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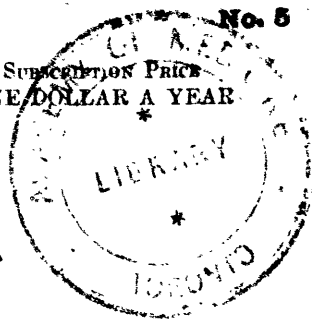
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CANADA

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MONTREAL

A Monthly Journal of Medicine and Surgery

EDITOR

F. WAYLAND CAMPBELL, M.A., M.D., D.C.L., L.R.C.P., Lond.

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The annual College fees are \$100.

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M. JACK, M.D., Registrar.

CANADA

MEDICAL RECORD

MAY, 1903.

Original Communications.

VALEDICTORY ADDRESS.

To the Graduates in Medicine at the 32nd Annual Convocation of the Medical Faculty of the University of Bishop's College, April 24th, 1903,

BY

WILLIAM G. REILLY, M.D., LECTURER IN MEDICINE.

GENTLEMEN, GRADUATES IN MEDICINE,

The presence here of the University officials, your professors and teachers, the audience in the hall, and the good natured chaff of the undergraduates are by this time all familiar to you, for have you not in the past three years grown accustomed to these closing exercises?

But to-day these exercises have a different significance to you. They mark a milestone in your life's history, and the exercises of to-day stand out in bold relief as the supreme moment which has come to you in your turn to become the occasion of this ceremony. It means that you have attained the end towards which you aimed when you enregistered as students in medicine in this school four years ago.

It has fallen to me, on behalf of the Faculty of this University, to say adieu, to speed the parting guest as it were, and to congratulate you on the completion of your academic course, and at the same time to express the good wishes of the Faculty

for your future success when you are about to leave the small world in which you have existed during the past four years, to launch forth on the billowy seas of a medical career.

On an occasion like the present an address dealing with some aspect of scientific medical work would not be inappropriate, but I shall content myself with a few remarks dealing particularly with yourselves and your relations to those with whom you may come in contact in after-life, rather than in discussing some scientific topic.

Four years ago you entered the college halls as freshmen, attracted thither perchance by the loyalty of those who previously had obtained from this school the foundation of their medical learning, or perhaps by the advice of friends of the University which you will now recognize as your Alma Mater.

In making the choice of the medical profession as your future calling, I assume that you did so from pure love of that branch of science, rather than from some ulterior motive. If this has not been your reason, or if you were induced by relatives or friends against your will, and simply acquiesced to please them, yours will be a rough and stony road, beset with despondence, grief and dismay, and will bring to you no reward which satisfies the soul, neither opulence nor social position.

Turning for a moment to your primary years in college, I have no doubt you have felt more than once that the work was onerous and the drudgery great, and that the daily round of lectures in anatomy, physiology, chemistry, etc., and the weekly grinds were more than were necessary to fit you for the practical training you were to receive in your hospital and clinical work. It was not then until you took up the study of disease proper, in your final years, that you realized the necessity for, and understood the reason why you were called upon to expend so much time and energy in the preparation of your primary subjects.

Now, however, a new light was shed, a new world was

opened to you and you realized, for the first time, that your hours of patient application day and night were for a great purpose, and I have no doubt you did not express any regret, but, on the contrary, an appreciation, and many a time you wished you knew more than you did of these same primary subjects. In your final years you have been patiently laying a foundation of knowledge, and it devolves upon you now to raise a superstructure which we, who are your teachers, hope and trust will proclaim you to your patients and to the public at large as men of science, whether it be as physicians, as surgeons or perhaps, in later years, as specialists, and we trust that the knowledge you have gained will prevent you in the future from degenerating into routine practitioners having no other aim than getting a livelihood and collecting together a small competence for your old age.

To-day, gentlemen, having satisfied the requirements of this University, you have taken the oath and have received at the hands of the presiding officer the long-looked-for reward and coveted title, and you go forth to your respective places of abode to there put into practice what has been taught you. While doing this it is well to remember that your success will depend almost altogether upon how you have taken advantage of the opportunities offered you by this school, and at the outset permit me to make this remark that the obtaining of a degree and the license to practice is but the beginning, for your professional education is by no means complete, although you have certainly mastered the elements, and as I have said before, satisfied the demands of this University.

The eyes of your teachers are upon you, and the public will scan carefully and criticize your every turn, and we look to you to uphold the honour and dignity of that noble profession to which it is now your privilege to belong, and our pleasure to call you one of us.

Certain professions are unalterably stereotyped, so to speak, for instance: the church, the law, but not so the profes-

sion of medicine to which you have just been admitted. Medicine is pre-eminently a progressive science, new facts and new ideas are being brought forth almost every day.

During your earlier years in practice most of you will undoubtedly have more or less spare time, and it behooves you not to rest on your oars, but while waiting, to keep abreast of the times by reading up the various branches, and keeping posted in the latest medical and surgical literature. To do this it is absolutely necessary to cultivate studious habits, to be systematic and methodical in the extreme, and your success will mainly be due to your capacity for work, your love of work, and your willingness to work.

To-day you are entirely different men from what you were four years ago; if not, you would have failed to pass the examinations demanded by your teachers and by the Board. This being the case, it remains with you to in some way advance the study of scientific medicine, for the work of the physician is not a trade in which he can perfect his skill once for all, but a profession based on learning without interruption, new facts, new methods and even totally new ideas. The conversion of a student into a doctor of medicine is far too commonly looked upon as the end of the period of learning. The graduate must look on his degree as a certificate that he is qualified to learn and as a security that his learning is in the right direction. Charles Setgwick Minot says that "routine medical practice is professional degradation." Therefore seek, by doing the best work possible, to advance the science of medicine in whatever ways you can, make accurate observations, and keep complete notes of your cases be they ever so trivial, and when anything of special interest arises report that to one or other of the medical societies in your neighbourhood.

Some of you will undoubtedly obtain positions as internes in a hospital for a greater or shorter time. To those thus fortunate I say, take advantage of every opportunity for observation, and study carefully each case, for when in practice you will meet with many cases calling for your most

earnest thought, and you are then often thrown entirely on your own resources.

Should a position in a scientific laboratory be available to any one of you fitted for that particular work, I would recommend that you accept it, for, although in some quarters the laboratory physician and the practical physician have not everything in common, one has to look for the greatest advance in the present history of medicine to the laboratory physician engaged in research work. A short history of some of the most recent advances will demonstrate very clearly what is meant. In 1879 Koch first drew attention to the utility of solid culture media; in 1882 the same observer demonstrated the presence of tubercle bacilli in the expectoration of tuberculous patients; in 1884 Loeffler gave to the profession what we now know of the diphtheria bacillus; in 1894 Councilman and Lafleur presented their communication dealing with amoebic dysentery; in 1895 Roux revolutionized the treatment of diphtheria by the preparation and administration of anti-toxin to those afflicted with that very fatal disease; in 1896 Widal enhanced our knowledge by his contribution relative to the blood of those suffering from typhoid fever; in 1897 Rontgen Rays came into use as a means of diagnosis, and still later as a valuable addition to our therapy, so that now the demand by the general practitioner for laboratory experts is almost universal. It must be remembered, however, that in the selection of one for laboratory work the mistake is often made that a man totally unfitted for original research is sometimes the one who obtains the position. To but few are accorded the privilege of being generals as it were, and one who is suited for a laboratory position must have special training in methods of precision, and must be able to observe correctly and to reason correctly and to learn from the unknown. To many, however, are accorded the privilege of being followers, and those of us who are the latter must be constantly on the alert to gather in the wheat which comes from the laboratory thrashing-mill, and to put into practice, whenever possible, the

knowledge thus obtained so that suffering humanity may get the benefit.

With the rapidly increasing amount of knowledge now necessary in the wide field of general medicine, concentration in work has become almost a necessity and has attained the position of being a distinctive feature. No one can deny that in this way better work has been done, a fact recognized both by the profession at large and the ever-watchful public. However, the family doctor will not be a relic of the past, and the man, who, by his industry and observation keeps abreast of the times, will find that neither his practice nor his income will be seriously lessened by the specialist. On the other hand, should the graduate become merely a routine practitioner he will only be a feeder for some practitioner in his neighbourhood, who, by his studious habits, has kept up to date. Some of you will, I have no doubt, be attracted by the glamour which surrounds the specialist, and at the outset of your medical career, nay, even before you have obtained your degree, desire to take up this or that or the other specialty. While it is perhaps laudable to have definite ideas as to what one purposes to do in the future, it is notorious that the danger of manufacturing a specialist out of unseasoned material is great. Specialists, in the true sense of the term, are not born into the profession as such, but become so by virtue of having had years of work as general practitioners previous to devoting their thoughts and energies along one particular line. This is almost always an absolute necessity, for it is essential that he who will become a specialist must have a broad foundation in physiology, pathology, anatomy and internal medicine, and must not be ignorant of the great and complex processes of disease. Nurslings never make good specialists, for the specialist rises high, because, in early years, his foundations were laid deep. I do not include, under the term specialist, those who confine themselves to internal medicine to the exclusion of other branches. Some of you will, no doubt, settle in perhaps a fair sized town or small city, and here you may desire to

confine yourselves to internal medicine or to general surgery. To those I offer a word, and that is regarding your treatment of, and your relations towards those who are already in practice, some perhaps for years in that town or city. Many of these practitioners will be much behind you in laboratory methods, and in the use of instruments of precision, and it will be to your advantage to commence practice by earnestly endeavouring to make each and every one of these practitioners your friend, that is to say, it will be better to live on bread and water with each one as your friend than to fare sumptuously every day with every one your enemy. Rest assured that not one of these practitioners, be he longer or shorter in the town, will hail with delight your advent. Should you, perchance, be called to see one of his patients in an emergency, it is advisable, and it will be to your advantage to notify the doctor at the earliest possible moment. It is an act of courtesy which may make the doctor your life-long friend, and it may not be long before opportunities will arise whereby you may be materially assisted and financially or otherwise benefited. Having now selected say, internal medicine or general surgery as your vocation, and you can do so in any town with from thirty to forty thousand inhabitants, it is well to let it be known with as little ostentation as possible that you do not take, *e.g.*, obstetric cases, that you do not do gynaecology, etc., and that you intend to confine yourself as much as possible to your own particular branch. Once having done so, it will be necessary to wait patiently, and it usually happens that your services will be asked for either by the patient, his friends; or by the doctor in charge when some unforeseen difficulty arises. By having made a friend of the physician in charge, you will be materially benefited. Should a position in the out-patient department of an hospital become vacant, seek by all honourable means to secure the appointment. There you will find material to investigate, and material on which you may lay the foundation of future greatness. Many members of the profession to-day who have attained the pinnacle of international eminence laid

the foundation of their reputations in the out-patient department or in the dispensary. A notable example of this is Lauder Brunton, who only recently was appointed to the inside service of the hospital with which he has been connected for many years. All have to wait, and while waiting take advantage of what may offer, and although the time may seem long and the pathway rough, be satisfied with the experience of those who have grown gray in practice and whose testimony is that the practice of medicine insures for its votaries a livelihood when the fundamental elements of truth, honesty and fidelity are used as a basis. In this connection it is to be remembered that speaking truth is perhaps artificial; men are no more born to speak the truth than they are to fire rifles, now and then a man makes a bull's eye, but many do not even hit the target. To speak the truth it is necessary that one should know what the truth is; honesty to one's self is as essential as honesty to others, and fidelity to friends means breadth of mind and will of iron.

In the pursuit of your profession in your earlier years, I am reminded of that philosophical statement made by Professor Osler in a lecture delivered here a few years ago, in which he said to the young graduate "take no thought for to-morrow." It is a comforting statement, to say the least, and although it is not the usual thing to think not of the future, it will be found that the young practitioner who does his work faithfully, conscientiously, and to the best of his ability, will not only secure a livelihood, but in the evening of his life, or when gathered to the great majority, have said of him that he exemplified in a high degree unselfish devotion to duty and conscientious fidelity to trust, and no higher tribute can be paid to a physician than that his honour as a gentleman was as freely to be trusted as his skill as a practitioner, and that his broad, sympathetic, moral and material support was freely given to all enterprises calculated to improve the social, material and moral progress of his fellow men. Seek then, therefore, whenever possible to instruct and elevate.

the lower classes, at the same time endeavouring to disseminate among all classes correct notions respecting the influence upon health of dissipation in all forms.

Having now briefly, although rather imperfectly, indicated what should be your attitude to your professional senior, I turn for a moment to discuss what are your professional obligations. In accepting your degree from the University and securing your license to practice you make an implicit contract with your patients to render professional service with care and diligence, on condition that you receive the usual monetary reward ; but in some cases you will get no monetary reward ; nevertheless once you have accepted the responsibility of a case it is incumbent upon you to treat that case with the same care and diligence as if you were getting the highest fee. It may be that this patient is a member of that numerous class which are unfortunate and have been stigmatized as the Lord's poor—here gratitude only is your reward, and it often happens that the poor man's gratitude is worth more than the rich man's gold, and the rule of charity for the physician is that he should willingly render to those such services as may be necessary. It often happens that you will meet with those who claim to have been cured by this, that, or the other quack nostrum, and your opinion will be asked by the laity as to the efficacy of the medicine or the benefit of a certain —pathy. On questions such as these it is well to observe at all times a discrete silence, not even saying, as did William III, who, when he was asked to touch Dr. Johnson, did so, but at the same time said " may God give you better health and more sense." The remarkable example of the credulity and superstition of the public in matters medical has been notorious for centuries, and, notwithstanding the progress of science in recent years, much credulity and superstition remains even until this day. While it is not so rife as it was in the seventeenth century, when weapon ointment and sympathetic powder were so much in demand, nor yet in the eighteenth century, when England was truly named the

paradise of quacks, it still obtains, chiefly through the introspection of the laity, fostered by men and women of education and talents who are afflicted with some form of mental obliquity. Probably the greatest supporters of quackery with whom you will come in contact, next to members of the fair sex, are ministers of religion. In the daily papers hardly an advertisement can be read without having testimonials from the clergy of the wonderful cures effected. Particularly in the country districts, while administering to diseased souls, the clergy love to essay the efficacies of new cure-alls for diseased bodies. This weakness must be attributed to their well known benevolence and desire to do good to their fellow men, and to those you must extend charity. To offset any argument which may be brought forward by them you have only to say, when pressed for an opinion, that when testing a remedy in any disease it is first of all necessary to be sure that the disease actually existed, secondly, that it was cured, and thirdly, that the remedy cured the disease. Be not led into controversy then concerning any of these remedies, for it only serves, although you should prove conclusively that the remedy is a fake; to advertise it still further. Southy says "man is a dupable animal." Quacks in medicine, quacks in religion, quacks in politics know this and act upon this knowledge, and although the days of weapon ointment, sympathetic powder and Perkin's tractors are past, other things equally as useless are being constantly foisted on a too credulous public.

A few moments ago I pointed out to you the necessity of forming studious habits and of adopting method, but I do not wish to intimate that your reading is to be confined entirely to matters medical. The concurrent pursuit of some department of learning not in the direct line of your necessity as medical men is essential chiefly for the integrity and health of your minds. It calms, elevates, restores the jaded powers, clears the intellect, cools the judgment and raises the moral tone. It makes the arduous life of the busy practitioner less a drudgery and more a liberty and a joy.

From morbid anatomy, from human physiology, which you must perforce study always in connection with disease and its processes, from the thought of sick men, from birth and from mortality, from professional reward and from anxiety, you must turn aside for some precious moments every day and be devout happy scholars and free men of the universe. From the foregoing you will at once see that to prevent the mind from running too much in a groove it is necessary to have some hobby. Not only will this divert from the thoughts, but it will be beneficial to yourselves and to those with whom you are thrown in daily contact ; what that hobby will be is a matter for each individual himself to determine.

Touching for a moment on the relations of this Faculty to you, I make bold to state that as a Faculty we are conscious of defects in our teaching perhaps even more so than you are. The Faculty has long felt that changes in the curriculum would be beneficial, inasmuch as the arrangement of lectures and clinics as at present existing is not ideal. The number of didactic lectures has been too great, for a lecture or a book only assists a student, and to remedy this endeavour is being made whereby the number of lectures will be decreased, such decrease to be replaced by personal laboratory or clinical courses of instruction. This arrangement has been rendered feasible by the lengthened course of the curriculum, and, although you will not have the benefit, your successors, the students now in their junior years, will surely appreciate it. It is hoped didactic lectures will, in the future, be given in the forenoon, thus leaving the students free at mid-day to attend the various clinics in the hospital.

Gentlemen, to-day as doctors of medicine, fully admitted to the honours of the profession, life opens before you all anew, and having bid you welcome to its cares and privileges, it remains for me, on behalf of the University, to bid you now farewell. Hereafter and elsewhere you will no doubt meet those who have been your teachers, on that broader stage, where all alike will stand before the criticism of con-

temporaries and will await their reward, and the merciful judgment of heaven. Let me venture to advise you that it will benefit us younger men in shaping our own careers to follow with becoming veneration the example of those who have been permitted by length of days, and by individual and moral eminence in their profession to be crowned with that cordial grateful honour gladly paid by society to venerable age, fruitful in wisdom and works, made beautiful and serene by virtue, and finally companions in arms, may you in the autumn of your lives enjoy that respect and material reward earned by an upright and honourable career, and may you have the inward consciousness of duty faithfully discharged, and when your work is done may you receive the approbation of Almighty God.

Practice medicine for the sake of being useful and doing something for your country and your countrymen, and emulate patriots who have labored for their country's good. If you do this, gentlemen, your lives will have been worthy, happy and useful and they will deserve the epitaph in which Johnson embalmed the memory of his friend.

“ When fainting nature called for aid,
And hovering death prepared the blow,
His vigourous remedy displayed
The power of art without the show.

“ In misery's darkest cavern known,
His useful care was ever nigh ;
Where hopeless anguish pored his groan
And lonely want retired to die

“ No summons mocked by chill delay,
No petty gain disdained by pride
The modest want of every day
The toil of every day supplied.”

To quote Bishop Brooks : “ Try to find the pleasure of your life in the work to which your life must be given. Study its principles. Make it delightful by the help which you are able through it to give to other people, and by the education which your own faculties are getting out of it.”

On behalf of the Faculty, gentlemen, I say adieu.

Progress of Medical Science.

MEDICINE AND NEUROLOGY.

IN CHARGE OF

J. BRADFORD McCONNELL, M.D.

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THE HOOK WORM DISEASE.

Through the enterprising research of Dr. Charles Wardell Stiles, of the government service, the attention of the medical profession has been directed with renewed interest to uncinariasis, a disease more generally known as ankylostomiasis. The public prints have treated the matter in the usual sensational manner, and so aroused popular curiosity that physicians are obliged in self-defense to regard it with something more than languid indifference. It would seem also, if Dr. Stiles' assertions be true, that the disease is more prevalent, especially in the southern states, than has hitherto been supposed.

In the Association Journal, Joseph A. Capps, of Chicago, publishes a timely article in which he recounts the later contributions to the knowledge of ankylostomiasis.

The parasite belongs to the family Strongylidae, sub-family Strongylinae, genus Uncinaria. There are many species, several of which exist in animals, but only two infest man. These are *Uncinaria duodenalis*, and latter recently identified by Stiles. The worms are from a half to one inch in length, with a strongly curved head, a mouth armed with teeth, and they live by sucking blood from the intestinal walls of the host. The larvæ, by means of which man is infected, reach maturity within eight days.

Uncinariasis is common in the Philippines. Ashford believes that it is widespread in Porto Rico. In this country it is endemic in the states bordering the Gulf of Mexico, viz., Georgia, Texas, Alabama, Louisiana and Florida.

Man contracts the disease by swallowing the living larvæ. Both food and drinking water may carry the contagion, but perhaps a more common method results from un-

cleanliness of the hands. The subject gets the hands covered with the larvae-contaminated mud, and in conveying food to the mouth ingests the parasites. In one drop of mud there may be dozens of embryos, so that a few exposures of this nature are sufficient to produce a severe infection. Among the "clay-eaters" the danger of infection is obviously very great.

The soil itself may owe its contamination to the careless deposit of feces from an infected individual. Thus one subject may cause an epidemic among workers in clay that was previously free of larvae.

In making the diagnosis, the occupation should be taken into account. Severe anemia should direct attention to the blood and stools. In typical cases an examination of the blood will show a condition resembling pernicious anemia. The diagnosis can be made with absolute certainty by finding the ova, which are characteristic, but are to be differentiated from those of *Oxyuris vermicularis*. After the administration of anthelmintics, adult worms may be found.

As to treatment, Dr. Capps says: "The disease is curable if recognized early and treated properly. The bowels should be cleared the evening before administering the anthelmintic. Thymol in a two-gram dose repeated in two hours and followed by a saline is effective as a rule. Santonin and male fern are not so satisfactory.

"Prevention can be best accomplished by:

"1. Drainage and drying of swampy lands.

"2. Where numbers of men are working in tunnels, ditches or canals, by examination of the feces of workmen and the exclusion of infected individuals.

"3. Proper disposal of dejecta unsuspected localities by burning or by disinfectants.

"4. Enforcement of cleanliness in washing the hands before taking food.

"5. A pure water supply."

WHY THE OPEN-AIR TREATMENT OF CONSUMPTION SUCCEEDS.

M. A. Veeder, Lyons, N. Y., maintains that the only attribute of air that need concern us in investigating the cause of the beneficial effect of the open-air treatment of consumptives is its temperature. The effect of varying degrees of heat or cold upon different bacteria has long been

known. The sharpness of limitation of temperature effects is especially well defined in the case of the bacillus of tuberculosis, its ability to thrive and form colonies beginning almost precisely at the temperature of the human body and extending a few degrees above that point. Feverishness of any sort may light up a tuberculosis infection previously dormant, and an ordinary cold or other slight ailment may thus seem to become the starting point of consumption. Large temperature variation controls growth and every other activity of all forms of life, and in the case of disease-producing bacilli there are critical temperature points at which small variations have a very decided effect on particular forms of bacterial activity. This is especially marked in the case of the tubercle bacilli. In tuberculous patients habitual out-door living has the effect of large temperature variation so far as the lungs are concerned and of small temperature variation on the rest of the body. This position is corroborated by the fact that the greatest benefit from open-air treatment occurs when the disease is located in the lungs, and in the early stages of infection, for it is probable that the bacillus is located very superficially in the mucous lining of the air passages for weeks or months after infection. If at this stage the individual houses himself up in a warm room constantly, the infection gains a firmer footing, while, if there is out-door living, there is improvement, and in many cases complete recovery. That the temperature of the lungs can be lowered to a considerable degree by the inhalation of air such as is met with in ordinary out-door living, may be shown positively by comparing the temperature of the air exhaled with that inhaled under these conditions. The habitual inhalation of fresh, cool air has also a tonic effect, and not only hinders the growth of the bacillus, but helps the body to react against it. Since it is merely the local application of cold to the lungs that is effective, there should be no discomfort to the patient though inadequate clothing. For cases in which an out-door life cannot be followed, the organization of sanatorium treatment is advocated, for the purpose of teaching those who are in the early stages the needful regimen for their own improvement, and also the measures necessary for the protection of others.—*The St. Louis Med. Review.*

FOUR KINDS OF MEN.

An Arabian apothegm divides men into four classes, as follows :

He who knows not, and knows not he knows not ; he is a fool ; shun him.

He who knows not, and knows he knows not ; he is simple ; teach him.

He who knows, and knows not he knows ; he is asleep ; waken him.

He who knows, and knows he knows ; he is wise ; follow him.

But there is a fifth class, and it is perhaps the largest of all. It is composed of those who know not, and yet think that they know. They are not merely ignorant of their ignorance, but so conceited that they regard it is the perfection of wisdom.—*Texas Med. News.*

AN INHALATION FOR MIXED INFECTION
IN PULMONARY TUBERCULOSIS.

Dr. H. E. Lewis says that in cases of mixed infection with markedly purulent expectoration, for the purpose of allaying laryngeal irritation and cough, the following inhalation has proved most satisfactory.

R	Compound tincture of iodine.....	4 drachms.
	Tincture of tolu.....	$\frac{1}{2}$ an ounce.
	Tincture of cinnamon	1 drachm.
	Carbolic acid.....	1 drachm.
	Chloroform.....	1 drachm.
	Alcohol, enough to make.....	4 ounces.

M. Use in a bottle with a large cork through which two glass tubes are run. Inhale by drawing through the shorter tube, which must not reach down to the liquid.—*Vermont Medical Journal.*

VARICOSE ULCERS.

R	Carbolic acid.....	$\frac{1}{2}$ drachm.
	Boric acid.....	2 drachms.
	Camphor.....	2 drachms.
	Ichthyol.....	5 drachms.
	Expressed oil almond.....	$2\frac{1}{2}$ drachms.
	Ointment zinc. oxide.....	$3\frac{1}{2}$ ounces.

To be applied after thoroughly cleansing the ulcer and surrounding tissue with green soap and hot water.—*Merck's Archives.*

PERIBRONCHITIS AND INTERSTITIAL. PNEUMONIA.

A Jacobi, (*Archives of Pediatrics*, January, 1903), says the majority of cases of interstitial pneumonia and peribronchitis are such as get well, if not anatomically, still practically, and their owners, when they finally die, succumb to some incidental process. Cases of hypertrophy of the connective tissue of the lungs which terminate in shrinking are most frequently observed during infancy and childhood. The patients suffering from this condition have asymmetrical chests; there is flattening on one side; diminished respiration over the corresponding part of the lung; slight or marked bronchophony; slight bronchial expiration, but no rales. There is usually a history of an attack of pneumonia, bronchitis, lung fever or a long ill-defined feverish disease during childhood. Such symptoms as have just been described are not invariably due to either tuberculosis or pleuritis. Interstitial pneumonia or, as it might better be called pulmonary hyperplasia with secondary sclerosis, is a frequent and frequently an independent disease. There is full recovery from it, at least so far as life is concerned, and it is not, as a rule, an obstacle to comfort and activity. The diagnosis of this condition from pleuritis is often difficult, and Jacobi has frequently had a suspicion that observations of apex tuberculosis which were not confirmed by the finding of bacilli in the sputum, were mistaken, and that, in truth, the disease was interstitial pneumonia which finally recovered with induration and retraction. In a general way, capillary bronchitis and lobar pneumonia have their symptoms behind and below; tuberculosis and interstitial pneumonia above and mostly in front; pleuritis with effusion below and usually behind, and tuberculous pleuritis both above and below. Patients suffering from this condition do not cough. In acute cases of this disease, the temperature may be high and remain so for a week, but, as a rule, high temperatures do not persist long. The treatment is chiefly prophylactic and should concern itself with the protection of the patient against infections and against colds. The diet of weak and anemic children should not consist of unmixed cows' milk too long; animal food and cereals are indispensable. Arsenous acid and phosphorus are of advantage as tissue builders. Children, 5 or 7 years of age, who do not thrive on that treatment and on food that contains enough iron, should be suspected of parasymphylis.

In such cases mercury, with or without iodides or iron, will often do good. When the heart muscle is feeble, a grain of digitalis daily, in divided doses, for a long period of time, will improve the circulation and thus nourish the heart and the rest of the body. Recent cell proliferation and recently formed connective tissue are absorbable, and should be treated with iodine, either in the form of potassium iodides sodium iodide, iodipin or hydriodic acid. Iron iodide is often useful when there is anemia but no fever. In some young and in many adults the further development of peribronchitis and interstitial pneumonia may be into emphysema, bronchiectasis, caseous degeneration, abscess gangrene, cavity and death.—*St. Louis Med. and Surg. Jour.*

THE TREATMENT OF CHRONIC HEART WEAKNESS BY BATHS AND EXERCISES.

Chronic heart failure may be divided into four stages. First, a period when compensation is efficient; secondly, a stage when the heart works well under favourable conditions, but fails under those of medium stress; in the third period, the circulation is never quite efficient, and a slight stress may turn the scale; in the fourth stage, cardiac enfeeblement is extreme and irremediable. In the first stage, as a rule, no treatment is necessary except a general warning against overstrain. But occasionally there may be excessive arterial tension or excessive pulse rate. Such symptoms may well be treated by the method to be described. In the second stage I consider baths and exercises unequivocally to hold the place of pre-eminence. The earlier the treatment is begun in this stage, the greater the value of mechanical methods. In the third stage, mechanical methods tend to become useless, and finally are contra-indicated, while drugs may still retain their potency. The application of mechanico-balneological treatment by the family physician is to be advocated because he is more likely to see the patient at the time when it is of greatest value. Baths and exercises may be said to conform more closely to Nature's methods, and, also, being more novel, to give scope for the beneficial influence of suggestion.

In endeavouring to assist an overtaxed heart, it is necessary first to lighten its load, and then to nourish its muscular substance and give the organ just as much work

as it can beneficially perform. Where cardiac dilatation and arterial tension are prominent, relief must be afforded by arterial relaxation. In cases of less severity gentle stimulation may be adopted. These effects can be brought about by varying the temperature, composition and duration of the baths. A temperature of from 92° to 95° F. produces moderate dilatation of the vessels, with slowing of the pulse rate. When the temperature is lowered to 85° F. contraction of the peripheral vessels is caused, with great increase in the force of ventricular systole, the total effect being one of stimulation. The most useful constituents of the bath are the chlorides of sodium and calcium, and carbonic acid gas. The greater the proportion of these, the greater the stimulating effects. The duration of the bath should be longer when a sedative action is required.

When the first indication is heart relief, to a bath of fifty gallons five pounds of common salt should be added, and five ounces of calcium chloride, together with half the contents of one of Sandow's boxes. The bath is given at 95° F., and lasts about fifteen minutes; the patient then remains recumbent for two hours. After a few days the temperature is gradually reduced to 92° F., while the proportion of saline constituents is doubled. As the patient improves, stimulating treatment is introduced by lowering the temperature of the bath still further, and increasing the added solids. Very gradually the temperature of the bath is lowered to 85° F., and the strength of the saline solution increased to 6 per cent. Beyond this it is rarely necessary to go.

Systematic exercises are chiefly of service in the early part of stage 2, or when relief has already been obtained from baths. They can be carried out without a specially trained assistant, by the following method:—Instead of the reversal of each exercise being a continuation of the initial part, an intermediate pause is introduced. Thus the first portion is made to last fifteen seconds, the part moved is retained in the position it has reached for five seconds, and the reversal is made to occupy fifteen seconds. In very muscular subjects extremely light weights may be placed in the hands. The pulse is counted immediately before the exercise, and again after three minutes have elapsed, by which time its rate should have fallen. This is the simplest test as to the prospective value of the exercises. During the exercises the breathing should be even and continuous. Instead of the Nauheim exercises, a system of weights and pulleys may

be used. At the end of a series of exercises it is well to examine the area of cardiac dulness and the position of the apex beat. If the area of dulness is enlarged, it may be taken that the dosage is too high. To sum up, the cases in which most benefit is derived are those of moderate dilatation, accompanied, and in great part caused, by general malnutrition. Cases presenting minor degrees of arterio-sclerosis may be accepted for treatment. Supposed cardiac neuroses, such as tachycardia and arrhythmia, often do well. There are many failures among elderly persons. Cases in which the imagination alone is at fault should not be treated, as they certainly detract from the reputation of the method. As to whether treatment is most satisfactory at home or abroad, the advantages of the climate of Bad-Nauheim, the experience of the local physicians, and the current enthusiasm are counter-balanced by the shortness of the season, the poorness of the meat, and the usual foreign habits.—Neville Wood, M.D. *in Med. Press.*

EARLY DIAGNOSIS OF PHTHISIS.

One of the questions creating the most interest at the present time is that of the curability of consumption. It is admitted by all that that hitherto hopeless malady is amenable to treatment under certain conditions when recognized in its incipient stage. Some go further and pretend that phthisis, in any of its stages, provided the lungs be not utterly destroyed, can be cured, or at least the morbid process may be arrested. In any case the chances are naturally infinitely greater where the malady is detected at its earliest stage. Professor Courtois-Suffit made an exhaustive study of the early diagnosis of pulmonary tuberculosis, which he has published in one of the medical journals, and of which I give a brief résumé.

CLINICAL SIGNS.

Progressive wasting, a very important sign in children — general fatigue, depression of strength, neurasthenia. Frequently is added a pyretic tachycardia and urinary troubles (in complete evacuation of the bladder), slight incontinence, thoracic pain, especially under the clavicles and the scapula, caused frequently by dry pleurisy.

Frequently also is found a pain remarked by Cater, and produced by pressing on the pneumo-gastric nerve at the

base of the neck. Digestive troubles exist frequently. Almost all the patients complain of a little dry cough, while the voice is more or less hoarse. Hæmoptysis is frequently the first manifestation of the malady; it is generally very slight and may not return for several months, and perhaps never.

The examination of the patient will reveal the following signs:—Frequently unilateral dilatation of the pupil, remarked by Destree and Harrington; red gum line noticed by Thompson, and considered as a very important sign by Caudressen, as he found it in sixty-nine true and twenty-three suspicious cases. The patient being undressed, the colouration, rarity, or, on the contrary, abundance of hair will be remarked, depression of the scapular fossæ, and a flattening of one side of the thorax.

There is a sign which should be always looked for: it is that which Boix described under the name of scapulo-thoracic amyotrophy or atrophy of the fleshy dome covering the apex of the lung affected, and interests all the muscles of the region—trapezium, deltoid, pectoralis, and scapular muscles.

Auscultation and percussion were particularly studied by Graucher and Fernel. The former reveals an inspiration, rough and grave, which according, to M. Graucher, is pathognomonic. It was due to the diminished calibre of the respiratory ducts and the roughness of their walls. Expiration is rude and prolonged, exceeding frequently the duration of inspiration.

In the studies he made on the phenomena of auscultation observed in incipient phthisis, M. Fernet drew attention to three distinct points, which were the apex of the lung, and were especially in the suprascapular fossa and the groove between the pectoral and the deltoid muscles, furnishing the signs above indicated; the inter-scapular space on the affected side (dulness and tubular snuffle) and, finally, at the base of the lung, dulness and subcrepitating râles).

Examination of the head reveals tachycardia, which is always a bad sign, even if no other plausible predisposing sign of tuberculosis can be found.

The fever in infected consumptives might always attract the serious attention of the medical attendant. According to M. Chrétien it presents three clinical types. The first is that which comes under the name of subjective fever. The patients do not present any rise in the temperature, but complain of malaise, lassitude, and depression every evening towards five o'clock.

The second type is the subfebrile described by Strempel. It is frequent. The temperature of the patients is normal in the morning, but rises one or two degrees towards evening.

The third and last type is characterized by continued fever with oscillations varying but slightly.

The early diagnosis of tuberculosis concludes M Courtois-Suffit, is a difficult problem to solve in a large number of cases and up to the present day we do not possess any pathognomonic sign on which we can positively make our diagnosis. Yet by careful study of the predisposing signs and the general symptoms and in particular of the temperature, we can arrive at an almost precise conclusion and institute treatment accordingly, and furnishing to the patient the best chance of cure.—French Correspondent in *Med. Press*.

ADRENALIN.

Adrenalin, according to Dr. E. Hartmann (*Kon Bl. f. Sch., Aertze*), is an extract of the suprarenal capsule of oxen. Wherever it comes, it sets up a transient acceleration of the circulation which is harmless. The function of the suprarenal gland was a double one; it furnished an internal secretion, the aim of which is to neutralize poisonous tissue-change products. Animals from whom the glands were removed died with symptoms of acute poisoning. A material was also prepared in the glands, which preserved the normal tone of vessels. Injection of the juice of the organ into healthy animals set up an increased resistance in the vascular system, particularly in the capillaries. In Addison's disease organotherapy frequently brought about a passing improvement. Last year Dr. Takamine, of New York, prepared a crystalline body from the glands of oxen which he called adrenalin. The crystals readily form soluble salts in combination with acids. In commerce the preparation has been brought out as a 1 per 1,000 solution of adrenalin hydrochlorate in physiological saline solution. If the skin of the arm is painted with this 1 per 1,000 solution, in the course of one or two minutes it becomes bloodless from contraction of the capillaries and remains in this state for two hours. Adrenalin allows the performance of all kinds of operations on the nose where before they were not practicable on account of the bleeding, but as the mucous membrane does not become anæsthetized, cocaine must also be used. The writer generally adds a few drops of the adrenalin solution to a 20 per cent.

cocaine solution and paints the mixture on two or three times at intervals of two to three minutes. If the artificial anæmia required be very marked, he dissolves the cocaine powder in the adrenalin solution. The bloodlessness of the mucous membrane lasts from one to two hours, when a hyperæmia of reaction comes on. He advised it also in local suppuration in the nose and in empyema of the sinuses. In obstinate epistaxis it does not always act promptly. Painted on the epiglottis it quickly reduces swelling. Catheterization of the Eustachian tube is rendered easier by preliminary painting with it and polypi of the middle ear are shrunk by application of it so that they can be the more readily removed.—*German Correspondent Med. Press.*

A FEW HINTS ON THE HAIR.

The only hair brush to be employed is one made of good stiff bristles. Another thing that aids the fall of hair is the pernicious habit of wetting it frequently or washing it often. Whenever the hair is wet a small quantity of some bland oil should be thoroughly rubbed in, in order to obviate excessive dryness. When the hair is falling out pretty rapidly, it becomes necessary to stimulate the scalp, and for this purpose the following makes an elegant hair dressing and stimulant combined :

R. Beta naphthol..... ʒ j
 Tinct. cinchona..... ʒ ij
 Spts. myrcia..... ʒ viij
 M. ft. lotio.

The hair should be well brushed twice daily, after applying the above, and should be oiled about three times a week.—*Med. Summary.*

NASAL CATARRH.

Dr. J. N. Anderson presents the following as his method of treating catarrh, which he says has been employed by him for a number of years with great success :

Nasal catarrh is a repeated attack of cold, which eventually leads to a chronic inflammation of the membranes of the nasal cavity.

The symptoms we need not dwell on, as they are well known to the medical profession ; however, the liver becomes affected very early in this disease, and requires attention

immediately, for which I have found the following to be a very successful treatment.

For the dislodgement of that tough mucous-like collection in the upper part of the throat I use—

R. Tinct. sanguinaria..... $\bar{3}$ ij
 Acid acetic..... \mathfrak{m} xx
 Syrup lemon.....q. s. ad. $\bar{5}$ iij

M. Sig.—Teaspoonful from one to two hours till dislodged

The dropping of this acid matter inflames the mucous membrane of the nasal cavity and throat, which is relieved by anointing the nasal membranes early in the evening with the following :

R. Hydrastine sulph.....gr. vj
 Bismuth subnit.....gr. xv
 Menthol.....gr. x
 Vaseline..... $\bar{5}$ j

M. Sig.— Use as directed.

During the day spray the throat with the following :

R. Fl. hydrastis (Lloyd's)..... $\bar{5}$ vj
 Distilled witch hazel..... $\bar{5}$ ij
 Aqua dest.....q. s. ad. $\bar{5}$ viij

M. Sig.—Use with atomizer three or four times daily.

As you well know, the disease soon becomes chronic, affecting the blood and stomach, producing a weak debilitated condition of the nervous system, requiring a good constitutional treatment, and I have had good success with the following, which has as one of its ingredients Howe's Acid Solution, which must be fresh, so I will give you the formula :

R. Iron sulph., pure..... $\bar{3}$ ij
 Nitric acid..... $\bar{3}$ j
 Alcohol..... $\bar{3}$ iv
 Aqua.... q. s. ad. $\bar{5}$ iv

Allow to stand forty-eight hours, and then it is in good condition to go with your blood treatment.

R. Howe's acid sol..... $\bar{3}$ j
 Tinct. nux vomica..... $\bar{3}$ j
 Tinct. valerian..... $\bar{3}$ iij
 Fl. ext sarsaparilla..... $\bar{5}$ ss
 Elixir Lactopeptine..... $\bar{5}$ ij
 Syrup simp.....q. s. ad. $\bar{3}$ vij

M. Sig.—Teaspoonful three times a day before meals.—

Am. Med. Jour.

GOITRE AND ITS TREATMENT.

By P. M. SATER, M.D., GRATIS, O.

TREATMENT.

As to the treatment of this disease, much has been written, both as to internal and external, yet in my own experience but very little can be said in favour of external treatment. The much lauded tincture of iodine, the simple iodine ointment, the red oxide of mercury especially, which we are told promotes absorption, all have proved quite unsatisfactory in my own hands. The latter, effective as it may seem, yet cruel in its action, is still used by many, but just why a patient should be subjected to such treatment is an enigma. After once anointing the growth with the ointment, then placing your patient near a hot stove or in the scorching rays of a hot sun, there to remain until the neck is blistered or absolutely raw, as I have seen them, creates a condition which, in my judgment, calls for treatment just as much as the original trouble for which your patient consulted you. But as some are yet firm in their belief that "like cures like," the barbarous practice of creating an external lesion to cure an internal one may still continue with many of our calling. We are all well aware of the fact that a submissive patient is *the* one preferred under all circumstances, but just why there are not more refractory ones when this line of treatment is instituted I at present am unable to say. As to the internal treatment, much might be said of iodine and its preparations in all forms of this disease, with possibly an exception to the colloid form, especially in recently developed cases. The same holds good with extract of the gland itself, the best results being obtained from the fresh gland itself in a majority of cases, rather than that in tablet form.

Perhaps the largest series of cases is that quoted by Augerer, who, with the raw gland, treated seventy-eight cases, in which only four or five were uninfluenced, the hard, firm forms remaining unaffected, while the soft, small and parenchymatous forms, especially in the young, were most favourably benefited, the fresh sheep's gland being used in all his cases.

The exact method of action of the thyroid gland when taken internally is a matter of some doubt as yet, but it is supposed to put the gland at rest, physiologically speaking.

The potassium salts referred to have proved all claimed for them in my experience, and for some time past I have used nothing else for my sheet anchor. It is my custom in assuming charge of a case of goitre to thoroughly clean out the alimentary tract by administering a few doses of mild chloride, with sodium bicarbonate and podophyllin; follow this with a hot salt water bath—twice a week (in some cases the bathing for mental effect only); then begin my treatment with potassium iodide in small doses, usually about two and a half grains freely diluted, after meals only. The next prescription contains five grains to each dose, while the third contains seven and one-half grains, and with the fourth prescription, if patient shows no signs to the contrary, about ten grains to each dose, this size dose being continued for a few weeks till the changes looked for appear (a diminution in size of gland), then is added one ounce of buchu, juniper and acetate of potassium, which later on is increased to two ounces, thus making one-half the amount of medicine buchu, juniper and acetate of potassium, and this combination continued until the cure is effected, which may be any way from thirty to ninety days, depending on the conditions present. A breaking out on the body resembling the eruption of measles at times develops in some cases, but a reduction in the size of the dose is all that is needed, but never a cessation of treatment.

Believing, as I do, that the addition of a diuretic enhances the action of the iodide as an absorbent and eliminating agent, this treatment has been very satisfactory in a number of cases recently treated and under treatment at the present time.—*Cincinnati Lancet-Clinic.*

SURGERY.

IN CHARGE OF

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AND

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A CONTRIBUTION TO THE TREATMENT OF FRACTURED PATELLA.

Two methods have been employed in the treatment of fractures of the patella at the Breslau Hospital during the past twelve years--(1) medico-mechanical method, and (2) suture of the patella. The choice of the method in any case depends upon the nature of the fracture as determined by careful examination.

For the purpose of laying down certain principles which may be of service in the selection of the proper method in any case fractures of the patella are divided into two groups : (1) " Blow " fractures, those resulting from direct violence : In this class the ligaments remain intact. (2) " Tear " fractures by which is meant those cases in which there has been solution of continuity in the ligamentum properium patellae and the quadriceps tendon or in the parapatellar ligaments. One finds very frequently a combination of these two conditions which would form a third class designated as combination fractures. These cases, however, are included under the second class, as the treatment is the same for all these cases. The essential differences between blow and tear fractures is that in the former the accessory ligaments remain attached to both sides of the patella, no matter into how many pieces the bone may be broken. A wide separation of the fragments, therefore, cannot take place. In tear and combination fractures the ligaments are torn, and a wide separation of the fragments takes place.

The only criterion for differentiating between a blow and a tear fracture in any individual case is the behaviour of

the quadriceps tendon. If, soon after the injury, the patient is able to extend the leg, this naturally points to maintenance of continuity of the ligaments. It may be the patient is unable to extend the leg on account of pain. On the other hand, in any attempt at extension, if the ligaments are torn, one notices a separation of the fragments, the quadriceps pulling up the upper fragment. In a similar way the gap is widened if the knee-joint is passively flexed.

Blow fractures are treated medico-mechanically; tear fractures are sutured. The medico-mechanical method of treatment consists in immobilization of the joint for a short time with elastic compression to hasten reabsorption of the effused blood, massage to the knee joint, especially the quadriceps; patient gets up at the end of a week with a removable plaster-of-paris splint. This splint is laid aside at the end of three weeks.

In suture of the bones the operation is performed without exsanguinating the limb. The transverse incision is used. The suture material at first used was silver wire. More recently brass wire is used, because much stronger. Three or four sutures are placed through the patella—according to the length of the fracture—care being taken not to include the cartilage. Great emphasis is placed upon the value of suturing the accessory ligaments on either side with one or two sutures. The wound is not drained. The subsequent treatment is the same as for blow fractures, except that it begins about a week later, that is, after the healing of the operative wound.

The results are given of an analysis of forty five cases treated at the Breslau Hospital. Of these, sixteen were treated without operation, while in twenty-nine cases there were thirty operations, there being one case of refracture. Of the sixteen cases, seven were examined subsequently, in five of which the patella appeared to be firmly united, but in three of these the X-ray picture showed a fissure at the line of fracture, while in the other two the line of fracture could no longer be made out. Of the nine cases which could be followed subsequently, in eight the functional results were good, while in one the result was only moderate.

Of the thirty cases treated by suture, in twenty-six the wound healed by first intention. The four cases of infection occurred early in the series when the technique was not so rigid as at present. In seventeen cases of operation the results were: fourteen good, three moderate, and one un-

satisfactory. In the last case the sutures had cut through and there was a separation of 1.5 to 3 cm.

Of fourteen cases subsequently examined, in twelve the patella appeared to the touch to be closely united, but the X-ray showed complete bony union in only eight of these. It is a striking fact that while digital examination showed apparent long union in a large number of cases; the X-ray showed this number to be relatively small.

The statistics show that both methods give good results with a proper interpretation of indications and a correct technique. These two methods do not stand in opposition, but the one supplements the other, and each has its own well-defined indications.—Prof. Von Mikulicz-Radecki. *Brit. Med. Jour.*

RESULTS OF OPERATIONS ON THE KIDNEY FOR TUBERCULOSIS.

Garceau has studied the results of operations on tuberculosis of the kidney in 194 cases collected from various sources. These results are compared with those reported by Bangs in 135 cases, and by Facklam in 88 cases, making a total of 415 cases.

In the 415 cases the immediate mortality was 17.8 per cent.; the general mortality was 29.4 per cent. The total number of cures after two years or over was fifty-eight, or 14 per cent. The percentage of promising cases, which includes all those well a few months following the operation, was 58 per cent. The operations for tuberculosis of the kidney as studied in this list are :

1. Nephrectomy.
2. Nephrotomy.
3. Nephrotomy, followed by nephrectomy.
4. Nephrectomy and total resection of the ureter.
5. Nephrectomy and partial resection of the ureter.
6. Resection.

In the author's series of 194 cases the per cent. of cures is 21, as against 7.4 and 7.9 per cent. in the earlier cases. While the results of operation upon tuberculosis of the kidney are disappointing, the later statistics are much more favorable. This is due to the greater care in the selection of cases for operation, and to the fact that with the improved methods for diagnosis patients have been operated upon earlier in the disease.

The percentage of cures is small, because in renal tuberculosis the primary focus is rarely in the kidney, the renal disease being secondary to a focus elsewhere in the body, and even when the urinary tuberculosis has been completely removed the primary focus may be the cause of subsequent death. In a series of 3,424 autopsies, tuberculosis of the kidney was found twenty-four times, but in every case it was associated with tuberculosis in other parts of the body. One cannot say definitely in these cases that the renal tuberculosis was secondary, but, considering the greater facility for infection of the organs more exposed than the kidneys, one must assume that the primary focus is in these organs thus directly exposed.

Of the 415 cases analyzed there were 122 deaths. Of these, about 40 per cent. were due to tuberculosis. Probably this figure should be much higher. Tuberculosis of the opposite kidney occurred in 5.7 per cent. The lungs were most frequently affected, and undoubtedly was the starting-point in the majority of cases.

In two nephrectomies death occurred in one instance seven years after the operation from tuberculosis of the opposite kidney, and in the other eight years after the operation from general tuberculosis. The most brilliant result was one of Czerny's cases, in which the patient remained well twenty-one years after the operation without any manifestation of tuberculosis in the meantime. Such a result is extremely rare. A patient operated on for tuberculosis of the kidney can never consider the future safe.

A comparison of the various operations shows some striking results. In nephrectomy the mortality was 17.4 per cent., while in nephrotomy it was 46.6 per cent. The percentage of cures in nephrotomy two years after the operation is only .56 per cent. The reason for the failure of nephrotomy is that a fistula persists, and this leads to a condition of sepsis, while we cannot be sure there is not present a tuberculous focus which may at any time give rise to tuberculosis elsewhere in the body.

Nephrotomy followed by nephrectomy has given relatively excellent results, and is recommended in patients with an abscess and when the general condition does not justify primary nephrectomy.

Resection of the kidney is condemned as a dangerous procedure. The renal tissue left behind is claimed to be unhealthy as determined by the test of its permeability with methylene blue, and it may contain foci of tuberculosis.

Ureterectomy with nephrectomy is the ideal operation, as it removes the whole focus of disease except that in the bladder. The final results are excellent. Complete recovery may result even when a ureter, known to be diseased, is abandoned, but the risks are great. The dangers are fistula, secondary abscess, persistence of a focus of infection, and continuance of the urinary symptoms.

The following conclusions are drawn :

(1). Tuberculosis is rarely, if ever, primary in the kidney, and the original focus is in some other organ in more direct contact with the external air in the majority of cases.

(2) The presence of a primary focus of disease in the body, even if the disease is thoroughly eradicated from the urinary tract, makes the ultimate prognosis in these cases doubtful at least.

(3) Such foci may remain permanently quiescent, but they may also become excited to activity by general low condition of the system or by causes unknown to us.

(4) Patients should be told of the danger as regards the future for them, and they should lead lives of the greatest regularity, with strict attention to hygiene. A change of climate is very beneficial in these cases.

(5) Reports of cures of long duration occur, but they have been few.

(6) Nephro-ureterectomy should be done in all cases in which the ureter is diseased and the patient's condition allows of it. The bladder should be subsequently treated if diseased.

(7) An abandoned tuberculous ureter is an especial source of danger on account of the great liability of subsequent tuberculosis.

(8) Nephrotomy alone should be rejected except as a preliminary to a later nephrectomy.

(9) Resection is not justifiable, for we can never be sure that the portion removed is the only portion diseased.—E. Garceau, M.D.—*Annals of Surgery*.

A REPORT ON TUBERCULIN AS A MEANS OF DIAGNOSIS.

Madison reports his experience with tuberculin at Danvers Insane Hospital, and presents his results obtained in a series of 400 consecutive cases for two and one-half years. All patients admitted to the female wards at the

hospital were given injections of tuberculin unless the condition of the patient rendered this impossible or undesirable. There was no selection of patients on account of suspected tuberculosis. The method used was as follows: The temperature was taken every hour for two to five days before the injection was given. The injections were given about 8 P. M., and for the next twenty-four hours the temperature was taken every two hours. If there was no reaction from the first injection, a second one was given three days later. After this second injection the temperature was taken for three days or longer if it was found desirable. The routine was adopted of giving a first dose of 4 mg., followed, if necessary, by 7 mg. as the maximum dose. Koch's original tuberculin, imported from Germany, was used. A .5 per cent. carbolic-acid solution was made up so that each cubic centimeter contained 2 mg. of tuberculin, and this solution was made up fresh every three to five days. Injections were not given if the temperature for two days previous reached above 99.5° F. A rise of 2° F. during the following twenty-four hours was considered a temperature reaction.

Madison reports in some detail six cases with the autopsy findings, which may be summarized as follows: In the first case there was well-marked reaction to 10 mg. The autopsy revealed neither active nor any evidence of old, tuberculosis. One cannot say, however, that no focus of tuberculosis was present, as a very small lesion might have escaped notice.

The following five cases showed no active tuberculosis but each showed more or less evidence of old tuberculous foci, which may be considered healed tuberculosis. The eighth case was one of fibroid tuberculosis. This case seems to lend support to the view that healed tuberculosis is capable of reaction. Not all cases of healed tuberculosis react, as several at autopsy showed old lesions, but did not react to the routine doses of tuberculin.

It is well established that cases of proved tuberculosis have not reacted to doses varying from 3 mg. to 10 mg. One finds in the literature reports of patients with tubercle bacilli in the sputum who did not react to such enormous doses as 24 mg. or even 30 mg. In these patients who failed to react the disease almost invariably has been far advanced, and represents only a small per cent. of the total number of cases.

Several writers claim to get reactions in non-tuberculous patients, but statements in regard to the per cent. of non-

tuberculous or healthy patients who react, without post-mortem examinations, are unreliable. Tuberculous lesions are frequently associated with other diseases. There seems to be more reason to believe that syphilis and leprosy may be capable of reacting. It is well known that syphilis and tuberculosis are often associated. Only one case of syphilis which reacted is reported in which no evidence of tuberculosis was found at autopsy.

In regard to leprosy it is claimed that a local reaction is obtained in the tuberculous form of the disease. Here again, however, we have a disease frequently associated with tuberculosis, and the autopsies in the positive cases have always shown tuberculous foci. Many of the discrepancies in the statistics of various writers may be due to (1) the difference in the standard required as constituting a reaction; (2) the size of the dose given; (3) difference in the tuberculin used; (4) deterioration of the glycerine preparation of tuberculin itself. Madison's experience leads him to conclude that the glycerine of tuberculin will deteriorate after several months, and earlier, if they have been opened. In twenty-two patients with positive signs failing to react with a fresh carbolic solution from bottles which had been opened from four to eight weeks the reaction was prompt to a preparation from a freshly opened bottle. Madison thinks that delayed reactions are to be explained as due to the deterioration of the glycerine preparation.

The danger in the use of tuberculin in suitable cases is very slight. In no case was there permanent injury.

1. Patients may react to tuberculin, and no evidence of tuberculosis be found at autopsy, as shown by Case 1.

2. The six cases following seem to demonstrate that completely healed tuberculosis may react.

3. Cases of proved tuberculosis may not react to the maximum dose.

4. The evidence is not conclusive that other diseases than tuberculosis may react to tuberculin.

5. The margin of error of the tuberculin test is considerable, and probably less than 10 per cent.

6. The maximum dose should be higher than 4 mg., and no more than 10 mg. Small increasing doses are not advisable, as the reaction is not so likely to be distinct on account of the tolerance which may be produced. An initial dose of 3 to 5 mg., followed by the maximum dose, is better.

7. The temperature should usually be normal before injections are given. When the temperature is distinctly above normal a negative result is of no value, as these patients will frequently not respond at all, even to large doses.

8. It seems quite certain that the glycerine extract of tuberculin deteriorates, and a fresh bottle should frequently be opened, care being taken to keep it in a cool, dark place. The .5 per cent. carbolic-acid solution should be taken on the day it is used, if possible. I believe that deterioration of tuberculin is the principal factor in producing delayed reactions.

9. It cannot be said that tuberculin injections are entirely without ill-effects, but their use among suitable patients is no more dangerous than the use of chloroform and ether for diagnostic purposes, and is quite as justifiable, as an early diagnosis of tuberculosis is of the greatest importance.

10. About 40 per cent. of all female patients admitted to the hospital react to tuberculin.—J. D. Madison, M.D., *American Medicine*.

THE USE OF PARAFFIN FOR SUNKEN NOSES.

Stephen Paget (*British Medical Journal*, January 3, 1903), in a lecture to post-graduate students, gives a *resumé* of the history of the use of paraffin in the treatment of saddle-nose since its introduction by Gersuny, of Vienna, in 1899. Prior to this, however, Gersuny had used it in four different cases in other parts of the body. In his first case, that of a young man, he injected melted paraffin into each side of the scrotum to assume the place of testicles removed by castration, and to enable the man to pass the medical examination required for admittance to the army. The second and third cases were to lengthen the soft palate after operation for cleft. The fourth was to raise a sunken cicatrix. Then came the fifth, the first one to raise the sunken nose. Each of these cases gave a good result.

Being so apparently successful in its use, many other men have followed his example, and have used it with more or less success in correcting deformities and restoring functions in different organs of the body.

Paget himself has confined his use of paraffin to correcting the deformity of sunken bridge of the nose, and has already treated twenty-six cases.

The only object of this treatment in saddle-nose cases is cosmetic—to improve the personal appearance of the individual; and it is claimed, when properly conducted, that the injection of melted paraffin beneath the skin of the depressed nose will accomplish much toward the desired end.

Paget's method of treatment is the following: The patient, instruments, etc., are prepared aseptically as for any other operation. Two assistants are required. An anesthetic is administered. Meanwhile the paraffin, in a suitable syringe covered by rubber sheeting, except the pointed half of the needle, is kept in a water-bottle six or seven degrees higher than the melting point of the paraffin. The skin is nicked and the needle, first dipped for a second or two into boiling water, is passed well under the skin, a little to one side of the middle line, below the point where the bridge ought to be, and directed upwards. The injection—the instrument holding several c.cms.—should be at the rate of 1 c.cm. every ten seconds. The assistant keeps up firm pressure all round the nose with his fingers, and by the use of a soft metallic ring. Cases differ in the amount of paraffin required, and surgeons differ in the melting point of the paraffin used. Paget prefers the melting temperature to be 110° to 115° Fahr.

The paraffin begins to set in less than a minute, but it remains doughy for about quarter of an hour. Hence the moulding to the required shape should be done at once and pretty vigorously, and must be continued until the paraffin has become hard and incompressible. The patient is put to bed, and a cold compress put lightly over the part. When consciousness is restored the patient is given a mirror and, while told to be quiet, is instructed to gently mould the nose now and then for several hours in order to get as perfect a form as possible.

Sometimes the work is done at one operation, sometimes at two or more. Another thing, the paraffin invariably shrinks a little on cooling so that a few drops may be required to be inserted later.

There is always a certain amount of soreness and occasionally persistent redness after the operation. But both in the end subside.

The chief dangers to be guarded against are the possibilities of resultant embolism, and too large injections of paraffin.

Although the general results in a large majority of cases

operated on have been satisfactory, and there have been no fatal issues, it has yet to be proved how well the treatment will stand the test of time. In closing, Paget says: "Only let nobody think that the method is so easy as it sounds. It is full of little difficulties; it wants experience, and it involves very grave responsibility."—*Canadian Practitioner*.

INDICATIONS FOR THE SURGICAL TREATMENT OF CHOLELITHIASIS AND CHOLECYSTITIS.

At the Society for Internal Medicine, Hr. W. Korte discussed the indications for the surgical treatment of cholelithiasis and cholecystitis. Since the commencement of the nineties this treatment has been in extensive use. Since that period he had himself operated in three hundred cases. The reach of the operation had been over-estimated. Whilst immediate operation had been desired by some surgeons in gall-stone troubles, it had been looked upon by others as the last refuge. The former's desire to operate whenever there was a stone in the gall-bladder before it got into the choledochus would be right if the second stage always followed the first. But this was not the case. Even after the most violent attacks a latent stage might come on that might last to the life's end—no recovery it was true, but its equivalent from the patient's point of view. The view had gradually developed that the mechanical condition played a part minor to that of infection. There were typical attacks of cholelithiasis that were set up by inflammation of the gall-bladder only. Then hydrops of the bladder took place from impaction of the stone in the choledochus. Hydrops might exist a long time without giving rise to trouble. So soon as infection took place, however, most serious symptoms came on. Large gall-stones that would not enter the choledochus sometimes occasioned attacks of colic which were also due to inflammatory causes. Also with stones lying in a recess in the duct without blocking it; jaundice and other symptoms appeared due to infection and swelling of the mucous membrane. Especially in the lower part of the duct bacteria were always present, particularly the bacteria coli, which were kept harmless by the constant passage of bile. If any disturbance of this flow through took place, serious symptoms might follow. The presence of gall-stones merely, therefore, did not form an indication for operation, but the kind and degree of inflammation was the guide.

There was another point : Did operation guarantee freedom from the trouble? Certainly not. After trouble might arise in three ways. Either through true recurrences or by pseudo-recurrences, or by retained calculi, or by adhesions. True recurrences were rare, but they did occur. Gall-stones arose from stasis of the bile and from infection. When after cystotomy the gall-bladder almost always became attached to the abdominal wall, kinking of the choledochus might take place and lead to stagnation of the bile. If infection became added, we had the condition for a new formation of stones. Stones had also formed around silk threads left in the gall-bladder. A case the speaker related showed that new formation of stones could not always be avoided.

All surgeons would concede that stones might be overlooked. As regarded attachments, the known ready formation of adhesions on the part of the serosa might easily lead to trouble after extirpation of the gall-bladder. The trouble was not serious, however, and it ceased on the separation of the adhesions. The patient's attention should be drawn to this. For the reason given, the speaker was very shy of operating in ordinary cholelithiasis. He operated in such cases at the wish of the patient. He adopted the same attitude in cases of dropsy of the gall-bladder, in which, generally, the symptoms were not very acute; in case they were, he proposed operation. In this group, however, internal treatment must be tried first.

There was a second group, however, that belonged to the domain of surgery. This group consisted of such cases as led to permanent invalidism, or were dangerous to life. Here after-troubles did not count. The period of time for operation was decided by continued existence of dull pain and discomfort after the acute attack had subsided, the gall-bladder being resistant and tender. The normal gall bladder could not be palpated—this could only be done when the walls were rigid from inflammation. In spite of suppuration, fever was not necessarily present. Suppuration appeared in two forms—acute suppuration and chronic empyema. Empyema should be operated upon as it might at any time pass into an acute stage; internal remedies were useless. Acute suppuration arose when bacteria found their way in. The inflammation here might be so acute that operation must be resorted to at once, otherwise one would prefer to wait until the attack subsided. The greatest danger in acute inflammation was

rupture of the sac, as in a case related by the speaker in which at the operation the gall-bladder was found very tense, containing numerous stones and having at one spot an ulcer almost ready to burst. He had operated in nineteen cases of acute empyema of the gall-bladder. If the jaundice present did not disappear, this was owing to inflammation in the deeper bile passages or from a stone being impacted in the choledochus. The choledochus stone was a pressing indication on account of the danger for cholæmia and ascending cholangitis with abscess of the liver. The operation was not easy and it had its risks. In the absence of acute symptoms, six to eight weeks might be awaited. In one case the speaker found pus in the choledochus even after five weeks.

A not unfrequent complication was carcinoma of the gall-bladder. Along with it empyema of the gall-bladder was often found. In cancer of the gall-bladder calculi were almost always found. When the flow of bile was hindered by a tumour of the pancreas, operation did not afford much prospect. Here cholecystetnerotomy might be performed, but the contents of the intestine might flow backwards and lead to abscess of the liver.

As regarded operation the fundamental principle was to make the field of operation accessible. If the gall-bladder was seriously diseased it should be extirpated. The deeper bile passages could only be inspected in this way. Here also was frequently met with infection, and then drainage of the choledochus was to be recommended.

From all that had been said it would be evident that the time for operation must be determined by the individual features of the case.—*German Correspondent in Med. Press.*

THROUGH AND THROUGH INTESTINAL SUTURE WITH REPORT OF ADDI- TIONAL CASES.

F. G. Connell, of Leadville, deviser of the suture which bears his name, makes this report and concludes :

The suture that aims to include but a portion of the bowel wall is dangerous: (a) because it is liable to fail to include any of the submucosa, in consequence leaving a weak stitch; (b) because if including any of the submucosa it is almost certain to penetrate the coat, leaving a stitch open to the dangers of capillarity.

By utilizing a through-and-through suture the danger of yielding is excluded.

By employing a suture that is knotted in the lumen the danger of capillarity is diminished.

It is acknowledged that the most appropriate place for the knot when all coats are perforated is in the lumen of the bowel.

It is undeniable that when the submucosa has been perforated accidentally the knot ought to be placed inside.

It is also undeniable that many so-called Lembert stitches perforate the submucous coat, and thus convert an intentional nonperforating into an unintentional perforating suture.

Undeniable, too, that owing to the extreme tenuity of the submucous coat (1-6 of the thickness of the needle which is to "penetrate but not perforate" it) we are utterly unable to differentiate between a perforating and a non-perforating Lembert stitch.

The logical conclusion is that the ideal location for the last and all knots in an enterorrhaphy is outside of the peritoneal cavity in the lumen of the bowel.

As a chain is no stronger than its weakest link, it is of practical import that the last one or two stitches be also perforating and knotted in the lumen.

The diaphragm by its valve-like action is of great value in the prevention of leakage.

The tying of the knot, according to the method described above, does not interfere with the establishment of firm union or tend to leakage.

The side-knot, or "square" stitch, in rendering a retaining suture unnecessary is superior to the top-knot or "circular" stitch.—*Am. Med.*

ASPIRATING FOR PLEURISY WITH EFFUSION.

In aspirating for pleurisy with effusion, cough usually begins after a fairly large amount of fluid has been withdrawn. It may serve to some extent to break adhesions, and in moderation may be beneficial. But if the cough begins very soon, and interferes with the removal of a sufficient amount of fluid, measures must be taken to stop it. The needle may be withdrawn, and the operation repeated next day, after a moderate dose of opium has been given to quiet nervousness. Better still, leave the needle in place shutting off the stop-cock, and tightly bandage the chest with a broad bandage,

pulled more tightly as the fluid is removed. This strong support to the chest will usually stop the cough, and is a good routine measure to adopt in all cases of pleuritic effusion.—*International Jour. of Surgery.*

PATHOLOGY OF EMPYEMA.

Dr. Bovaird (*Med. News*) says: The points in the pathology of empyema upon which he would lay emphasis are:

1. Its frequency in children.
2. The frequency of bilateral cases.
3. The impossibility of drawing a sharp distinction between serofibrinous pleurisy and empyema.
4. The creamy consistency of the exudate in many cases.
5. The frequency of sacculated effusions.
6. The frequency of pneumonia, as a preceding or accompanying lesion.

7. So far as concerns the bacteriology of empyema, the pneumococcus is present in the great majority of cases in children, especially in the thick creamy exudates. The streptococcus or staphylococcus pyogenes is found in a much smaller percentage of cases, especially in those not associated with pneumonia and characterized by thin purulent exudates.

8. Tuberculosis is present in but a small percentage (6 per cent.) of cases.—*Archives of Pediatrics.*

PATHOLOGY OF INEBRIETY.

Abstract: In all cases changes of the capillaries and vascular system, beginning with irritation, inflammation, and merging into sclerosis and cirrhosis, are present. The cells and dendrites are atrophied, retracted and eroded. Changes occur in the middle and inner coats of the artery in the brain, liver and kidneys.

Arthritis and neuritis are prominent in all cases.

The heart is either atrophied or enlarged.

Fibrous and calcinous deposits with thickening of the meninges and hyaline degeneration are common.

Aploptic foci are found throughout the brain with infiltration of the connective tissue. These conditions are both inherited and acquired. Alcohol in many cases lights up and intensifies the condition.—*Quarterly Journal of Inebriety.*

Jottings.

One grain of chloral hydrate, given every three hours, rarely fails to cure nettle rash.

Monobromide of camphor, in ten grain doses, until the brain feels it, is an excellent remedy for nymphomania.

Crude petroleum, poured upon a burned surface, and covered loosely with cotton, will subdue pain almost at once.

The fluid extract of *ustilago maydes*, one-half dram, cured a case of hiccough that had resisted all other treatment for days.

Cocoa-butter suppositories, containing ten to eighteen grains of iodoform, is excellent for fistula in anus and painful piles, etc.

An ointment made of yellow oxide of mercury, two grains to one ounce of vaseline, applied lightly once a day, cures granulated lids.

Jaborandi, in doses of from five to ten minims, promotes diaphoresis in retarded labours, favours general relaxation and overcomes rigid os uteri.

The frequent application of oil of eucalyptus, with a camel's hair brush, gives speedy relief of pain in chilblains, and soon effects a cure.

An ethereal solution of menthol, ten to fifty per cent. applied by a camel's hair brush, averts boils, carbuncles and inflammatory gatherings, and cures itching eruptions.

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Editorial.

IS APPENDICITIS INCREASING IN FREQUENCY.

The Dublin *Medical Press* of recent date, says:

“The extraordinary prevalence of appendicitis, at the present time is a favourite topic of conversation among the public generally. One is constantly appealed to say whether it is a new disease, and, if not, what explanation can be given of its apparent prevalence as compared with days within the memory of young adults, when its occurrence was all but unknown, and figured little, if at all, in hospital records. Nothing, of course, is easier than to adopt the explanation lightly given and as lightly accepted with regard to the greatly increased mortality from cancer, viz., that it is only a question of nomenclature, the selfsame symptoms having previously been described under other terms. Unfortunately, neither individual experience nor hospital records afford much support to this view. Those of our readers who are able to recall the state of affairs twenty years ago will in great measure share the surprise felt by the public at the remarkable frequency of symptoms which, in their own experience, were

then but exceptionally met with, and when encountered were almost invariably benign in character. This aspect of the question is very lucidly and carefully dealt with by Dr. Y. A. MacDougall in an article published in the current number of the *Lancet*. It was not until 1887 that he first met with lethal cases of appendicitis, and since that time he has met with them in ever increasing numbers. The most curious feature of the inquiry is that the records of several large general hospitals fail to show more than an infinitesimal proportion of cases which, by any stretch of the imagination, could be accorded the post-humous title of appendicitis. Since the records of post-mortem examinations are available there can be no question of any modification of nomenclature, and one is driven to seek elsewhere for an explanation. Even when a knowledge of the pathology of this form of perityphlitic inflammation first became generally known the cases were comparatively few in number, and the disease was considered to be one for medical rather than surgical treatment. The tendency to recurrence, which is now recognized to be such a marked feature of the disease, does not appear to have attracted the attention of the physicians of twenty years ago; in fact, in the light of our present knowledge, one is certainly tempted to believe that a new symptom-complex has made its appearance in the medical firmament. We must remember, however, that the ordinary attack of appendicitis is of comparatively trifling severity and unless its grave possibilities are understood, is extremely likely to pass well nigh unperceived. A little tenderness in the region of the right iliac fossa, a slight rise of temperature and some abdominal discomfort, associated, perhaps, with constipation, may be all that the patient complains of, and it may be conceded that even at the present day thousands of such cases are dealt with on ordinary medical lines without a thought of their possible dependence on catarrh or inflammation of the vermiform appendix. In times gone by the vast majority of such attacks were recovered from in the course of a few days without

attracting any particular attention. They would doubtless do the same now, were it not that in order to save the lives of the minority early operation is resorted to irrespective of the gravity of the particular attack. Then again the undiagnosed cases of perityphlitis which, in times past, ran on to suppuration and culminated in general peritonitis or pelvic abscess did not come into hospital until a stage had been reached at which it must have become difficult to distinguish the starting point of the mischief, especially as experience had not yet taught pathologists to scrutinize with special care that intrinsically insignificant organ, the appendix. It is highly improbable on the face of it that the appendix should suddenly have developed undreamed-of aptitudes for mischief, and although the statistics of the past fail to afford any confirmation of the view we prefer to think that this was due to a failure of perception due to the lack of accurate pathological knowledge."

INSURANCE AGAINST APPENDICITIS.

We learn from a contemporary that insurance firms, like everyone else, must move with the times, and that the latest security which is offered by the world-known "Lloyds" is an insurance against appendicitis. The prevalence of appendicitis, or perhaps its fashionable character, has suggested to one of the most prominent firms in Lloyd's, that perhaps a cautious public might like to insure against its risks, and so for a premium of five shillings the assured, who suffers from appendicitis, will receive a sum which will go a long way towards discharging his bill for medical attendance. In return for this premium, if the assured has to undergo an operation for appendicitis he will have his direct expenses paid up to £200, or, in the event of his death under or from the operation, his representatives will receive a like sum. It is stated that a large number of people have availed themselves of the offer, and are now protected from the monetary losses which an attack of appendicitis

might involve. The premium charged two and a half per cent., is identical with that asked a year ago for insuring against smallpox, and should prove a source of profit to the enterprising guarantors. Our contemporary omits to mention whether any preliminary precautions are taken to ascertain whether the insurer has an—outwardly, at least—healthy appendix, but we presume that such is the case, and that he must be furnished with due medical credentials to that effect.

Book Reviews.

Book on the Physician Himself and things that concern his Reputation and Success, by D. W. Cathell, M. D., twentieth century (eleventh) edition, Royal Octavo, 411 pages, beautifully printed with ornamental chapter readings. Extra cloth, price, net, \$2.50, delivered. F. A. Davis Company Medical Publishers, 1914-16 Cherry Street, Philadelphia.

In the preparation of this last edition this notable book has been practically rewritten throughout. A vast amount of material contained in the previous edition was entirely thrown out and new matter added to such an extent as to materially increase the size of the book, thus causing the price to be raised from \$2.00 net to \$2.50 net. This remarkable book in the ten previously issued editions reached a sale of nearly 50,000 copies, a circulation never before attained by any medical work in a like period of time. It is indeed a unique book which every doctor should have. Many physicians have denied themselves the possession of this work because they had perhaps glanced over a loaned copy, or had considered it simply a book for amusement. The facts are that while it is indeed amusing, it is a book of solid worth, which every doctor should have and read thoroughly, and keep for reference. This general statement admits of very strong demonstration. The doctor, like the clergyman, is always a public character, especially in the country towns. His services may be asked for as the result of the most indirect influence, while in like manner impressions may be produced entirely without the knowledge of the doctor, which will not only alienate patients, but divert prospective business to some other physician. The old story of how the magnificently educated physician often fails while the ignoramus with more tact succeeds is explainable in exactly this way. There is a right and a wrong way of doing everything. A community will often forgive a doctor more readily for an error in diagnosis than for a "break" made in the course of his personal relations with the general public, which may indicate ignorance of human nature.

In Dr. Cathell's book all these delicate points are taken into account, and hundreds of suggestions are made which show very plainly how easy it is to get on the wrong track in these respects. This is especially the case with a young physician, who may, like the renowned character in Mark Twain's novel, be designated as a "Pudd'nhead," on account of the most trivial error in department. A special feature of the new edition of Dr. Cathell's book is the introduction of hundreds of apt quotations in display lines which tend to lighten up the character of the book and make it even more readable than in preceding editions. The investment of the price of this book is a small sum compared to a doctor's reputation.

Of course, such a comparison is entirely ridiculous and absurd; on its face there can be no such comparison. Nevertheless, we have the testimony of hundreds of the brightest physicians this country has ever known to the effect that the possession of such a work as Cathell's book on "The Physician Himself" would, at the outset of their careers, have been worth hundreds of times its price as an unerring guide to govern their relations with the general public.

The grateful remembrance in which the painstaking preceptor is held by the earnest student is one of the compensations of the physician whose value cannot be estimated in money. The presentation of a copy of "Cathell" to the proud possessor of a new diploma will always be accepted as a peculiarly appropriate gift. Once more we advise those who read this notice to obtain a copy.

F. W. C.

Transactions of the College of Physicians of Philadelphia, Third Series, Volume the twenty-fourth, Philadelphia, printed for the College.

The Committee of publication has favoured us with a copy of this book, which contains all the papers read before the Society from January to December, 1902. The volume opens with memoirs of Dr. John Ashurst, Jr., Dr. Alfred Stillé, Dr. William Fisher Norris and Dr. J. M. Da Costa, all men well known to the profession as eminent teachers of the Philadelphia Schools. The various papers cover a variety of subjects, and all are more or less interesting. We have read several of them with profit.

F. W. C.

A Text-Book of Practical Medicine. For the use of Students and Practitioners. By William Gilman Thompson, M.D., Professor of Medicine in Cornell University Medical College, Physician to the Presbyterian Hospital, Bellevue Hospital, etc., New York.—New (second) edition, thoroughly revised. In one octavo volume of 1,104 pages, with 62 illustrations. Cloth, \$5.00; leather, \$6.00; half morocco, \$6.50 net. Lea Brothers & Co, Philadelphia and New York.

A book on Medicine of over one thousand pages, which has been in such demand that the first edition was completely exhausted in less than two years, and a second revised edition was called for,

must be a standard work. But when we find that the author was the well known professor of medicine in Cornell University, Dr. William Gilman Thompson, and that it emanates from the house of Lea Brothers & Co., of Philadelphia and New York, we may be sure that it is no ordinary publication. In the original preparation of this work Dr. Thompson built upon the firm foundation of sound pathology, but throughout the entire structure cardinal principles are ever kept in view, namely, that curative medicine is the rightful object of every practitioner. The cured patient is of inestimably more importance to the physician than the most interesting pathological specimen. Therefore, while drawing liberally from every contributing science and giving without stint from his own rich experience of twenty years in private and hospital practice and in teaching, the author devoted particular care to the therapeutical sections of his work making his direction for treatment so clearly detailed and so precise that the volume furnishes the most useful presentation of modern applied medicine. The progress in a knowledge of dysentery, yellow fever and malaria, immunization, preventive inoculation and sero-therapy has been so great since the first edition that the present chapter had to be entirely re-written. Much of the matter on diseases of the blood and heart and of the digestive system are new. The chapters on functional nervous disorder are especially good. We have read a few chapters at random and in each we have found the same clear convincing style. For instance, page 971 on tabacconism. Poisoning may arise from the use of cigarettes, cigars, chewing tobacco, pipe smoking and snufftaking. The limit of toleration of tobacco before symptoms of intoxication appear varies in the same person from time to time. It is reduced by acute disease, and with fever the desire for tobacco usually ceases. Some men may smoke a dozen or more cigars daily for years with impunity and as they grow older suddenly develop serious tabacconism. As a rule pipe smoking is the most injurious form of use of tobacco and as in the case of alcohol those who are much in the open air, vigorously exercising have the greatest toleration for the stimulant. Symptoms of tabacconism are chiefly digestive and nervous. The tongue is coated, the breath is foul, there may be nausea, vomiting, flatulence and constipation is the rule. In cases of long duration there is emaciation, the skin is sallow, the throat is congested, the mouth dry and there may be superficial ulcers within it (stomatitis). Perspiration is common, nervous symptoms are primarily palpitation and restlessness with insomnia, apprehension and hypocondriasis.

Treatment.—Tobacco should be absolutely withheld. Tapering off is unsatisfactory and prolongs the misery. Insomnia and restlessness may be prevented by the bromides, trional and codeine. The bowels should be opened with calomel (gr. v. to x.). After serious cases the use of tobacco should not be resumed for six months or a year and not then if palpitation recurs. This is a very good sample of the eleven hundred pages besides some sixty

illustrations. We can heartily recommend the work to advanced students and practitioners.

A. L. S.

Veasey's Ophthalmology. A Manual of Diseases of the Eye. For Students and General Practitioners. By Clarence A. Veasey, A.M., M.D., Demonstrator of Ophthalmology in Jefferson Medical College. Philadelphia. 12mo. 410 pages, with 194 engravings and 10 full-page coloured plates. Cloth, \$2.00 net. Lea Brothers & Co., publishers, Philadelphia and New York.

Dr. Veasey in his manual has succeeded in giving to the student of ophthalmology a first-rate guide to the study of the diseases of the eye. One great advantage this book possesses is that it is very clear, for the author has concentrated his thoughts on the essentials such as symptoms, diagnosis, treatment, etc., avoiding the profitless discussion of unsettled theories which so often takes up so much space in text-books.

The book is profusely illustrated and unusually well printed. A point that will appeal to the student is the remarkable low price.

G. H. M.

PUBLISHERS DEPARTMENT

Conclusions so startling as those reached by Dr. Wallace's *Fortnightly* article on "Man's Place in the Universe" could not go long unchallenged, and the April number of the *Fortnightly* brings a prompt reply no less an authority than the Savilian Professor of Astronomy at Oxford. Professor Turner's article will be reprinted in *The Living Age* for May 9.

The intense interest felt in the ecclesiastical situation in England at the present time is reflected in the April magazines. Two notable articles from "The Nineteenth Century and After" will be reprinted in *The Living Age*, Viscount Halifax's strenuous appeal to the High Church party, entitled "The Crisis in the Church," will appear in the number for May 9, and Lady Wimborne's earnest presentation of the opposite view, "The Church's Last Chance," in that for May 16.

Some very clever parodies on fashionable forms of fiction—the romantic novel, the kailyard novel, and the rest—will be found in the "Letters to a Literary Aspirant" which *The Living Age* for April 25 reprints from *Blackwood's Magazine*.

Human nature does not change much, and readers of the diverting article on "Servants and Service in the Eighteenth Century," which *The Living Age* for April 25 reprints from *The Cornhill Magazine*, will be astonished to find so many of their own domestic grievances at least a hundred years old. The picture of the departing guest, "tipping" his way out, between rows of expectant servants, is particularly realistic.