to find Sir Clifford Albutt drawing attention to the difficulties of digital estimations. He writes: "The finger gives us no oncographic information it is apt to take amplitude for pressure, especially in slow pulses, whereas in high pressure the arterial excursions are less. I have met with no physician who has patiently compared his finger impressions with the indications of the sphygmomanometer, who has not confessed that his

finger had much to learn and to unlearn, and that part of the lesson is the fallibility even of the most erudite touch."

It has been, and unfortunately is still, customary to pay almost exclusive attention to systolic or maximum pressures. Systolic pressure are, however, so readily influenced by temporary conditions, such as excitement, attention, etc., that single readings are apt to be misleading, even when taken with the utmost care. A difference of 30 mm., or more, is not uncommonly observed between two observations taken within the space of time occupied by a consultation. The diastolic pressure, however, is less subject to fluctuations from phisic causes, and from other points of view often gives the more valuable information, and should therefore always be recorded. The term "pulse pressure" is used for the difference between the systolic and diastolic pressures.

In young men the normal systolic pressure is about 120, and the diastolic 70-80 mm. A useful, and approximately correct, rule for age variations is to add 5 mm. to the systolic pressure for each 10 years increase from 20 to 60, and about half this amount to the diastolic pressure. In women rather lower pressures are the rule, and in children of 10 years of age the systolic pressure should be from 105-110, and the diastolic about 65 mm.

Although diastolic pressures are, as compared with the systolic, relatively constant, they are nevertheless, *other factors remaining constant*, a function of the length of the diastole. The longer this interval, or, in other words, the slower the heart-rate, the lower the diastolic pressures will be. The systolic pressures are influenced, and even to a greater extent than the diastolic, by the cardiac rate; so that all records of blood pressures should be accompanied by a statement of the pulse-rate at the time of estimation, and inferences must be made with due consideration of this factor.

Hypertension has received more study than its reverse, hypotension; the presence of a definitely lowered pressure may be of considerable assistance in the early diagnosis of conditions such as pulmonary tuberculosis and Addison's disease. Hypertension is observed in some forms of "heart disease," and extreme pressures may be present in cases of interstitial hephritis. Also, to a lesser degree, and as an inconstant feature, in other degenerative conditions of the kidney. It is, however, to a disease in which the high pressure is not secondary to any determined morbid state, and to which Sir Clifford Albutt has applied the term "hyperpiesia", that I wish to draw attention.

It is constantly stated, even at the present day, that arteriosclerosis is not only associated with, but causes an increase in the systolic blood

pressure. I think that when gross changes in the arterial walls are present, an increase in the *pulse pressure* will usually be observed, as much perhaps due to a fall in the diastolic as a rise in the systolic pressure. It has, however, I believe, been demonstrated (eliminating comparatively trifling alterations in pressure) that arteriosclerosis in itself does not produce rise of blood pressures. Primary atherosclerosis, which is a common degenerative change of advanced age, and called by Sir Clifford Albutt "decreascent atherosclerosis," is not accompanied by any marked rise in blood pressures. When, however, arterial changes are found in association with a high pressure the degeneration is presumably secondary to the pressure and directly due to mechanical stresses as a causative agent. The distinction between the two types of arteriosclerosis is of great clinical importance, both from the point of view of treatment and prognosis. Further, if we eliminate from this group of arterial degenerations cases due to interstitial nephritis, there remains a not uncommon type, in which arterial degeneration is accompanied by high, and frequently excessive, pressures. It is to this disease that the term *hypertensia* is applied. There seems little doubt that to this group many cases formerly called "prescleroses" by Huchard, and "pre-nephritis" by Mahomet, properly belonged.

Before considering the early symptoms of this disease let me quote from Sir Clifford Albutt a description of a moderately advanced case: "A patient of 55-70 years of age, or sometimes still younger, will tell us that in ascending hills he has found himself pulled up by shortness of breath; perhaps also by a substernal constriction. His countenance may be healthy, or may be too florid, or may show a sallowish ground tint with a splash of ruddiness upon the malar eminences, tints apt to turn bluish on exertion; . . . or the symptom to drive the belated patient to the physician may have been a sudden hitch in his talk, or a vertigo, or a passing paresis of a hand or arm. Probably we shall be told that, if naturally of energetic temperament, he had of late lost his elasticity, had become more sluggish, fretful and despondent, especially early in the day; he would 'pout upon the morning, cheering up a little towards evening, . . . or he may speak—and this is a significant symptom—of unaccountable 'bronchial colds'; and with this he may have had 'billiousness,' with lassitude, peevishness and drowsiness, and perhaps one or more unaccountable attacks of nose bleeding."

Not uncommonly the nervous irritability is the first symptom to attract attention, and so these patients are frequently treated for neurasthenia, sometimes for long periods, and valuable time is thus lost. One of the earliest physical signs may be a rise in the diastolic pressure, soon,

however, to be followed by a systolic rise. The increasing strain thus thrown on the heart is met by an hypertrophy. So long as this compensatory growth of muscle can compete with the rising pressures, which it may do for some years, no cardiac symptoms arise, but a time inevitably comes when the myocardium, after a game fight, is no longer able to meet the demands of the increasing peripheral resistance and cardiac failure supervenes. To try to effect improvement in this stage by giving cardiac stimulants, is similar to flogging a weary horse who has been making a noble effort to pull a cart up-hill with the brakes on, the therapeutic inference is clearly to try and take the brakes off, but frequently this is overlooked. When, however, we are in the presence of heart failure, the patient has reached a late stage of the disease, the curtain is being rung down on the fourth act, and only palliative measures are now possible. At an early stage in the disease changes occur in the coats of the arteries, probably due largely to the unusual mechanical strains caused by the high pressure.

The physical signs will, of course, depend on the stage at which the disease has arrived; it may, however, be convenient to consider some of the more important signs separately:—

(1) *The blood pressure.*—The systolic pressure will be found to lie between 180 and 280 mm., and maintained at this level, with a corresponding rise in the diastolic pressure.

(2) *Arteriosclerosis.*—Progressive changes take place in the arterial walls. It must not be forgotten, however, that the distribution of arteriosclerosis may be, and indeed usually is, localised and patchy, especially in the early stages. For example, the cardiac and cerebral vessels may have undergone extensive degeneration, before palpable changes in the peripheral vessels can be detected; or the dorsalis pedis may be markedly affected and the radials apparently normal. Not rarely the retinal vessels give the first indications of the degenerative process. It is probable that arteries containing powerful muscular coats can to some extent protect them from the injury resulting from mechanical pressure strains, by contraction.

(3) *Cardiac signs.*—Hypertrophy, especially of the left ventricle, is sooner or later inevitable. Care must be taken, however, not to overlook those cases in which the hypertrophy is present without any increase in the area of absolute dulness. The first sound at the apex often has a changed tone and an apparent lengthening. When once appreciated this change in quality of sound is an undoubted aid in diagnosis. The aortic sound is usually accentuated, and has a ringing or hollow tone.

(4) *Urinary signs.*—It is mainly to a consideration of the condition of the urine that the differential diagnosis between this disease and interstitial nephritis will rest. The polyurea and granular casts of interstitial nephritis do not occur, although in the urinary deposit from a case of hyperpiesia epithelial cells and hyaline cast may be found, granular casts are rare, the specific gravity is not much lowered, nor has the presence of albumen when found the same relationship to meals and exercise as in interstitial nephritis.

Heart failure, as evidenced by the usual syndrome of a tired-out myocardium or apoplexy, are the two most common fatal terminations. In connection with cerebral haemorrhage one may perhaps be allowed to refer to a point of practical importance. Cerebral haemorrhage, even when occurring in a patient with decreascent atherosclerosis, may be associated with a very high blood pressure. If the patient has not been seen previously, the existence of the high pressure may wrongly suggest the advisability of a venesection, for in such a case the rise in pressure is a conservative process, nature's attempt to preserve life by forcing blood into vital centres "blanching under the effects of cerebral pressure from the haemorrhage." On the other hand, if the high pressure was the primary cause of the giving way of the arterial wall, a prompt venesection may save life. An examination of the heart may give us the clue we require; in the absence of hypertrophy the observed high pressure is probably transient and conservative, whereas its presence would suggest that the high pressure preceded the haemorrhage.

Death may also be caused by pulmonary infaret, an acute and rapidly fatal oedema of the lungs, or a terminal pneumonia, the latter not being uncommon in these patients.

Nothing definite is yet known as to the underlying cause of this disease. It has been suggested that an alteration in metabolism leads to the presence in the blood of a vascular irritant poison, which, producing an arterial constriction, raises the blood pressure, circulatory changes thus produced in turn further hamper the normal metabolic processes. In any case a vicious circle appears to be set up which, if not artificially broken, leads within a few years to a fatal termination.

The treatment is primarily dietetic, and this alone in the early stages may be entirely successful. Alcohol, tea, coffee, soups, meat extracts, gravies, tobacco, salted or tinned foods must be strictly eliminated from the diet. Other animal foods (procured by the death of the animal) more or less restricted according to the patient's condition. Animal foods, which do not necessitate the death of the animal, for example, eggs, milk, or cheese, are permissible; also cereals, fruits,

vegetables, etc. Drugs are of little or no use, except to relieve symptoms, and no drug is known which has any lasting effect in lowering the blood pressure. The nitrites, used with discretion, serve a useful purpose in relieving headaches and other symptoms. Sir Clifford Albutt has recommended the employment of "high frequency," and considers it worth further trial. There seems to be no doubt, however, that if it is to do good a current of sufficient amperage must be used. Machines giving a current of only 300 mille amperes are useless for this purpose, and I am informed many machines on the market do not develop as much as 100 m.a. Dr. Stewart has been treating some cases for me, and has been using a current of 1,000 mille amperes or over. So far we have only had a few cases under this treatment, and although their number is too small on which to base any definite opinion, the results have been encouraging, and I think undoubtedly worth continuing. This seems to be the only sort of "fancy treatment" that has given any prospect of improvement, although many have been tried—galvanism, baths, aerated and still, etc.

It appears established that if the case comes under proper treatment at a sufficiently early stage, cure may be expected, although a relapse may occur and call for a second course of dieting, etc.; when, however, the case is only seen in a later stage, cure is impossible, although considerable amelioration may follow suitable treatment, and a fatal end perhaps be postponed.

In conclusion, may I say that an attempt has only been made to outline roughly the principal features of a disease, which hardly seems to be receiving the attention its importance or its frequency deserves, especially in view of the fact that if untreated it is inevitably fatal, whilst in its early stages it is curable.—Selected from *Med. Jour. South Africa*.

THE TOXEMIAS OF PREGNANCY.

Elmer S. Waring, M.D., Florence, S.C.

THE obstetrical aspect which it is my lot and privilege to discuss with you gentlemen this evening is that of the toxemias of pregnancy. I feel not a little at a loss inasmuch as it has been my experience only to have the opportunity to care for a few cases of pernicious vomiting of pregnancy while one year on the East Medical Service of the Massachusetts General Hospital. A man who has not served as house officer at an obstetrical hospital or who has not suffered the hard knocks of his own mistakes through years of practice is not very apt to speak feelingly on this subject. Perhaps some of you, falling in the latter category will warm up to the discussion.

My paper will consist of Williams' classification, a few salient points on pathology, etiology, symptomatology and treatment; also of some gleanings from two papers by John E. Talbot of Worcester, Mass., concerning especially the aetiology and prophylaxis, and finally of a few cases from the records of the Florence Infirmiry, reporting in detail one case which is still in the infirmary.

Certain French observers hold that such slight affections as mild headache, salivation, certain skin eruptions on the one hand and such serious disease as eclampsia on the other represent respectively the early and the advanced stages of one and the same process which they designate as hepatotoxemia. Vomiting, albuminuria, yellow atrophy of the liver and eclampsia may all be manifestations of disturbed metabolism—but these are pathologic and etiologic groupings. What we are most interested in is a clinical classification which Williams gives as follows: Six types of the toxemias of pregnancy: 1: Pernicious vomiting, 2: Acute yellow atrophy, 3: Nephritic toxemia, 4: Pre-eclamptic toxemia, 5: Eclampsia, 6: Presumable toxemias.

Pernicious vomiting of pregnancy is but an exaggeration and prolongation of "morning sickness." There is generally a combination of at least two of the three factors,—neurotic, reflex, and toxic. The woman who makes her own diagnosis of a first pregnancy before her catamenia is overdue—if she has more than the average amount of "morning sickness" is very apt to have all of that excess due to causes justly classed as neurotic.

The hygienic treatment is social as well as personal. If she is and expects to continue to be happily married she must have her time occupied so as not to become too introspective. Mental and spiritual compatibility with her husband are as essential as physical compatibility. Many of the women seen in a clinic like this have no demonstrable psyche and we wonder how they can appear to suffer from the identical nervous malady as that which afflicts our typical high-strung, precocious, over-educated, physically frail young Southern woman. There is somebody in the medical profession who can get under the skin of the latter type and set her permanently on the right track. That somebody may as well be here as in Baltimore. Has the psychically deficient woman of our cotton farms imagination to be appealed to? Is there someone who can get under her skin? I fear not. But enough of this psychotherapeutic theorizing.

The woman who has an exaggeration of "morning sickness," must have endurable routine, enjoyable diversion, and compatible family relations. Her routine or work ought not to be too strange or to familiar,

too severe or too prolonged; but it can not be too absorbing or too interesting. Washing dishes is perhaps about the commonest and yet the most impossible kind. If she lives by work, play, love and worship she is apt to keep down 95 per cent. of three meals a day for nine months. If she lives by work alone, or worse still by none of these, she is apt to have neurotic, reflex, and toxemic elements in her morning sickness, and to have it become pernicious.

A warm drink 15 or 20 minutes before lifting her head from the pillow in the morning, an ampoule of corpus luteum twice daily to overcome the ovarian insufficiency is likely to suffice as specific diet and drug measures. Not to infringe upon the domain of the hygiene of pregnancy, let us assume a case at the end of the fourth month when first seen in consultation. How is the distinction between reflex neurotic and toxemic to be made? Not by sheer guess work, not by observation that sees with the eye but not with the brain; but by a combination of the three following: 1—A thorough history from the patient herself checked by a reliable relative not in the patient's presence; and a thorough routine examination endeavoring to detect especially a reflex cause such as malposition, and foci of chronic absorption of toxins. 2—The closest observation and sizing up of the patient by a nurse who is good at judging women, especially pregnant or nervous women, and at expressing to you her findings in terms that will prejudice no one. 3—The determination of the total nitrogen and the ammonia in the 24 hour urine. If the ammonia remains 5% or less of the total nitrogen toxemic vomiting is absolutely ruled out. If it exceeds 15 or 20% it clearly indicates that the patient is seriously ill. If the ammonia coefficient falls after a few days rest in bed 48 hours or more total abstinence from mouth feeding, continued energetic rectal feeding of not over 6 oz. of normal saline containing 1 or 2% glucose and 5% sodium bicarbonate, or 5% alcohol, or peptonized milk or eggs; and moral suasion—the diagnosis of neurotic vomiting is permissible; but if the coefficient remains stationary or rises, one probably has to deal with the toxemic variety, and the diagnosis becomes absolute if torpor, coma, or coffee-ground vomit appears.

For neurotic vomiting the regimen outlined above together with the absolute confidence of the patient in the physician is all that is required. For toxemic vomiting the treatment par excellence is induction of abortion. This should be done as soon as the diagnosis is made. Chloroform should be avoided, and under ether or nitrous oxide a vaginal hysterectomy, or in the case of a soft and patulous cervix, the use of Goodell's or Hegar's dilators is indicated.

Acute yellow atrophy of the liver. The first fatal case in a pregnant woman was reported in 1706 by Kerbering. Between 60 and 65% of the cases occur during pregnancy. The condition may occur at any period of pregnancy, Beatty and Mason having described cases at the sixth and eighth weeks respectively. Usually, however, it occurs during the later months of pregnancy or in the first days of the puerperium. A woman who apparently was in perfect health may be seized with intense headache, pains in the abdomen, and possibly severe vomiting and purging. In a short time she becomes torpid or violently delirious and soon passes into a condition of coma which may or may not be disturbed by convulsions. There is generally a certain amount of jaundice which may vary from a mere discoloration of the conjunctivae to pronounced general icterus. The diagnosis is difficult. Marked jaundice with the other symptoms of eclampsia or pre-eclamptic toxemia, is sufficient. In the absence of marked jaundice demonstrable progressive diminution in the size of the hepatic dullness, and the presence of leucin and tyrosin crystals in the urine, with a high ammonia coefficient should be sufficient to warrant the diagnosis and the corresponding treatment, that of emptying the uterus as rapidly as is consistent with the safety of the patient.

The pathologic picture in the fatal cases, (and they are not all fatal as Dr. F. S. Newell has personally assured me) is that of an almost complete lobular parenchymatous degeneration, while the interlobular spaces with their blood-vessels and biliary canals are but little changed. This is almost the opposite of the periportal necrosis of the characteristic eclamptic liver.

Nephritic toxemia, our third consideration, is perhaps after pre-eclamptic toxemia more common than any one of the six. This because it may occur and recur frequently without ever being diagnosed clearly. Williams believes it to be the underlying factor in women who repeatedly give birth to premature infants and present a history of being perfectly well up to a certain period of pregnancy when edema and albuminuria suddenly develop. In such cases the urinary symptoms may persist for some months after delivery, but eventually disappear to reappear at about the same period in each subsequent pregnancy. In these cases the quantity of urine may be normal or even increased in contrast to the scanty dark urine of pre-eclamptic toxemia. To know the blood pressure and the urinary findings in the non-pregnant state is all important in making this differentiation.

Naturally it is but a brief step from this condition to chronic glomerular nephritis, and the prognosis of nephritic toxemia is ultimate-

ly as bad, as the strain of pregnancy usually accentuates the original nephritic process. The treatment is identical with that of pre-eclamptic toxemia, while if convulsions or coma occur it is along the same general lines as for eclampsia.

Pre-eclamptic toxemia occurs several times in every one hundred pregnancies and is far more frequent in primigravidae. It usually appears in the latter part of the second half of pregnancy, and occurs but rarely in its early months. It should be suspected whenever the patient complains of headache, lassitude or edema and particularly if the urine is diminished in amount and contains albumin. The symptoms vary from euphoria, through slight malaise to those indicative of profound auto-intoxication. In this event the patient may complain of severe and persistent headache, violent epigastric pain or visual disturbances which may vary from slightly impaired vision to complete amaurosis. Given a very ignorant or questionably trustworthy patient of neurotic temperament the only way to prevent the frequent occurrence of pre-eclamptic toxemia is to insist upon the routine urinalysis and blood pressure reading every four weeks during the first six months and every two weeks during the last three months. The appearance of any albumin or the rise of 15 or 20 points in the systolic pressure necessitates repetition of these tests twice as frequently.

The prognosis is usually fair but it is entirely dependent upon the amenability of the symptoms of treatment. Chronic renal disease rarely results from this type of toxemia, and it is Williams' experience that it is unusual for it to recur in succeeding pregnancies. This of course, is not a universal rule, but it would appear that one attack confers a relative immunity upon the patient just as in eclampsia.

As to treatment the patient should be put to bed and kept warm; put upon a restricted diet omitting meats and the coarse vegetables, or better still upon a diet of two quarts of milk per day, with a few relishes to relieve the monotony. The milk is an ideal diuretic, besides which abundance of water or cream of tartar lemonade (1 dram to the pint) should be given. The milder saline laxatives, enough to make three or four stools daily is sufficient in the way of intestinal elimination. Bi-daily blood-pressure readings and albumin tests should be carried out for eclampsia has been known to develop right under the most vigilant and painstaking obstetricians. If in spite of this observation and these prophylactic measures the blood pressure mounts higher and convulsions threaten, the next steps in order are drastic purging with magnesium sulphate which it is well to give in black coffee to prevent nausea, half grain doses of elaterin every two hours which the pharmac-

ologists tell us is eleven times as powerful as croton oil; hot packs, and bleeding. After this there is nothing left but induction of labor or rapid operative delivery. It is too frequently forgotten that the life of the child may be almost or quite equally as important as the life of the mother. Fetal heart observations and objective and subjective fetal movements must be repeatedly used as a guide along with the sizeup of the whole social problem in making the respective evaluations at the different stages of the emergency.

Eclampsia concerning which we have all had some bitter experiences, I shall not take up in detail, but illustrate with a case. It is so very variable in the different types of obstetrical practice that no reliable figures as to its frequency are available. In some German clinics it varies from .15 to .6 per cent., and the French have commented on a marked variation from year to year. At the Boston Lying-In-Hospital there have occurred but two cases in the out-patient deliveries of twelve to fifteen hundred a year, in the past eleven years, so efficient is their pre-natal care. In hospital practice some 70 to 80 per cent. of cases occur in primiparae; and twins or hydramnios increase its likelihood 4 to 5 times. To quote Williams verbatim: "The use of veratrum viride which is highly praised by so many American writers, has never appealed to me on theoretical grounds, and Sturmer's statistics from the East India Medical Service, where it was used for twenty years, show a maternal mortality of 45 per cent. After reading the enthusiastic report of Mangiagalli and of Craigin and Hull concerning its merits, I felt that I was perhaps not doing my duty to my patients by rejecting it. Accordingly in a series of cases I gave it to every other patient while the alternate patient was treated in identically the same manner except for the veratrum. While the hypodermic administration of 5 to 10 minims of the fluid extract, repeated if necessary, undoubtedly led to a marked slowing of the pulse and occasionally to an almost alarming fall in blood pressure, the patients did neither better nor worse than those who did not receive it. For this reason I have abandoned its use."

The sixth heading, *Presumable Toxemias*, can be disposed of briefly. Headaches, hiccough, salivation, abnormal cravings, non-contagious skin diseases, such as impetigo, herpes gestationis, peripheral neuritis, and puerperal insanity may all be grouped as presumable toxemias. Some cases of mania and of melancholia have occurred with the urine failing to reveal the slightest evidence of toxemia, and yet the mental derangement promptly disappeared after the employment of milk diet, rest and eliminative treatment. DeLee says: "It is more than possible

that some of the diseases we call toxemias are in reality infections, the casual bacterium still eluding our crude methods of investigation.

Now let us consider in conclusion the aetiology of the toxemias as a whole from as practical a viewpoint as possible. Williams speaks of six lines of investigation, viz. 1—foetal metabolism, 2—the entrance of foetal or placental elements into the maternal circulation, 3—poisoning by substances formed or retained in the placenta; 4—disturbances in the maternal metabolism; 5—anaphylactic reaction; 6—Mammary toxemia. Attempt is made to fit one of these six theories as to the cause of eclampsia. I do not see how any one of them can fit as the cause of any of the toxemias, unless it be that disturbances of maternal metabolism fits in a very general sense. Certainly such a proposition can not be considered either the determining cause or the exciting force. The former is what we want to discover in order to remove it and thereby stamp out the disease. Of it Williams confesses ignorance in these words: "Our clinical experience leads us to believe that it (eclampsia) is dependent upon a profound toxemia, which is probably metabolic in origin, but we are as yet ignorant whether the chances originate in the maternal or foetal organism or both."

On the other hand Talbot of Worcester demonstrates in 97 consecutive cases evidence of chronic sepsis in the teeth. We know that pregnancy, itself a perfectly physiological process, can break down the reserve power of the heart in a full blown case of mitral stenosis to the point of decompensation. Why can it not break down other organs whose reserve power may have been weakened by some previous or concurrent process? Every tissue which is in the process of production is in its stage of lowest resistance. The kidney, the liver, and the placenta are the three principal organs of metabolism of the blood. It is through these three that the blood stream is most sluggish; and it is these three that are most damaged as shown by the pathological findings at autopsy. It is therefore, a reasonable hypothesis to say that the symptoms of toxemia of pregnancy with or without convulsions are caused by the retention of normal physiological waste products of the developing pregnancy, this retention being due to the damaged functional powers of the kidneys, which damage has been brought about by the toxins of chronic sepsis in the blood. There is clinical evidence that this hypothesis is true. The roentgen ray has demonstrated that a high percentage of "saved teeth" have abscess formation at the end of the roots. That pyelitis is known to be a more frequent complication of pregnancy than formerly can well be explained on the recent increase in the number of undrained foci of infection which have resulted from dental practices.

Nearly every baby which in Talbot's experience has developed hemorrhage of the new-born has come from a mother in whom was demonstrated foci of infection in the teeth, and a high percentage of such mothers have shown some signs of toxemia during pregnancy. Antepartum hemorrhage due to premature detachment, partial or complete, has long been recognized as a common accompaniment of toxemia of pregnancy. Talbot believes that this phenomenon is due primarily to an injury done the placenta either by a local infectious process, or by the toxins of sepsis in the blood stream, followed by a hematoma which may dissect the whole or a part of the placenta away from the uterine surface.

Eugene S. Talbot has a rule worth remembering, that a patient's health is worth more than all the natural teeth. From time to time in the past thirty years he has repeatedly called the attention of the profession to the fact that modern dentistry is producing more disease than any other one cause. The profession is beginning to realize the truth of this statement.

Talbot's excellent article ends with these words, and I wish to end my paper with the same words: One needs to be a believer in only a part of the statements made to be impressed with the seriousness of the situation and with the need for the removal of all known foci of infection when associated with pregnancy.—The Charlotte Medical Journal.

DIAGNOSIS AND PROGNOSIS OF LOSS OF VISION FROM ACCESSORY SINUS DISEASE.

The principal points brought out by Leon E. White, Boston (*Journal A. M. A.*, May 29, 1920), are that blindness may originate in the accessory sinuses, that some cases will recover spontaneously, while others will result in permanent loss of vision unless prompt and proper attention is given. Etiologically they are generally divided as: (1) those due to a direct spreading of the infection to the sheath of the optic nerve; (2) those due to the toxemia from infection in the sinuses, and (3) those due to hyperplasia. It is usually easy to diagnose the first two types either from inspection or from the roentgenograms, although pus not possible to detect previously is occasionally found on operating. As the nasal and roentgen-ray examinations are frequently negative in the third, the hyperplastic, type, when the middle turbinate is not involved, the diagnosis is much more difficult. Many of these cases have a condition so elusive as to be difficult of detection either microscopically or macroscopically. Twenty-five cases are analyzed.

CURRENT MEDICAL LITERATURE

FALLACIES REGARDING NARCOTIC DRUG ADDICTION

S. Dana Hubbard, New York (*Journal A. M. A.*, May 22, 1920), believes that so long as addicts can obtain cheap supplies of drugs without personal risk, very few will apply for hospital curative treatment. Narcotic drug addiction can be stopped by sufficiently stringent laws, strictly and uniformly enforced. Public narcotic dispensaries are not desirable or satisfactory in dealing with the problem of drug addiction. This method has been given a careful, thorough and extensive trial in New York, and the conclusion has been reached that it is unwise to maintain such an institution. The clinic was found to possess all the objectionable features and opportunities of abuse presented by the ambulatory treatment of private physicians prescribing to the addict when at large, except one factor, namely, financial profit to a few physicians performing this character of service (fifty-five out of 8,400 registered in New York). Ample provision should be made for hospital or institutional treatment to cover the stage of withdrawal and for the control, care, and moral and mental as well as physical upbuilding of those persons who require it and show the possibility of profiting from such treatment. Prevent the addict from getting his drug, and in very many instances he will cure himself, and if unable to get the drug he will stay cured. It is always well to treat all cases under medical supervision, and physicians experienced in this line of medical practice know that a very small dose of the drug (from one-fourth to one-half grain hypodermically) will control all manifestations of withdrawal. Hubbard maintains that the work of reclaiming narcotic addicts is well worth while. Of the many undesirables, no less than one-half can be brought back to useful lives, and one-fourth should be in some institution where with suitable care and training, many can be made useful citizens instead of merely being impediments and parasites.

TESTICLE TRANSPLANTATION

Operations have been performed by L. L. Stanley and G. D. Kelker, San Quentin, Calif. (*Journal A. M. A.*, May 29, 1920), in eleven cases with human material, and five with testicles removed from young rams. The time elapsing since the use of the animal tissue has been too short to make any deduction as to its value. In five patients, only one testicle was implanted into the scrotum, while in six others, double transplantation was performed. Results have been apparently as good with the

single as with the double graft. One whole testicle of a ram was embedded in the scrotum of each of two patients, but they began to slough in seven and sixteen days, respectively. One came away entirely, while a small part of the other remains after six weeks. In three other cases, only half of a ram's testicle was used, but in all, sloughing began seven days after the operation. The authors are of the opinion that the transplantation of human testicles has a decidedly beneficial effect on the well-being of the patient. They do not believe that the implant lives. Probably during the process of necrosis, certain bodies are given off into the lymphatics or blood stream which stimulate the patient in some unknown way. The authors are unable to determine whether these beneficial effects are due to any action of the interstitial cells of Leydig or any other definite part or parts of the testicle, although they have certain evidence which seems to show that possibly the interstitial cells have more effect than the seminiferous structures. On microscopic examinations of the testicle to be implanted in one case the epithelial cells of the seminiferous tubules were vacuolated and more or less degenerated. In places the intertubular tissue was dense and cellular. There were small islands of these cells scattered about, which might have been interstitial cells. They were relatively large, with rounded nuclei. The same tissue engrafted into a eunuchoid, aged 43, caused sexual desire to appear, whereas it had not been present before. The length of time which these beneficial effects last has not been definitely determined by this work. It is probable that it lasts more than a year. All the patients that are benefited are still enjoying this improvement.

HOW TO REMOVE THE CRAVING FOR ALCOHOL.

Jaguaribe and Regnault begin by quoting the old proverb, "Who has drunk will drink." We must distinguish between the wilful and the will-less drinker. Of these the former are less common. They are men of great energy and firmly believe they can protect themselves from all abuse of the drink. The habit is thus readily acquired and becomes associated with an imperious daily craving for the thrill of alcohol. When they seek to resist the craving they only defer it by some hours. They then deliberately weigh the apparent gains with the sacrifices and make a choice. The problem is a very old one, and the wise man has often played a trick on his subconscious self and its burning desire rather than to test his will too openly. Thus Cesar Borgia, after having become a heavy addict to wine, reduced the capacity of his glass by the cumulative addition of drops of melted wax until he had weaned himself from the desire. A more rapid process consists in rendering the drink nauseating

by the addition of ipecac. It is the old trick of placing bitter substances on the nipple to wean a baby or on the finger tips to cure a child of nail biting. The search for substitutes has sometimes led to good results, but it usually is a case of robbing Peter to pay Paul. The psychology of the willful drinker is best explained by the creation of a second personality through the addiction, which is subject to its own laws. While the strong subject may become an aboulic as a result of prolonged addiction there are others who are aboulic by nature, and who put up no struggle at all. These are weaklings from the start, and demonstrate it in all aspects of life. The drug robs them of the little will power which they may have possessed. These subjects, which are rare in Latin peoples, are best adapted to psychotherapeutic management.—*Medical Record*.

ANTHRAX

A review of fifty-one cases treated at the Massachusetts General Hospital from 1888 to 1918 is made by Albert J. Scholl, Jr., Los Angeles (*Journal A. M. A.*, May 22, 1920). Anthrax bacilli were found in 81.2 per cent. of the cases. The mortality in the cases reviewed was 13.7 per cent. Four of nine patients (44 per cent.) treated surgically died; only three (7 per cent.) treated nonsurgically died. Forty-two patients had lesions on the face and neck. Cervical infections are especially dangerous; two of the patients treated nonsurgically died from respiratory difficulty resulting from the associated edema. The patients treated nonsurgically were confined to bed. Their lesions were left absolutely alone and exposed to the air; no special general measures were carried out. In several of the surgical cases a rapid increase in the edema, a steady decline in the patient's general condition, and death several hours later definitely pointed to the operation as the causative factor. The average duration of the disease in patients that recovered was twenty-three days. Death in the seven fatal cases occurred on an average of four days after the onset of the disease. Thirty-eight infections were in men engaged in handling hides; of these twenty-three were leather tanners. All of the patients treated were males except one. This was a girl, aged 17, who was employed sorting bristles in a brush factory.

THE LIMITATION OF STARVATION IN DIABETES MELLITUS.

Thomas W. Edgar, in (*N. Y. Medical Journal*), believes that too much stress is being placed upon the sugar content of the urine in diabetes, while other manifestations of the disease are neglected. He says we are treating diabetes (by starvation) in a manner that is neither actually nor relatively conducive to the health and economic status of our

patients, to say nothing of the hardships inflicted. According to the rule in all seemingly chronic progressive diseases, and diabetes is no exception, the general practitioner bases his treatment on the hypothesis set by the investigator or research worker, who is too often a laboratory enthusiast without clinical experience. Pancreatic extracts are being placed on the market for the diabetic on the supposition that the pancreas is the exciting factor in the production of the disease, yet no definite lesion has been demonstrated to exist in the islands of Langerhans. The writer points out certain possible errors in the statistics that purport to show marked reductions in the number of deaths under the starvation treatment, and questions whether starvation is a harmless procedure. Personally he feels that it is dangerous and should never be indulged in without the supervision of a competent physician. Prognosis in a case of diabetes, whether severe or mild, should not be based on the rapidity of sugar reduction, but on the amount of food that can be ingested without the production of an excess of the lower fatty acids. Frequent starvation not only reduces the action of internal secretion to a minimum quantitatively during resistance, which in this case is carbo-hydrate, but drains the body of its glycogen content. This removes all available stimuli which might otherwise cause activity. The caloric power of the organism is reduced in its production of heat and energy. Resistance is lessened; metabolism is weakened; undernutrition invites infection, and tolerance decreases progressively. The writer records rather startling results from the use of a serum, which is prepared from the blood of rabbits after they have undergone a series of maneuvers capable of activating the various internal secretory glands to increased action. The serum contains the internal secretions in hormone form. With this serum he has been able to increase the carbohydrate tolerance of certain cases from 25 to 60 per cent., and in some cases cause an absolute arresting of the disease, as evidenced by loss of all subjective and objective symptoms, as well as gain in weight, which has been progressive.—*Medical Record.*

SUCCESSFUL TREATMENT OF GIARDIASIS

Following the observation that not only the cysts of *Giardia intestinalis* and *Chilomastix mesnili*, but also those of *Endameba Coli*, rapidly disappeared from the stools of man following intravenous injections of neo-arsphenamin, and that the cysts of *Eimeria stiedia* disappeared from the feces of rabbits following intramuscular injections of heavy doses of neo-arsphenamin, E. I. Carr, Lansing, Mich., and W. L. Chandler, East Lansing, Mich. (*Journal A. M. A.*, May 22, 1920), made use of this

treatment in a case of giardiasis and obtained a permanent cure. The patient had been infected with *Endameba histolytica* and *Giardia intestinalis*. On establishment of the diagnosis of amebic dysentery by the identification of *Endameba histolytica*, one-half grain of emetin hydrochlorid was administered hypodermically daily, together with two aleresta ipecae (Eli Lilly Company) tablets by mouth three times a day after meals for fourteen days. Stool examinations were made daily. *Endameba histolytica* disappeared from the stools on the second day and did not reappear. No cysts of this organism were encountered. There was no appreciable decrease in the number of cysts of *Giardia intestinalis*. A sulphur treatment was instituted in the hope of controlling this flagellate. No change in the patient's condition was observed. Finally 0.6 gm. of neo arspenamin was introduced into the blood stream. Three hours after the treatment no cysts were found. The cysts did not reappear in the stools during the six days following the treatment. About one month later, an examination of the stool revealed numerous cysts of *Giardia intestinalis*. Within one week, three intravenous injections of 0.6 gm. each were made and, following the second injection, calomel and castor oil were administered by mouth. The patient recovered completely.

TYPHOID FEVER DEATH RATE

Typhoid death rate in New York State decreases from 19 per 100,000 in 1906 to 3.3 per 100,000 in 1919. During 1919 the typhoid death rate for the entire State reached the lowest figure ever recorded, namely, 3.3 per 100,000. In this connection it is interesting to compare the condition of the water supplies of this State during 1919 with the condition in 1906, when the typhoid fever rate was 19.0.

In 1906 there were some 400 public water supplies which served a population of about 6,100,000. About 50 of these supplies received some purification either by slow sand or mechanical filtration and served a population of approximately 700,000. In 1919 there were 510 public water supplies serving a total population of about 8,700,000. Of these water supplies 125 were purified either by filtration, chlorination, or both, and served a population of about 7,000,000. It will be seen, therefore, that in the 13 years from 1906 to 1919 the number of people served by public water supplies had increased from 6,100,000 to 8,700,000, or approximately 43 per cent., while in the same length of time the number of people receiving purified water had increased from 700,000 to 7,000,000 or an increase of 1,000 per cent. The significance of the last figures in comparison with the reduction of typhoid fever is exceedingly striking

insofar as the decrease in typhoid during this period is almost inverse ratio to the proportion of the people receiving purified water and should leave little doubt in the mind of any one familiar with epidemiology as to typhoid fever during this period having been largely waterborne.—*Health News.*

INDUSTRIAL HEALTH CONSERVATION AN ECONOMIC NECESSITY

Conservation of the health of industrial workers, often scorned in the past as an experiment or a fad by both employers and employees, is to-day recognized by both as of the utmost importance. To the employee it means higher physical tone, less time lost through sickness and disability, better working conditions and incidentally through these factors, a greater income. To the employer, it means increased production, greatly lessened labor turnover, and a mutual understanding between capital and labor. With the present labor scarcity and high cost of living, industrial health measures are a factor neither side can afford to neglect.

The field of industrial health conservation, once limited largely to first aid and the reduction of industrial hazards, is now conceded to include all matters which conduce to the physical, mental, as well as the moral welfare of the employee during working hours. It should include a medical examination of all applicants for employment, the removal of remedial defects and the mental and physical adjustment of the man to his job. No less important, though often overlooked, is the preparation of, or provision for, the right kind of food, properly cooked and served, and suitable recreational and educational facilities.

Successful health conservation in industry can only be achieved by a form of self-government, neither paternalistic nor socialistic, but administered through the intelligent co-operation of executive and worker and for the best interests of both.—*Health News.*

“CHRISTIAN SCIENCE” AND SLOPPY THINKING

A New Jersey salesman, who claims to have been a member of the “Christian Science” faith for three years, was recently found guilty of manslaughter because he had permitted his 9-year-old daughter, who was suffering from diphtheria, to die without medical treatment. The little girl was given “treatment”—“absent” and otherwise—by a professional “Christian Science” practitioner. The man was fined \$1,000 and costs. The judge, in imposing sentence, is reported to have said:

“In the light of present-day science, which is the result of many years

of progressive experiment and demonstration, no one is justified in neglecting the use of such agencies as have been shown to be efficient in the treatment of malignant and contagious diseases, and this is especially true where one is charged with responsibility over the life of another, and particularly of a child of tender years, who has no option but to rely on the common sense and good judgment of its natural protector."

The verdict has brought to light, as such verdicts are likely to do, the loose thinking that characterizes so many of the so-called intellectuals of to-day. Well-meaning people, who deny that they are followers of Mrs. Eddy, have written to the newspapers denouncing the verdict and declaring that it is little less than a crime that a man should be punished for following the dictates of his conscience. The main point stressed by such people seems to be that as children occasionally die of diphtheria under medical treatment, there is no reason for getting excited when a child dies under "Christian Science" treatment. The argument, of course, is fallacious. The efficacy of the modern scientific medical treatment of diphtheria is not a matter of theory, belief or conscience—it is a matter of fact. Its efficacy is demonstrable as is the efficacy of the Westinghouse air brake. The parent or guardian who fails to give his child or ward the benefit of modern medical treatment for diphtheria becomes as culpable as a railroad would be if it failed to equip its passenger trains with air brakes. Sometimes, it is true, the air brake fails to avert a fatality; but that is not the fault of the air brake, nor is it any argument for its abolition.

If an adult in his own right mind wishes to be treated by "Christian Science" or any other unscientific methods, there can be no objection, provided the disease from which he is suffering may not, through such treatment, become a menace to the community. Children of tender years, however, should not be sacrificed to the distorted views of those who are supposed to be their protectors.

Religious beliefs should be respected and, in general, they are respected. Where, however, religious beliefs conflict with the general welfare, such beliefs must give way. Presumably, the Mormons were sincere in their belief in polygamy; that particular tenet of their religion, however, had to give way to the more enlightened belief of the rest of the community. The Doukhobors that migrated to Canada were undoubtedly sincere in their belief that they should go nude, and the practice of this belief was undoubtedly less of a menace to the community than are some of the bizarre views held by "Christian Scientists" regarding the cause and treatment of disease. Nevertheless, the Doukhobors had to put on clothes. It is conceivable that we might have transplanted

to this country some of the religious beliefs of India, but it is doubtful whether public opinion in the United States would ever look with equanimity on Sutteeism, even though the widows might declare that being burned on the funeral pyres of their deceased husbands was a matter of their own personal belief and was none of the concern of the general public. Only a few weeks ago a man in Chicago shot his son with the avowed intention of killing the boy because he feared the lad was acquiring bad habits and he wished to save the boy's soul. We have not yet noticed any letters of indignation protesting against the man's arrest. Possibly this is because he represents a minority. Should such beliefs ever reach the dignity of a religious cult with money and well-organized publicity machinery behind it, there would doubtless be found many to defend the killing of minors for the purpose of saving them.—*Jour. A. M. A.*, May 22, 1920.

NEW TREATMENT FOR LEPROSY APPARENTLY SUCCESSFUL.

The United States Public Health Service has reports of what appears to be a cure for leprosy, it was announced by Surgeon General Hugh S. Cumming recently.

Thus one of the world's most dreaded maladies, regarded as a hopeless and incurable scourge of humanity since early history, would seem to have been conquered by officers of the Public Health Service in the leper colony in the Hawaiian Islands.

For some years the belief has been gaining ground that leprosy could be cured, and encouraging progress was made by several investigators. The starting point for this study was the observation that now and then the course of the disease appeared to be favourably influenced by treatment with chaulmoogra oil. The treatment, however, was attended with many difficulties and could not be carried out in all cases. At this point the Public Health Service enlisted the co-operation of Prof. L. E. Dean, head of the chemical department of the College of Hawaii, and president of that institution, suggesting that attempts be made either to isolate the active constituent of this drug, or to devise means for making its continued administration feasible. The latter has been accomplished by preparing what is known as an "ethyl ester" from the Chaulmoogra oil. The treatment has been carried on at the Leprosy Investigation Station at Kalihi, Hawaii, the work being directed by Dr. J. T. McDonald, director of the station. The results of the treatment thus far have been so satisfactory that lepers come willingly for treatment, a recent inspection by Hawaiian health authorities failing to disclose a single secreted case of leprosy. Following a course of treatment, extending over about a year, 48 lepers, treated according to the new

method, were paroled in October, 1919. Up to now they have remained free from disease. At the present time the treatment has been administered only at the receiving station, but it is hoped to provide facilities for the treating also of lepers in the leper colony at Molokai.

Surgeon General Cumming's announcement relates to lepers who have been treated by the new method and have been under observation for a considerable period. Moreover, the decision as to apparent cure has, in the case of each patient, been officially determined, not by officers of the Public Health Service, but by a special parole board, which alone has authority to discharge a patient from custody.

The Public Health Service is now conducting a very careful study of the treatment, making detailed records of all the cases and taking photographs of the lesions once a month. Details concerning the treatment will be published in the near future.

PERSONAL AND NEWS ITEMS

Detectives, on 11th August, visited what was called the Mayo-Curtis Medico Institute of Research in Winnipeg and arrested Russell Dumas, formerly of Toronto, who was operating it under the name of Dr. Gordon Mayo. It is alleged the man had carried on an extensive practice and that his patients were under the impression the place was a branch of the Mayo Brothers, of Rochester, Minn. The suite was elaborately fitted up. Eight specific charges were laid against Dumas, including that of practising without qualifications as a medical man.

A painless method of treating diseases of the gall bladder, which it was claimed would eliminate surgical operations in more than fifty per cent. of such cases, has been perfected by Dr. Frank Smithies, University of Illinois. Dr. Smithies' device consists mainly of a small, egg-shaped perforated ball, about one-quarter of an inch in diameter, and one-half inch long, and 54 inches of rubber tubing about the size of a lead pencil. The ball is easily swallowed by patients and the contents of the gall ducts are painlessly drawn through the tube by suction. After the silver ball has been swallowed and correctly placed by X-rays, a solution is poured down the tube causing a relaxation of the gall duct.

Beginning September 7, a course in optometry will be commenced at the Central Technical School, Toronto. Two complete courses are offered in the department, qualifying students to take the examinations of the Board of Examiners in Optometry of Ontario; namely, for optometrists and for prescription opticians. The class for optometrists, which will be the first of its kind so complete, will continue until June

29, 1921, the fee for which is \$200. The course for prescription opticians, which lasts only until January, 1921, calls for a fee of but \$80. Dr. A. C. McKay, principal of the school, will be assisted by Wellington Graham Maybee, Francis Crombie Trebilcock, M.D., Arthur Smith, M.A., John Clark Thompson, M.M., James McQueen, B.A., and Ivan S. Nott, in conducting this new course. Candidates must be at least 19 years of age and must have completed two years in High school to enter the course for optometrists, and must be over sixteen and have a fair elementary education to enter the other course.

The University of Toronto staff must wait a while before they get any increase in salaries. The estimates for maintenance have been passed by the Drury Cabinet, but the estimates for salaries, which show a very substantial increase, have been held up. The Government has no intention of increasing salaries until the Civil Service Commissioner has reclassified the inside civil service.

Mr. and Mrs. E. C. Whitney, who recently wrote to Mayor Fisher of Ottawa, offering \$100,000 to the city for the construction of a sanitarium to fight tuberculosis, sent for his worship on 20th July and presented him with one hundred \$1,000 Victory Bonds to turn over to the city treasurer.

Dr. F. S. Vrooman, assistant medical superintendent of the Ontario Hospital at Brockville, has been notified of his appointment as assistant superintendent of the Ontario Hospital, Toronto. He will assume his new duties in August. For a time he was medical superintendent of the provincial institution at Cobourg, and since the death of Dr. J. C. Mitchell has been acting superintendent at Brockville. Dr. W. K. Ross, who leaves the Kingston institution to take Dr. Vrooman's place, will assume charge early in August.

The cost of maintaining the Board of Health this year promises to add considerably to the burden of the taxpayer. The smallpox epidemic which carried through into the new year is to blame. At the beginning of the year the present Council appropriated for the Board of Health \$2,400. Of this \$2,384.47 has already been spent, and the Council has voted an additional sum of 558.30.

Another important change went into effect at Speedwell Hospital, Guelph, when Dr. McMurragh, of Toronto, took over the duties of medical superintendent, succeeding Dr. G. N. Urie, who is at present taking some well-earned holidays. There are rumours that Dr. Urie will not return to Speedwell, but they could not be confirmed to-day. Another new member of the medical staff is Dr. Earney, who has been transferred from Byron Sanitarium, and another physician is to be appointed

soon. They will take the places of Drs. Dunning and Heath, who recently severed their connection with the institution. This constitutes almost an entirely new medical staff at the hospital, and so far as can be learned no further changes are contemplated.

The clinical congress of the American College of Surgeons, to be held in Montreal October 11 to 15, promises to be the largest medical convention ever held in Canada. It will differ from other medical association meetings in that the program is largely clinical, and held at the hospitals throughout the city. Because of this, the attendance of the members of the college is strictly controlled and limited by registration, and admission to all sessions will be by ticket.

The popular theory of cerebral localization, which has held the support of scientists for nearly a century, has just been attacked vigorously by Dr. Traube, of Paris, who has cited scores of instances during the war of complete recovery from injuries to the parietal and frontal sectors, even when there was considerable loss of cerebral substance. Dr. Traube told of one case in particular of a French soldier who had been struck in the occipital region by a shell and had lost more than a third of the left hemisphere. He was cured without any trouble in so far as mobility, general sense or even intellectuality were concerned.

Mrs. Elma Campbell on reading in the newspapers that her husband, Dr. Harry E. Campbell, formerly a prominent physician of Pittsburg, had been found dead in a rooming house in New York, after working as a dishwasher in a restaurant for two years, identified the body at the morgue. Mrs. Campbell said that she and her daughter left the doctor three years ago owing to his "eccentricity."

Col. G. W. Badgerow, M.D., C.M.G., F.R.C.S., London, was recently in Toronto, where he was educated and where some of his relatives reside. He has acquired much distinction as a specialist in London, England.

Dr. and Mrs. John A. MacMurchy, of Dresden, Ontario, announce *the birth of a son on first July.*

Calderwood Military Hospital at Kingston *has been closed.* The patients have been removed to Sydenham Hospital.

Dr. MacNaughton, of Hamilton, has been appointed superintendent of the Provincial Hospital at Cobourg. The doctor was assistant superintendent of the Ontario Hospital at Hamilton for a number of years. The institution will be conducted as a regular hospital for mental and neurotic patients. Sub-acute, acute and chronic cases will be treated only, and women patients only will be admitted to the institution.

OBITUARY
E. C. McNICHOL, M.D.

The late Dr. McNichol had practised in Cobourg, Ontario, for upwards of forty years. When he began practice he acted as superintendent of the Cobourg Hospital for the Insane. He took a keen interest in public questions and was a well-known public speaker. He was educated at Queen's University.

JOHN C. MITCHELL, M.D.

Dr. Mitchell graduated from Trinity University in 1875 and practised for many years at Inniskillen. For the past ten years he held the position of Superintendent of the Hospital for the Insane at Brockville. He was also Associate Professor of mental diseases in the University of Toronto. He died after a brief illness at the age of 70.

JAMES ANDERSON, M.D.

Dr. James Anderson graduated in 1880 from Toronto School of Médecine, and Victoria University. He had always practised in Hamilton, Ontario. He died in St. Mary's Hospital, Rochester, Minnesota, after an operation for cancer of the throat. Those who were students in Dr. Anderson's years will recall his genial and lovable qualities.

PETER McLAREN, M.D.

Dr. McLaren died at his home in Ormston, Quebec. He was a graduate of McGill of the year 1872, had resided for 48 years in Ormston, and was 79 years of age at the time of his death.

JAMES C. McALISTER, M.D.

Dr. McAlister, a Hamilton practitioner, died in that city at the age of 59.

JOSEPH W. CULL, M.D.

Dr. Cull died at his home in Mitchell, Ontario, at the advanced age of 82.

S. T. HUDSON, M.D.

Dr. Hudson died at his home in Roslin, Hastings County, on 12th August, after a lengthy illness. For more than fifty years he had practised in the County of Hastings, and was in his 78th year at the date of his death.

J. R. McDERMID, M.D.

Dr. J. R. McDermid, superintendent of the Provincial Deaf and Dumb Institute in Winnipeg, was drowned while in swimming at Minaki on 6th August. Dr. McDermid, who succeeded his father in the charge of the deaf and dumb institution about ten years ago, went to his summer cottage at Minaki and went swimming at midnight. When others in the party left the water, Dr. McDermid was not present and they thought he had preceded them. Next morning his body was found in ten feet of water. Apparently he had been the victim of a sudden illness and had sunk without a cry. He was about 35 years of age.

WILLIAM J. FISCHER, M.D.

Dr. William J. Fischer, surgeon, author and poet, passed away at his home in Waterloo 15th August, following a lingering illness. Dr. Fischer was born in Waterloo in 1879, son of the late Mr. and Mrs. John Fischer. Dr. Fischer attended Western University where he received the degree of M. D. After practising medicine for a time in London he opened a practice with Dr. J. H. Webb, in Waterloo, later engaging in practice for himself. In recent years Dr. Fischer was connected with the Mutual Life Assurance Co. of Canada as assistant medical examiner.

Dr. Fischer was the author of two popular novels and two volumes of poems and a book of short stories. He also contributed many articles to magazines. He was a corresponding member of the American Literary Society, and a member of the Authors' Club, London, Eng. He has been a member of the senate of Western University. He was a collector of singing birds, his collection being one of the most varied in Canada.

BOOK REVIEWS

INTERNATIONAL CLINICS

A quarterly of Illustrated Clinical Lectures and Especially Prepared Original Articles on Treatment, Medicine, Surgery, Neurology, Paediatrics, Obstetrics, Gynaecology, Ophthalmology, Otology, Orthopaedics, Pathology, Rhinology, Laryngology, Hygiene, and other topics of interest to students and practitioners. Edited by H. R. Landis, M.D., and Chas. H. Mayo, M.D. Vol. ii. thirtieth series, 1920. Philadelphia and London, J. B. Lippincott Company, Montreal, Charles Roberts. Price, \$10 per year.

This volume is a splendid addition to those that have preceded it. The articles are all excellent and timely. There are five special clinics, six articles on medicine, one on industrial medicine, two on surgery,

two on paediatrics, one on obstetrics, and one on neurology. Our duty is one of commendation. This series of volumes should find a place in every library.

REPARATIVE AND ORTHOPEDIC SURGERY

Published under the direction of E. Jeanbrow, P. Nové-Josserand, L. Ombredanne and P. Desfosses. In 2 Volumes, pages 1340, with 1040 illustrations. Paper covers, 80 francs. Masson and Company, 120 Boulevard Saint-Germain, Paris.

We have here two very valuable volumes on reparative and orthopedic surgery. The authors have spared no pains to bring their work up to date. The type and paper are all that could be desired. We can speak in terms of unqualified praise of this great work. It should be in the hands of all who do any surgery of the kind herein discussed.

PRACTICE OF MEDICINE.

Edited by Frederick Tice, M.D., Professor of Medicine and Clinical Medicine, and Head of the Department of Medicine, University of Illinois, College of Medicine. Foreword by M. W. Ireland, M.D., Surgeon-General, U. S. Army. New York. W. F. Prior Company, Inc., 1920.

The first three volumes of this very superior practice has come to hand. Everything about it is excellent. The binding, paper, typography, and illustrations all make one feel that the best that can be produced is to be found here. It is on the loose-leaf plan, so that pages can be inserted as corrections come out. The furnishing of these additions is the duty of the authors. This system of medicine certainly looks like a winner.

MISCELLANEOUS

CLOSING MILITARY ORTHOPAEDIC HOSPITAL

By November it is expected that all military patients in Military District No. 2 will be transferred to the Department of Soldiers' Civil Re-establishment, when the Dominion Orthopaedic Hospital on Christie St., Toronto, will close its doors to amputation cases. Although the building is to be utilized as an armories, the orthopaedic limb factory, now in operation at Christie Street, will continue to operate there. The patients who are still at the D. O. H., when the change takes place, will go to Brant House, Burlington, with the exception of the cot cases, who may be transferred to Euclid Hall.

According to the announcement made by Major-Gen. Williams, O.C. of this military district, it is probable that the Militia Department will take over the D. S. C. R. at the same time, so that there will no longer be any necessity for a separate ministry and administration.

The Christie Street building, when the change is completed, will be one of the finest armories in the Dominion. It will be the headquarters of the Machine Gun Brigade, Engineer units, Signallers, Army Service Corps' units, Army Medical Corps' units, Corps of Guides, Mississauga Regiment, York Rangers, two companies, and headquarters of the Peel Regiment, the Irish Regiment and the Toronto Regiment.

Since the date of its acquisition from the National Cash Register Co. on March 1st, 1919, the hospital has never accommodated less than 600 patients, and at certain times there have been 1,000 in the building. Hundreds have passed from there to other hospitals or out into civilian life. Prior to the occupation of the Christie Street building there had been considerable criticism directed against the Government for its treatment of hospital cases in Toronto, but since that time the conditions have been all that could be desired.

THE HEALING OF WOUNDS

Physicians at Bellevue Hospital, New York, have announced the discovery of a new solution known as "chlor-sal" for healing wounds which might ordinarily necessitate amputations.

The discovery was made by F. A. Mardon, a trained nurse, of No. 303 West Eighteenth Street. He had been experimenting twenty-five years.

According to physicians the discovery is an advance on similar solutions which contain chlorine, and therefore rapidly deteriorate. The solution has been successfully used on Richard Sully, of No. 1 Prospect Place, and on John Featherston, a friend of Dr. John W. Brannon, president of the Board of Trustees at Bellevue.

AVERAGE GENERAL MORTALITY, TORONTO.

During July the number of deaths registered by the Medical Officer of Health was 460, exclusive of still births, or a rate of 10.5 per thousand population. This rate, according to Dr. Hastings, does not vary greatly from the July rates in previous years, except that for July, 1919, which was remarkably low. The deaths from all causes were as follows:

	Deaths.	Rate per 1,000.
July, 1920	460	10.5
July, 1919	380	8.8
July, 1918	449	10.8

VITAL STATISTICS

The opinion of the provincial health authorities that the removal of the free postal privilege would seriously interfere with the making of health returns by doctors and local boards of health, is confirmed by the record of returns for the month of July. The return of cases of communicable disease for the month show only 2,347 cases compared with 5,118 cases in June, and while there has been some improvement in the health of the province during the month, the very decided reduction is largely due to the removal of the franking privilege allowed on such reports.

Even with many reports not sent in the health record for the month does not compare at all favorably with that of July last year when only 816 cases of communicable disease were reported. The poor showing last month was largely due to the continuance of the measles epidemic, 1,419 cases being reported.

The detailed returns show:

Diseases.	—July, 1920—		—June, 1920—	
	Cases.	Deaths.	Cases.	Deaths.
Smallpox	142	0	249	0
Scarlet fever	169	4	371	12
Diphtheria	302	46	342	45
Measles	1,419	15	3,613	22
Whooping cough	106	5	151	15
Typhoid fever	35	8	31	12
Tuberculosis	161	82	220	184
Infantile paralysis	2	0	2	1
Cerebro-spinal meningitis ...	3	3	9
Influenza	6	6	39	29
Acute influenzal pneumonia	2	2	10
Acute primary pneumonia..	116	260
	<hr/>	<hr/>	<hr/>	<hr/>
	2,347	287	5,118	599

Venereal diseases reported by the local Officers of Health:—

	July, 1920	June, 1920	July, 1919
	Cases.	Cases.	Cases.
Syphilis	131	169	83
Gonorrhoea	135	183	139
Chancroid	0	4	7
	<hr/>	<hr/>	<hr/>
	266	356	229

TSETSE FLY AND SLEEPING SICKNESS

The dreaded Tsetse fly, called by the natives obawli, which carried the fatal sleeping sickness, prevails in countless numbers in the Congo country, in Africa. As a result of its bite, many natives and an occasional European have suffered and died from this insidious disease of the tropics.

The fly is apparently increasing in numbers. Along the lower levels of the far interior thousands of people have died from the sickness, and here the tsetse abounds in the greatest proportion. Its victims are often infected for months before they know it. Local physicians, where there are any, which is rare, and some of the missionaries scattered throughout the Congo, have been taught by physicians especially sent out by the French government to make a blood test by a simple method which definitely determines whether or not one has fallen victim to the disease.

Not every bite of the tsetse fly, however, brings on the sleeping sickness, as is commonly believed outside of Africa. If this were the case, with the tsetse prevailing in such numbers, there would not be a human being left alive in Central Africa, and newcomers would shortly perish. As a matter of fact, only once in a number of times does the bite of the tsetse prove to be infected with the virus of the sickness. No one in the Congo can escape being bitten occasionally, no matter how closely he may guard himself against it, and anyone with a purpose, such as study of jungle life, is doubly exposed to its bites, and must trust to luck or Providence in the outcome.

The tsetse fly is of a dark-brown color, though it looks black. Its wings overlap on its back, and with its peculiarly-formed body it appears to have the shape of a catfish, only it is shorter in proportion to its width. It is, therefore, a villain that looks its part. It is very stealthy in attack, and almost as if it had a knowledge of human anatomy, it nearly always attacks a part of the body which one cannot conveniently reach. On the back and shoulders, and on the legs under the deck of the canoe, where it is able to ply its proboscis undisturbed and for a brief moment unnoticed, it attacks.

The daylight variety of tsetse stealthily sinks its proboscis into the skin, causing no pain, and therefore seldom attracting the attention of the victim until too late. It fills up with the blood and withdraws its proboscis. Then its victim feels the sting for the first time. The proboscis is shaped like a barbed spear, which tears the sides of the tiny wound, and the stinging and itching sensation continues for an hour afterward.

When it has drunk its fill of blood, it is inclined to be a bit drowsy, and slow of movement and its human victim seeks vengeance, by frantic blows about its line of flight. But the tsetse seems as tough as leather. One can strike it hard, and even roll it up in one's fingers, and it will fly away without injury, though a bit ruffled by its experience. This variety is the dreaded enemy of canoe travelers, as it hangs about the rivers in the daytime, seeking whom it may devour.

Another and rarer variety of tsetse is a fiend of the night, different from its river cousin. Instead of a noiseless method of attack, it comes with a headlong rush, buzzing like the monster that it is. One can sometimes hear it buzzing thirty feet away. It flies with such violence that it often hits a solid object and knocks itself almost senseless. But it never does itself much harm, for it recovers in a moment and starts again as viciously as ever. Its attack is of necessity swifter than that of the diurnal tsetse.

WRAP UP THE ABDOMEN TO PREVENT SEA-SICKNESS.

Perhaps there is no complaint for which more different remedies have been suggested than for that distressing malady, sea-sickness. But in this particular form of illness what is one man's meat is only too often another's poison.

For instance, in some cases a small dose of opium acts like magic, curing at once all that horrible dizziness. In others this drug is quite useless.

Dr. Dubois, a distinguished French physician, has laid it down that the very best preventive is to inhale pure oxygen gas. The amount he recommends is from 30 to 40 pints. Oxygen relieves the strain on the breathing mechanism, and gives the lungs a rest. He has found this treatment excellent if the gas is used before starting or before the patient begins to suffer.

A treatment which the contributor has personally tried and found extremely useful is an eminently simple one. Get a flannel bandage twelve feet long and about six inches wide, and wind it firmly around the whole of the abdomen. It seems to steady one's inside!

Some people swear by a similar but lighter bandage wound around the forehead.

But perhaps the best preventive of all is to lie down flat before one begins to feel "swimmy," and to keep quiet for the first 24 hours at sea. That and fresh air and a little starving works wonders.

SPECIAL NOTICE TO PHYSICIANS.

The Executive of the Victorian Order of Nurses is making very earnest efforts to meet the demand for an efficient and complete nursing service for this city, especially for those who are unable to employ a private nurse. Just as quickly as Graduate Nurses can be secured, we are adding to our staff to meet the demand.

Greater efficiency will be attained in carrying on our nursing work, if physicians in attendance will notify the head office, as early as possible, of cases of *Expectant Mothers* for whom nursing service will be required. It is proposed that Victorian nurses will be ready, at the desire of the attendant physician, to pay two or more visits to the expectant mother.

The Order has always taken a deep interest in the welfare of the babies during the first twelve months of existence. It has been decided to establish a small clinic to be held at the home, 281 Sherbourne Street, where the nurses will be glad at your request and with your approval, to interest themselves regularly in watching the development of babies they have nursed under your care.

For further information, please phone Head Office, Main 2307.

SIR WILLIAM J. GAGE,
Chairman.

H. H. LOVE,
Hon. Secretary.

MEMORANDUM ON THE MEDICAL FELLOWSHIP.

The best tribute to the need for the Fellowship of Medicine, is the steady flow of medical post-graduates to London from the British Dominions overseas. The Fellowship was founded in July, 1918, at a meeting convened by Lord Eustace Percy with a view to establishing a body which might unite the British profession with their overseas brethren in closer bonds of sympathy, Sir William Osler acting as President to the time of his death.

There are the best of reasons why the English-speaking medical man should come to London. The great city and its environs comprise a population of over 10,000,000 souls, thus affording an amount of clinical material which cannot be approached for variety of interest by any other city in the world. London is the natural centre and headquarters of the British people, and the traditions of London are the inherent traditions of our race. Hitherto the requirements of medical post-graduates have never been adequately met. The Fellowship of Medicine is now steadily co-ordinating an organization which embraces every general hospital and most of the special hospitals within the

metropolitan area. The medical man who arrives in London from the Dominions will find a hearty welcome, and every opportunity for study that the schools can offer.

A Canadian medical journal, whilst advocating London as a Mecca for medical study, suggested that here was another case in which England must wake up. A perusal of the recent issues of the weekly Bulletin of the Fellowship proves that London is very wide awake, and, whatever faults the Old Country may be accused of, sleepiness is not a failing of the present generation. At the offices of the Fellowship of Medicine the overseas medical men can obtain detailed information with regard to study in every branch of medical and surgical work. If he takes out the monthly ticket of the Fellowship practically every door in medical London is open to him. Intensive courses in various branches are now running throughout the year, and lectures are given day by day. The Bulletin provides a daily programme of work in the wards and out-patients' departments of the hospitals affiliated to the course, together with a syllabus of each course, and a list of the daily lectures. Application for copies of the Bulletin is welcomed, and, if correspondents will state the particular subjects they are interested in, information of future arrangements will be forwarded from time to time. The offices of the Fellowship of Medicine and Post-Graduate Medical Association are at present at the House of the Royal Society of Medicine (by courtesy of the Royal Society of Medicine), No. 1, Wimpole Street, London, W. I., England.

IN MEMORY OF DR. W. D. YOUNG.

In the erection of a handsome water fountain, unveiled at the memorial service at Kew Beach Park, Toronto, the residents of the Beaches district have put into concrete form, in so far as that is possible, the veneration in which they hold the memory of the late Dr. William D. Young for his life of service and sacrifice. More than 2,000 were present at the ceremony to pay tribute to the unselfishness of this member of the medical profession who devoted himself unstintedly to the welfare of others. In the absence of Sir John Eaton, who was unavoidably detained, Thos. Clayton, as representing the residents of the district, unveiled the fountain. Mayor T. L. Church accepted the gift on behalf of the City of Toronto, while Dr. George S. Young and Mr. James Gregory expressed the appreciation of the family for the tribute which had been paid to one of its members. Addresses were also given by ex-Mayor Oliver and W. E. Nugent, chairman of the gathering.

Rev. T. W. Pickett, an old friend of the deceased, pronounced the opening prayer. Rev. James and Mrs. Young, the parents of the late Dr. Young, his wife and four daughters, occupied prominent seats on the platform.

The fountain is in Italian renaissance style, 14 feet high, mounted on an Indiana limestone platform, and surmounting it by three steps. There are four carved archways, five pateras to each arch, the background being colored blue with gold facings. In the centre of the arches is a bronze figure of a child. In each archway is a water basin containing a drinking fountain.

On the east and west sides are bronze medallions of Dr. Young. The four friezes bear the inscription: "Service was his aim; friend of the needy." On a bronze plate at the eastern side of the monument is the inscription, "In grateful memory of Wm. D. Young, whose services to the residents of this district were characterized by a spirit of devotion, self-sacrifice and true philanthropy."

DOCTORS IN COUNCIL MEET AT NORTH BAY.

At the meeting of District No. 9, of the Ontario Medical Association, held on the steamer Northern Belle, on 13th August, after a sail across Lake Nipissing and down the French River, a number of interesting papers were read. Among these was one on "Preventive Medicine and the General Practitioner," by Dr. W. Yerton George, D.M.C.H., of North Bay, and a paper on "Blastomycosis," by Dr. A. E. Ranney, North Bay. Dr. D. A. Campbell, of North Bay, followed with a paper on "The Thomas Splint."

The evening meeting was devoted to organization, and an address was given by Dr. J. Heurner Mullin of Hamilton, Ont., president of the Ontario Medical Association, on the "Organization of the Medical Profession in Ontario."

Among those present were: Dr. J. E. Freeburg, Magnetawan; Dr. J. E. McKee, Elk Lake; Dr. F. J. Donnelly and wife, Iroquois Falls; Dr. M. D. Peelar and Dr. P. A. Coulomb, Sturgeon Falls; Dr. F. McKee, Cache Bay; Dr. H. L. Barber, Burk's Falls; Dr. R. Mallyon, Sundridge; Dr. Delan, Powassan; Dr. Grant, Gravenhurst, and the local doctors and their wives. Dr. E. Brandon was highly complimented by all on the success of his novel and delightful plan of holding the first session of District No. 9 amid such pleasant surroundings. Wind and weather, genius, talent and experience all conspired to make it an occasion that will long be remembered by those present.

FOR THE INFORMATION OF WHOLESALE AND RETAIL DRUGGISTS AND OTHERS CONCERNED.

Under the amendment to the Opium and Narcotic Drug Act, which was passed at the recent session of Parliament, it is provided that the same shall come into force on a date to be fixed by proclamation of the Governor-in-Council.

It is the intention of the Department to have this Act proclaimed and come into force on or about September 1st, next.

Under the new Act, all wholesale druggists, manufacturers or dealers are required to obtain a license to deal in these drugs, for which an annual fee of Twenty Five (\$25) Dollars is charged. All retail druggists who manufacture narcotic drugs, or preparations containing the same, are required to obtain a license, for which an annual fee of Five (\$5) is charged. All druggists, other than those who manufacture, and every physician, veterinary surgeon and dentist is required to make a declaration that they are engaged in the sale or distribution of these drugs. Forms will be supplied by the Department on application to be filled in and returned as required under the Act.

The Act also requires all druggists, whether wholesale or retail, and all manufacturers to keep a record of their receipts, together with a record of the quantity manufactured, and a record of their sales. These records are required to be kept in a special book kept for this purpose, and after a prescribed form.

Another important change under the new Act is the limiting of the number of ports in Canada at which these drugs may be imported or exported, and the provisions whereby opium and other drugs intended for export must be packed and marked in such a manner as to denote the contents of the packages.

Provision is made under the Act for the sale of preparations intended for internal use which do not contain more than two grains of Opium, or more than one-fourth of a grain of Morphine, or more than one-eighth of a grain of Heroin, or more than one grain of Godeine to the fluid ounce. Provided, however, that such preparations must be medicated to sufficiently preclude the possibility of their being purchased simply to obtain the narcotic effect, and further that such preparations must have printed on the label or wrapper in a conspicuous place the following warning: "IT IS UNLAWFUL TO ADMINISTER THIS PREPARATION TO A CHILD UNDER TWO YEARS OF AGE AS IT CONTAINS OPIUM AND IS DANGEROUS TO ITS LIFE."

The maximum penalty for infraction of the Act has been increased from Five Hundred (\$500) Dollars to One Thousand (\$1,000) Dollars,

and a minimum penalty of Two Hundred (\$200) Dollars is provided.

It is the intention of the Department at a later date to furnish all druggists with a copy of the regulations, together with a copy of the Opium & Narcotic Drug Act, with amendments to date.

Department of Health, Ottawa, July 28th, 1920.

HARD LUCK.

I went to a ten-dollar doctor
 With a thundering cold in my head.
 He thumped on my chest, made a blood-pressure test,
 And "Go get your teeth out," he said.
 Despairing, I went to another
 Distinguished and costly M. D.
 He looked up my nose through a section of hose.
 And "Go get your teeth out," said he.

I sought an expensive young surgeon
 Who put an X-ray on my spine,
 Wrote down the amount of my leucocyte count
 And told me to say "Ninety-nine;"
 And when he studied my tonsils
 And tongue from above and beneath,
 He said: "You must go to a dentist I know
 And get him to pull out your teeth."

A specialist next I consulted,
 A master of medical art,
 And stripped to the bone while a portable phone
 He fastened just over my heart.
 He listened for six or eight minutes,
 Then gulped in an ominous way
 And murmured, "My lad, your condition is bad,
 Those teeth must come out right away."

I shall leave all I have to my widow;
 I know that it isn't a lot,
 But she won't take it hard, for I'm only a bard
 And a little is all I have got.
 Three doctors have sagely assured me
 That inside of a week I'll be dead,
 Beyond the least doubt if my teeth don't come out—
 And I haven't a tooth in my head.

—The Bloodless Phlebotomist.

MEDICAL PREPARATIONS

ANTIPHLOGISTINE IN SYPHILIS.

A very valuable and interesting work has just been published by The Macmillan Company, New York. It is entitled "The Treatment of Syphilis," and is from the pen of H. Sheridan Baketel, A.M., M.D. The volume covers very thoroughly and convincingly the field of intravenous and intramuscular medication, and the administration of arsphenamine or neoarsphenamine. It gives in minutiae, step by step, the proper methods for the actual introduction of arsenical products into the system.

Speaking of the after treatment in cases where intramuscular injections have been given, the author says:

"In England and on the Continent it is the habit, after giving an intramuscular injection, to cover the surrounding parts with sterilized absorbent cotton fixed with elastic collodion. The patients were instructed to rest in bed for twenty-four hours and, according to various reports, the majority of them complained only of stiffness in the hip and thigh and occasionally of pain in the lower extremity.

"Some physicians also utilize a clay dressing, like antiphlogistine, in place of cotton. It is their custom to cover the entire gluteal surface with a thick layer of properly heated antiphlogistine and to cover this with gauze, and over that absorbent cotton. This application seems to work well following the intramuscular injection and, not only aids in the prevention of pain and to a considerable extent prevents any abscess formation, but enables the patient to attend to his ordinary affairs."

Dr. Baketel is Professor of Preventive Medicine and Hygiene and Lecturer on Genito-Urinary Diseases and Syphilis in the Long Island College Hospital, Brooklyn, N.Y.; Attending Syphilologist and Chief of Clinics at Volunteer Hospital, New York; Genito-Urinary Surgeon to the House of Relief of the New York Hospital; Lt.-Col. Medical Reserve Corps U. S. Army, etc., etc.

PREVENTS THAT TIRED FEELING.

There are good reasons why some men obtain most benefit from tobacco by using it in the form of chewing tobacco. The very set of chewing is conducive to meditation, to turning things over in one's mind, and in whatever form tobacco is used it has a soothing influence. When chewed it is also a means of overcoming a dryness in the mouth which is one of the first signs of fatigue. Chewing tobacco prevents that tired feeling.