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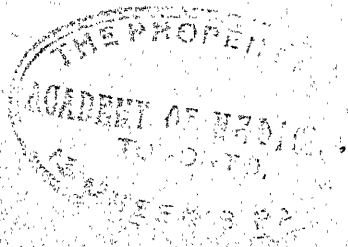
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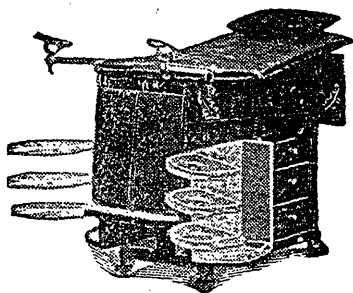
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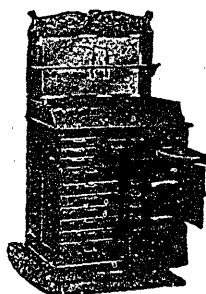
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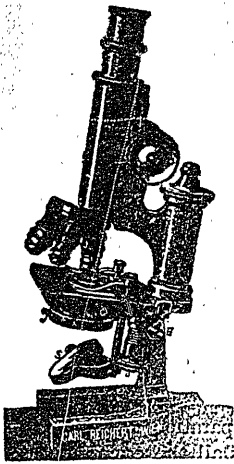
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## Original Communications.

### ADDRESS IN SURGERY.\*

THE CONTRIBUTION OF PATHOLOGY TO SURGERY.

By JOHN STEWART, M. B., C. M., Edin., Halifax, N. S.

There is no finer chapter in the history of our race than that which deals with the exploits of the early navigators of the fifteenth and sixteenth centuries. The sea was not then what it is now, mapped and measured, and marked by innumerable highways of travel. It was a dim mysterious realm, with unknown bounds, little more was known of its nature than when Homer sang, with a grand vagueness, of the Streams of Ocean.

And yet, from Palos or from Bristol men set forth urged by the deathless yearning of the human heart to know and to do, with no guide but the scanty scraps of experience, and their own hardy resolution, without sextant, without chronometer, without log-book, without chart, they sailed out into the vast unknown, unmeasured, unsounded sea, fearing but daring mystery, and hoping for the Hesperides.

The seamanship of those heroes was perfect, their navigation, their knowledge of the principles which lay at the foundation of their art, their equipment in all that is now deemed essential, was crude and rudimentary. How could it be otherwise when Newton was yet unborn, when the old Ptolemaic theory of the universe still held sway and at a time when success and failure were attributed to the benign

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\* Delivered before Canadian Medical Association, Montreal, Sept. 16th, 1902.

or baleful influence of the stars by which they sought to guide their course?

Long and slow was the process of their science, centuries were to pass before their dreams came true, many and various were the sources from which help came, and even to-day there are problems unsolved, and a still elusive goal.

Nothing is more striking in the evolution of nautical science than the marvellous development of the last century, due chiefly to the introduction of steam as a motive power. It has created a new epoch.

I knew an old sea-captain who told me that when he was an apprentice he sailed one winter morning in a brig called the "Westmoreland" from Belfast, bound out to St. John, N. B., "And," said the old man, "after boxing about the Western Ocean for one hundred and forty days we brought up in Cork Harbour." Compare such a contingency with a voyage in such a ship as the "Oceanic," which leaves her dock with the punctuality of clockwork, a scarcely greater punctuality than that with which she arrives in dock on the other side of the Atlantic.

The contributors to this wonderful advance may be divided into two classes. There was the practical sailor, quick to observe, ready to act, full of resource, with all

"The virtues which his perilous life  
Extracts from Nature's elemental strife."

And there was the philosopher, the man of reflection, who pondered the reports of these adventurers in strange seas and under new skies, and sought for explanations of mystery, who followed Learning for her own dear sake, and counted himself happy if only he might know the causes of phenomena and evolve a Cosmos from seeming chaos.

A parallel, not altogether fanciful, may be drawn between those pioneers of ocean travel and the early masters of our craft. Those made their way through the uncertain world of waters, very synonym of change and unrest, guided on the one hand by their own hard-won experience and the traditions of their fathers, and on the other by the application of principles laid down by men who made a philosophic study of Nature, who searched into the secret of the sea, who built up the Sciences of Astronomy, Geography and Hydrography.

And these worked in the sphere of the human organism, mysterious, intricate, inexplicable, and they too worked on two lines, the long and

wear and often fallacious track of Empiricism, and the ampler but often disconnected road constructed by those whose chief aim was, in the words of him who led the vanguard, "to study and search out the secrets of Nature."

There was a Cosmography—of a kind—and methods of measuring space and time before Copernicus and Tycho Brahe, and there must have been some sort of a pathology, some notion of the nature of the morbid processes in the mind of the first prehistoric surgeon who plugged a wound or opened an abscess. The troglodyte surgeon must have had some notion why he chipped holes in his patient's skull.

But was the lore of the medieval mariner, regarding the earth as a fixed expanse around which the heavenly bodies wheeled, casting a horoscope to secure a favorable voyage, sailing a wonder-sea of mystery and portent, anchoring to the Kraken's rugged side and being well acquainted with the Mermaid, more unscientific than that of his brother the surgeon? What a limbo of fantastic and irrational notions filled the minds of our colleagues of the Middle Ages! Yes, even of men who lived a century ago and whose voices still have power.

It is difficult for us to realize the strange notions of a time when the ancient humoral pathology in a very solidist manner, still projected itself into the vortex of the Renaissance, when honoralist and solidist rose, struggled and sank, to reappear in new disguises as they do to this day, when the vitalist imagined his "Archæus," when skilled clinicians considered scabies a typical dyscrasia, and when a keen and cultured mind could believe in the "*pulvis sympatheticus*," and when the grotesque philosophy of Paracelsus with its strange fore-gleams of latter day truth, held sway. Medieval pathology is like a dark and troubled sea where gleams of truth shine pale through wildering mists and where conflicting currents seethe and boil—"dark fluxion—all unfixable by thought."

And what Navigation was to Seamanship, Pathology is to Surgery.

Advance in nautical science was conditioned by the advance in the study of natural phenomena, by invention of instruments of precision, and the application of these to the purposes of the mariner. From China came the mariner's compass; from Nuremburg came the watch, precursor of the chronometer; from Flanders came Mercator with his charts; Scotland sent Napier with his logarithms; England supplied Hadley and the sextant; and the fore-runner of the Nautical



Almanac—the mariner's vade mecum—in the shape of the first Almanac, came from Poland.

And nothing is clearer than that progress of surgery depended on the study of vital phenomena and the application of the results of these studies and of new methods to the problems of disease and injury.

The pyrotechnics of Paracelsian dreamery were still blazing on the dim coasts of the old-world pathology when the morning star of the new era appeared in the person of the first real anatomist Versarius, and day dawned with William Harvey, the Columbus of modern medicine. Harvey led the way in the application of experimental methods to biological questions. The result of his great discovery was a complete change in pathological ideas, and a new school of pathology soon arose under the guidance of the famous Boerhaave at Leyden. He, impressed by the study of the physics of the circulation, and aided by the discovery of the capillary system by Malpighi, and of the red corpuscles of the blood by Swammerdam and Lewenhoeck, initiated the study of the local changes in diseased parts, and soon the first text-book of general pathology was brought out by Gaubius, distinctly biological in its view, and having for its text the maxim of Boerhaave "*Morbis est vita praefer naturam.*"

It was under the influence of these views and the new methods of study that Morgagni produced his epoch-making book, "*De Sedibus et Causis morborum,*" of which Virchow says, "it was the first time that the sum total of actual knowledge of the material alterations which disease occasions in the body, was brought before the world."

With this, pathological anatomy began and the way was prepared for John Hunter. He it was who introduced the experimental method into the study of disease; and, by virtue of his intuitive genius, his amazing capacity for work, and his practical applications of the results of his researches, has well earned the title *Father of Scientific Surgery*. "From the time of Hunter to the present time" says Billroth, "English Surgery has had something of grandeur and style about it."

In the vast field of subjects which Hunter explored it is difficult to single out any one for pre-eminence. But it is undoubtedly on the score of his celebrated operation for popliteal aneurysm that he is generally known as a practical surgeon. Mr. Butlin, in his interesting Cavendish Lecture, tells us, not without a stroke of humour, of the great expectations he had formed of interesting instances of the direct influences

of pathological study on practical surgery, and how he found absolutely nothing of the sort in the history of medicine until he came to Hunter's operation, which he calls "the *one* example, the *only* example, up to that time, of deliberate surgical invention founded on the study of pathology by the man who made the invention."

But it is not in particular instances only, in improved methods of diagnosis, in aids to operative surgery, that the contribution of pathology is found. It is rather in the new principles gained, and in the new attitude towards nature and phenomena, that pathology has ennobled surgery.

Hunter helped us to understand our power of interrogating nature, of interpreting her answer, and our power of applying the knowledge so gained to the practicable problems of our art. This was the beginning of Scientific Surgery, but much remained to be done, and it is noteworthy that the chief actors in the movement now were among the surgeons. Who can estimate the value of the impetus given to pathology by Xavier Bichat in his studies of the tissues, or of Andral in his hæmato-pathology? After Bichat came Dupuytren, the practical surgeon, and in England Charles Bell revolutionised our theories of the nervous system.

The next great advance was to arise from a study of plant life, and the researches of Schwann and Schleiden paved the way for the Cellular Pathology of Virchow—the basis of our present system of pathology.

And a shadow falls upon us gathered here as we realize that the Veteran Master, the undisputed leader of pathological thought and progress for over fifty years, has fallen, and we unite in the desire to lay our spray of cypress on the tomb of him whom we all considered the greatest German of our time.

But with all these new acquisitions, the exact anatomical knowledge, the clearer views of morbid action, there was still for the surgeon an unexplored sea of mystery. The pathologist went on his way rejoicing in his rapidly increasing store of knowledge, the surgeon still lingered, with anxious mind and heavy heart, for the question of questions to him was still unanswered.

The healing of wounds was the Enigma of Surgery, and the characteristic difficulty was the uncertainty attaching to the healing process. Here a wound healed quietly and soundly, without pain and without causing constitutional disturbance, and there it became

inflamed, suppurated for weeks, causing intolerable anguish and exhausting the patient. Why the difference? Why so much danger from the thrust of a pike than the stroke of a sabre? Why should a fracture of the leg, in which a splinter of bone had cut through the skin, be so much dreaded, while multiple simple fractures were seldom dangerous to life? Why was the peritoneum virtually a closed door to the surgeon's desires? Why did the implication of a joint add so terribly to the danger of a penetrating wound? Who can estimate the amount of anxious thought that has been given to this subject, who can gauge the disappointment that resulted from the application of so many theories? Empiricism was at its wits' end. Cold lotions and warm poultices, stimulating liniments and soothing ointments, wet dressings and dry, no dressings at all—all had their advocates, their occasional successes and their inevitable failures. The only certainty in the whole sad field was the certainty of failure, the certainty that however brilliant a series of cases a surgeon might have, it was sure to be broken some day, for some inexplicable reason. We can only wonder at the marvellous correctness of some of the guesses at truth that were made, and admire the results which were sometimes attained by men who would almost appear to have had an intuitive, if unconscious, knowledge of the truth. Witness, for instance, the extraordinary results of Alanson at the Royal Infirmary of Liverpool in the beginning of last century. And mark that Alanson was a pupil of John Hunter.

The idea of *Materies Morbi* is a very old one, and doubtless the idea that this might be a species of living matter is also old. The notion of the parasitism of disease crops up repeatedly in the history of pathology. Monti, in his "fundamental data of modern pathology" claims for his fellow countryman Agostino Bassi, the distinction of being the founder of the doctrine of pathogenic microbes.

However this may be, it is certain that by the close of the eighteenth century this conception was present in the minds of many scientific workers.

It was reserved for Schönlein to prove in 1839 that the disease known as tinea, and considered as a typical "humoral" disease and not only so but hereditary, was really due to the growth of a fungus.

About fifty years ago Davaine and Chauveau proved that the disease known as anthrax was caused by the presence of an organism discovered in the blood of affected animals by Pollender in 1849.

The mists of conjecture were condensing and trickling into clear tiny rivulets, and soon these were collected by the genius of Pasteur into the grand fountain-head of the mighty stream of bacteriology. But the practical surgeon had gained nothing towards the elucidation of his enigma. Perhaps at no time was their greater helplessness in the treatment of wounds. The advance in methods of diagnosis and improved methods of operating, introduced by such men as Syme and Nelaton, and other brilliant surgeons of the period, and the great discovery of anæsthesia, had stimulated operators to increased activity. But the surgeon and his patient seemed the sport of a capricious fate. Epidemics of septic fever, pyæmia, hospital gangrene and erysipelas decimated hospital wards and often attacked fifty per cent of all operation cases, and hospitals were being closed. Surely surgery was suffering eclipse.

Then came Lister, and the dark hemisphere rolled in one grand movement from its age-long penumbra into noonday. Surgery—modern surgery—was born. In the chronology of our craft time is divided into before and after Lister. The shadows of fear, anxiety and uncertainty left the surgeon's face, for now that

“Wise, rare smile was sweet with certainties.”

It is a fascinating thing to trace the history of a great discovery, and when the time comes to write the history of the Listerian Renaissance, it will be found the romance of surgery.

“The great artist,” says Amiel, “is a simplifier.” “Art is simply the bringing into relief of the obscure thoughts of nature; a simplification of the lines, a falling into place of groups otherwise invisible. The fire of inspiration brings out, as it were, designs traced before hand in sympathetic ink. The mysterious grows clear, the confused plain; what is complicated becomes simple, what is accidental, necessary. Every ideal is the key of a long enigma.” Lister's ideal fitted the key to the enigma of surgery.

I do not know that we are yet in a position to understand the profound change which this ideal brought into pathology. We cannot yet find a proper perspective to view the work of him who is in surgery what Newton was in physics, “that master mind of which,” as Pearce Gould says, “we owe the greatest impetus that surgery has ever felt.”

As the new system was developed step by step with irresistible logic

an exact experiment, what illimitable vistas opened up before the surgeon, what realms undreamed of before.

“Then felt I like some watcher of the skies  
 When a new planet swims into his ken;  
 Or like stout Cortes when with eagle eyes  
 He stared at the Pacific—and all his men  
 Look'd at each other with a wild surmise—  
 Silent, upon a peak in Darien.”

Lister, like Hunter, united in himself the pathologist and the surgeon, and like him he worked on the lines of Harvey and “searched out the secrets of nature by way of experiment.” The greatest contribution of pathology to surgery is through experimental surgery.

I have already had the honor of bringing before this Association some of the grounds on which we claim Lister as a great pathologist. His work on Inflammation, on the Coagulation of the Blood, and on the action of the Nervous System, as a powerful factor in pathological processes, has been of direct and inestimable value to surgery, apart from his *Magnum Opus*. I will now indicate some of the ways in which the pathological researches of others have directly influenced surgery. I shall choose three great departments of operative surgery.

The old operation for popliteal aneurysm was to tie the vessel on either side of the tumor, cut it open, turn out the clot and allow the wound to heal by suppuration. The mortality was very high, the usual cause of death being secondary hæmorrhage from the proximal ligature cutting its way through the artery. The current pathology of aneurysm, founded mainly on some observations of Haller, ascribed aneurysm to a weakening of the vessel wall. Hunter came to the conclusion, from clinical and *post mortem* study that aneurysm was due to disease of the arterial coats. But he was not content to think so. He experimented on the dog and found that mere weakening of the vessel by removal of portions of its outer walls did not lead to aneurysm. He proposed to tie the artery high up where it was healthy, arguing that the current in the artery being thus shut off, pressure in the aneurysm would cease, and coagulation would take place; also that the collateral circulation would be sufficient to keep up the vitality of the limb without causing appreciable reflux into the sac. And what of the tumor itself? Instances had been recorded by Valsalva and others of the disappearance of aneurysmal tumors which had undergone spontaneous cure, and whether Hunter was aware of this or not he seems

to have trusted to absorption for the removal of the solidified contents of the sac, and we all know the brilliant success that proved his reasoning true.

A more modern instance of an operation conceived in the same spirit is afforded in the first nephrectomy by Gustav Simon of Heidelberg. A patient came under his care suffering from a ureteral fistula. In the sixties probably no surgeon had yet dreamed of ureteral anastomosis and removal of the kidney seemed to offer the only chance of cure. But was the operation feasible?

It must have been long known, thanks to morbid anatomy, that one kidney might be destroyed by disease and the patient yet remain healthy. It was a quite different matter to remove a kidney by operation without any opportunity for compensatory changes to take place. But experimental pathology had furnished proof in the hands of Zambecarius that, in the dog, one kidney might be removed, without appreciable injury to health. Simon repeated these experiments. He learned that the chief danger was from peritonitis, that there was not much fear of hæmorrhage, that uræmia was not to be dreaded, that neither albuminuria nor cardiac hypertrophy followed, and that compensatory hypertrophy occurred in the remaining kidney. And so in 1869 he removed the kidney and succeeded in curing his patient of her distressing malady.

Few things would have amazed and delighted John Hunter more than the recent developments in Brain Surgery, and especially the steps by which the perilous ascent was gained. Diseased brains have been examined since the time of Morgagni, but it was the genius of Broca which first pointed to a *sedes morbi* for aphasia. The same fortunate blending of clinical acumen with exact morbid anatomy enabled Hughlings Jackson to extend our knowledge of the dependence of intercranial diseases on local alteration of structure. But it was necessary to have the irrefutable proofs afforded by the experiments of Fritsch and Hitzig and of Ferrier, before the surgeon could project his chart of cerebral surgery, and sail for the island of Reil.

Now it is evident that I need not weary you by going into further details to show how pathology in its various departments of morbid anatomy, etiology, chemical, microscopic and experimental pathology has contributed to the advance of surgery. Every day brings new evidence.

Our understanding of morbid processes has been and is still being enlightened, our power of diagnosis is increased, and our ability to cope with disease and injury is extended.

It is often said that the foundation of surgery is anatomy and this is true in a sense, for anatomy is the first step in pathology. A knowledge of anatomy is absolutely essential to the study of the human body. But anatomy deals with dead matter, pathology with living, if morbid, activities. Anatomy is finite, but pathology, as the permutations which may occur in anatomical elements, is infinite, and it is the realm which the surgeon must explore who wishes to have a firm grasp of the principles of his art. Much has been learned but more lies waiting discovery. There is always another "peak in Darien" and many surmises to make sure.

*"O mare o litus verum secretumque museum quam multa invenitis quam multa dictatis."*

Navigation owes much to the various institutes founded to further its study. Who can tell the value of the early naval schools in Spain, or of the Greenwich Observatory? And so if pathology is to flourish provision must be made for its study. Every hospital should have its Pathological Institute.

And here we know we shall find ourselves in collision with that section of the public to whom science is uncongenial and medical science an abomination. Pathological study may not always seem interesting or profitable. The ancient mariners would have smiled to think the Tuscan artist with his optic glass could be of any benefit to him, and perhaps Galileo was thinking more of descrying new lands rivers and mountains in the moon than of assisting the sailor, nevertheless he was helping to lay the foundation of the Science which was to make the modern sailor's work possible.

And when the father of our own illustrious Lister, applying his knowledge to the physical and chemical characters of glass, perfected our achromatic microscope, there were practical surgeons who would certainly have failed to see any bearing which his work had on theirs.

When watches were first made in Nuremburg, the only thought in the maker's mind, probably, was the accurate registration of the passing of time. But Gemma, the Italian, intent on perfecting methods of navigation, seized the idea of the watch at once as a means of computing longitude and led the way to the use of the chronometer.

And the gain is not necessarily all one way, for the practical surgeon, making careful clinical records, may furnish the pathologist with new ideas, and if one may wrest the words from their original meaning he,

“Doomed to go in company with Pain,  
And Fear and Bloodshed, miserable train,  
Turns his necessity to glorious gain,”

and may help to introduce new forces into the healing art.

Here in Canada, while we have had ample experience of the anti-vaccinationist, we have scarcely made the acquaintance of his colleague the anti-vivisectionist. But the signs of the times indicate that full scope will soon be given to his vituperative faculty, for in the Universities of McGill and Toronto pathological research has fairly started on its way.

If we cannot however “mollify the spirit of captious contradictors,” we may perhaps deprive them of an audience by teaching the public that those who devote their time to the investigation of disease and who may sometimes find it necessary for the elucidation of the problems submitted to them, to inflict pain on animals, may be lightening the burden of humanity as well as he who directly mitigates its pains, and that their work may be regarded like that of every conscientious surgeon, as a sacred duty, a responsible task, carried out “As ever in the great Task-Master’s eye.”





## A PLEA FOR THE SURGICAL TREATMENT OF APPENDICITIS.\*

By G. CLOWES VANWART, M. D., Fredericton, N. B.

Much has been written and said on the subject of appendicitis. I shall make no attempt to treat the subject *in extenso*, but rather base my remarks on personal experience, with no references to text-books, etc.

We may classify diseases of the vermiform appendix in point of time, as primary and recurrent. Clear cut symptoms are not present in every case,—this being particularly true in the first twenty-four hours of the disease. The tripod of symptoms which prevent an error in diagnosis are:—

1. Pain: at first, sudden and acute, referred to the epigastric or umbilical regions; later becomes localized over the site of the appendix.

2. Rigidity: this follows the localization of pain and is most marked in the right lower quadrant of the abdomen.

3. Tenderness in the right lower quadrant of the abdomen: this being a constant symptom from the beginning of the attack.

Pain at first colicky is most marked in acute cases and may last only a few hours: as in those cases where pus forms rapidly. Tenderness is the most constant of these symptoms as would be expected from the fact that inflammation is present. The point of maximum tenderness is always between the attachment of the appendix to the cæcum and its apex. In recurrent attacks the only positive symptom is tenderness; and when these attacks are mild, diagnosis is often difficult, particularly so in the female sex. In cases that are seen early the position of the appendix can be determined, but if the organ contains pus and the sac has ruptured, its location becomes a more difficult matter.

It is not my intention to enter into the minutiae of differential diagnosis. Obscure cases of enteric fever may sometimes be confounded with an attack of appendicitis, since pain in the ileo-cæcal region is present in the early stages of both diseases: but the pain is

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\*Read before meeting of Maritime Medical Association, Charlottetown, July, 1902.

less acute in the former and there is not the muscular rigidity. Influenza of the digestive type is often at first confounded with a mild attack of appendicitis. Many cases of indigestion are the reflex symptoms of an inflamed appendix.

To illustrate: H. G. L., male, aged 24, consulted me in April 1901 for indigestion. I learned from him that "just two years before he had suffered from a severe attack of cramps which left him sore." He had been taking remedies with more or less regularity up to the time of consulting me. During an acute exacerbation he would have nausea, vomiting and abdominal pain, and was improving from such an attack when I first saw him. On examination I found marked tenderness about the so called "McBurney's point", with temperature and pulse normal. The patient consented to an operation and was at once removed to the Victoria Public Hospital. The appendix was found post-cæcal, pointing toward the liver and adhering to the cæcum. Two faecal concretions were present, walled off at the distal end of the appendix, the latter showing marked chronic inflammation. An uninterrupted recovery followed the removal of the appendix and there has been no recurrence of his former trouble.

The thermometer should not be relied upon for much assistance in diagnosis, since in the presence of pus there may be little or no rise of temperature. To illustrate: R. B., male aged 12, after considerable physical exertion suddenly developed intense pain in the abdomen. He had tenderness at first about the umbilicus. At the beginning of the third day the maximum point of tenderness was two inches below the edge of the liver in the right hypochondriac region. Third day, temperature normal, pulse 90. I advised immediate operation, and found the appendix posterior and to the inner side of the ascending colon, with a length of four and a half inches. The distal end contained a sac of pus and was on the verge of breaking; but no adhesions were found. The appendix was removed and the patient made a rapid recovery. To further illustrate: Mrs. F. C. H., aged 26. In this case the temperature never rose above 100° Fah., and the pulse was never below 110. The patient was operated on at the beginning of the third day, the appendix being found ruptured and gangrenous with deposits of septic lymph on the neighbouring parts. Prompt operation, removal of the appendix, and thorough irrigation of the infected area saved this patient's life.

As a cause: I have noticed that attacks have followed undue

physical exertion as illustrated in case number 2 of this paper. The anatomical position of the vermiform appendix on the psoas muscle and the cæcum filled with fæces is to my mind a sufficient cause to produce an irritated condition of this organ. Constipation was present in a majority of cases. In none of my cases have I found sufficient evidence to warrant the conclusion that an attack may be precipitated by over-eating. There is in my opinion a close relationship between appendicitis and tuberculosis: fully twenty-five per cent of my cases occurring in families of tubercular tendencies.

After opening the abdominal cavity I have always been able to find the appendix except in those cases where it has sloughed off. Behind and to the inner side of the cæcum is the most common position. In but one case have I found it to the outer side of the cæcum. I have never found the appendix pointing toward the pelvic cavity except in the female sex.

Three cases that had been allowed to go on to pus formation and the abscess cavities drained but the appendices not removed, subsequently came under my care for operation. In two of these cases the appendices were found small, contracted and curled on themselves and adhering posteriorly to the cæcum. In the third case the appendix was large, inflamed and contained pus, being bound down by adhesions to the outer side of the cæcum. A rapid recovery followed the removal of the appendix in each case.

Should the appendix be removed in every case when the abscess is drained? It is not always possible to do so and even when possible is not always safe. In cases where the cavity is imperfectly walled off I would hesitate to disturb the parts; but should temporarily treat the abscess by irrigation and drainage. On the other hand where the cavity is well walled off, my treatment is to remove the appendix. Cases that are seen early and under constant observation and allowed to go on to pus formation with rupture are, in my opinion, improperly treated. It is needless to say that it is no uncommon thing to find an abscess at the first examination. I have seen cases in consultation where the attending physician, knowing that an abscess was present, hesitated about operating but preferred to wait hoping that the patient would improve under rest and medical treatment, thus totally ignoring the surgical principle that pus must have vent. An abscess should be suspected when tenderness and pain continues, vomiting persists or distinct tumor felt. A rapid pulse is a reliable sign of suppuration.

I have never seen a chill to denote that pus was forming. The case in which the symptoms do not subside in thirty-six hours from onset of the disease is an operative one.

The idea of this paper is to suggest early operation in inflammation of the vermiform appendix whether catarrhal or suppurative. If early operation is insisted on the pus cases with fæcal fistula and other annoying complications would not exist. The question is asked: "Should we operate in every case?" When the peritoneum is affected and distended, skin leaky, temperature subnormal, pulse rapid, feeble and compressible, my answer is negative. In cases of this nature the system is overrun with sepsis and a general anæsthetic produces too great a shock. In such a condition I would prefer to use a local anæsthetic, opening the abdominal wall and irrigating as much as possible by means of a normal saline solution.

The arterial supply of the appendix is from the mesenteric artery which may be compared to the trunk of a tree with its branches. By ligating the trunk all supply to the appendix is cut off and this makes practically a bloodless operation. I prefer ligating the artery and tying off the appendix with chromicized catgut, closing the abdominal incision with silk-worm gut, and covering the stump with serous membrane if possible.

I am not an advocate of gauze drainage in appendicitis operations. This frequently causes excessive exudation of lymph which may result in annoying peritoneal adhesions and lifelong discomfort to the patient. Its use leaves a weak spot in the abdominal wall inviting the development of hernia. It also acts as a foreign body; and I have known it to depress a patient as well as prolong the condition of shock. Iodoform gauze does not drain well and is very apt to cause iodoform poisoning. If the greater part of the toxic material be removed by careful irrigation the lymphatics and leucocytes will attend to the rest much better than the surgeon with any complicated device.

When I see a case in its early stages I try to avoid the use of opium and its alkaloids, since it locks up all the secretions except that of the skin and masks the progress of the case. Morphia may be used in small doses if the pain is very great. Fractional doses of hydrargyri chloridi mitis *cum* sodii bicarbonatis may be given to arrest the nausea and clear out the digestive tract, while enemas of soap suds

with turpentine are found effective. The advantage of having the intestinal tract empty during an operation is plain to any surgeon.

**AFTER TREATMENT.** I do not give morphia for the reason already stated. Although the patient complains of pain it does not last longer than fifteen or eighteen hours. Cases do best on a liquid diet from ten to fourteen days. I have noticed that the tongue is much coated, and the breath offensive in some cases even in the presence of normal pulse and temperature and the patient on the road to rapid convalescence.

The following is copied from my case book: F. M., male age 17, labourer. Previously in good health with no former serious illness. Week before consulting me had cramps for two days. Said he got some better. Constipation from that attack until I saw him Nov. 15th, 1901. Night of Nov. 14th, 1901, attack of cramps, suffered all night. Nov. 15th, 11 a. m. temperature 100°, pulse 100. Cramps and rigidity of abdominal muscles. Ordered turpentine stupes, enemas and fractional doses of calomel. Pain so great forced to give  $\frac{1}{8}$  grain of morphia hypodermically; 5 p. m. patient still in pain, enemas effective. Had to give another  $\frac{1}{8}$  grain of morphia hypodermically. Advised immediate operation. Patient consented. Operated on at Victoria Public Hospital at midnight. Abdomen scaphoid. Tenderness greatest above McBurney's point. Incision two inches long. Appendix found post-cæcal, pointing upwards with abscess in distal end ready to break. Appendix removed with ease. Wound closed. Temperature normal on third day after operation and continued so all through convalescent period. All of superficial and part of deep sutures removed on fifth day. Remaining deep ones on seventh day. Wound not dressed again until the twenty first day. On the twenty-first day patient fitted with abdominal pad; left hospital cured.

In conclusion I may say that my only cause for regret has been not that I operated upon a case of appendicitis but that I did not operate earlier.

## SENILE PERITONEAL TUBERCULOSIS.\*

By ARTHUR BIRT, M. D. (Edin.), Berwick, N. S.

At the risk of harping on a rather hackneyed theme, I venture once more to direct your attention to the subject of tuberculous disease as it affects the serous membranes. I do so with the more confidence because the case with which I shall attempt to illustrate my text forms a rather striking contrast as regards the age of the patient, the difficulty of diagnosis, and the results to be expected from surgical procedures, to the one which I had the pleasure of bringing to your notice at the Maritime meeting last July.

*Case Report* The patient in the present instance was a nulliparous, married woman, 60 years of age, of good build, but rather spare and sallow. Her health had been good until the present illness, with but two exceptions, *viz.*, she had suffered for many years from a tendency to looseness of the bowels following diet errors or emotional stress; and, nine months before I saw her, she had passed through what was diagnosed by her physician as an attack of pneumonia, from which she recovered after a few weeks illness, but without regaining all her former strength and vigour. When the patient came into my charge she had already been confined to bed for three weeks suffering from abdominal pains, anorexia and a tendency to diarrhoea.

At this stage the patient did not look noticeably ill. There was no definite icterus. The pulse was 80, respiration quiet, and temperature normal. She complained of occasional shooting pains on movement in the upper abdominal segment, "soreness" in the lower epigastric region, and of slight colicky pains on defæcation. The abdominal contour was natural with a slight degree of tumidity (meteorism). Palpation showed a moderate tenderness along the junction of the epigastric and umbilical regions, and over this area there was slight muscular rigidity with a very ill defined sense of resistance. Percussion was resonant all over. Vaginal and rectal examinations showed the uterus rather enlarged, freely moveable,

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\*Read before the Medical Society of Nova Scotia, New Glasgow, July, 1902.

and lying backwards and to the left; cervix healthy and fornices soft, but slight tenderness on high pressure in left one. No discharge was noted. The rectum was apparently free from disease. Examination of the urine was also negative. The edge of the liver could be made out rather below its normal position, smooth and not tender. The gall-bladder was not in evidence. The spleen did not seem enlarged nor was any information obtained from the blood examination. No enlarged glands were noticed.

With one's attention now focussed on the digestive tract, carcinoma of the *stomach* was first eliminated by inflation and the test meal, the formal procedure showing an organ of normal size without any obvious growth, the latter proving the constant presence of free hydrochloric acid in fair amount. There was, too, neither nausea nor vomiting. The possibility of the *pancreas* being the seat of disease was then considered, but the absence of jaundice, the freedom from stomach symptoms, the absence of sugar from the urine, and of fat excess from the fæces, seemed rather against it although the position of the tenderness and resistance, the fact that it seemed to shift a little with respiration and the clay coloured offensive stools did not to my mind altogether allow disease of this organ to be excluded. The *colon* now seemed to be the most probable offender, a view which gained some colour from the old history of diarrhoeal attacks, which it was thought might have resulted in a chronic colitis with dilatation and thickening, especially as the tenderness seemed to follow the line of the transverse and, to some extent, the ascending colon pretty accurately. The stools, however, contained no excess of mucus and no blood, whilst inflation of the colon seemed to make the resistance more prominent, thus pointing rather to malignant disease of the transverse colon. Against this was the rarity of malignant disease in this precise position, the absence of any definite signs of stricture, of "Wyllie's patterns," of hæmorrhage from the bowel and the bright eye and non-cachetic appearance of the patient. Omental growths were also considered; but, to cut a long story short, the diagnosis remained open for about a month, at the end of which period, the physical signs having developed somewhat, I asked Dr. John Stewart, of Halifax, to see the case with me, with a view to deciding for or against surgical interference.

There was now a rather more marked degree of tenderness in

the epigastric and umbilical regions, and some extension of the transverse area of resistance at their junction, the most painful spot lying a little above and an inch or two to the left of the umbilicus. There was also tenderness and ill-defined thickening to the left of the uterus near the pelvic brim. Vaginal examination gave results as before. There was still slight general tumidity of the abdomen, but no sign of free fluid could be elicited. There was, perhaps, a suggestion of "doughy" feeling on palpation. The patient had lost flesh slowly. Tenesmus was present at intervals, and the motions were pale and fairly formed. The extension of the tenderness and the ill-defined character of the resistance felt in at least two points of the abdomen, now pointed to involvement of the general peritoneum, either tuberculous or malignant; and, after a careful re-examination under chloroform, the former was selected as the more probable condition, although we did not feel able even yet to exclude malignant disease. The points which decided in favour of tuberculosis were:—The appearance of the patient; the lack of virulence in the progress of the disease; the ill-defined nature of the thickening felt (suggesting multiple adhesions); the absence of free fluid and of definite nodules, more or less umbilicated; the moderate character of the pain; and last, but not least, the history and residual signs of pleural involvement, this latter giving us (assuming the disease tuberculous) a definite primary focus.

Operation was deferred for the time being and the patient was put, at Dr. Stewart's suggestion, on the treatment recommended by Burney Yeo of late years; *viz.*, a pill of iodoform and creosote, with the regular inunction of an ointment containing iodoform over the abdomen. The usual anti-tuberculous measures were, of course, taken.

Medical treatment, however, proved of little avail and the case slowly but steadily progressed until, at the end of another six or seven weeks, she presented the third and final picture. At this stage the patient was markedly emaciated; the abdomen was greatly distended, the lower segment being now the more prominent, and projecting forward and rather to the right. The squareness of free fluid was still lacking. Over the area of greatest prominence, (Vide Fig.) the percussion sound was nearly flat, with an extremely high pitched tympany on lightest per-



cussion. There was also a vague sense of fluctuation over this area but no "thrill." The flanks, especially the right, were a little more resonant. The abdominal wall was still quite thick in contrast to the general emaciation. As to her symptoms, pain was now much more marked, requiring moderate doses of morphine; it was referred chiefly to the old site and was occasionally felt with great severity in either groin. There was continual regurgitation of food and bile, from compression of the stomach. There was a trace of albumin in the urine. Urination and defæcation were difficult, and marked œdema of the sacrum and lower limbs had supervened.

Before the patient had arrived at such a pass the question of laparotomy had been mooted more than once. In view, however, of the patient's age, the anomalous physical signs, the disinclination of herself and relatives, unless some permanent and definite result could be promised, and the rather unsettled state of present medical opinion as to its value in such a case, the idea was reluctantly abandoned. A fortnight before death, permission was given to introduce a trochar to try and reach the encysted fluid, which was presumably present. This was promptly done, midway between pubes and umbilicus, and it was felt to pierce a greatly thickened, gristly peritoneum, but, in spite of various manipulations, I failed to strike the fluid and did not again have an opportunity to try. The patient lingered for two or three weeks and finally died from simple asthenia, owing to continual vomiting of food. In the last few days of her illness the left pleura was noted to contain some fluid.

*Autopsy.* A considerable deposit of fat in abdominal wall. Lower part of omentum adherent to abdominal wall, forming with intestine the front wall of a cavity containing a large amount of turbid serum in the lower central zone. Sparsely scattered miliary tubercles on peritoneal surfaces, in mesentery, etc. The resistant mass in epigastric and umbilical regions was composed of laminated adhesions, between thickened omentum, colon, liver, etc. The adhesions were firm and fibrous, and only a few scattered miliary tubercles were detected in the laminae. Subdiaphragmatic adhesions were also present. Liver moderately enlarged and markedly fatty. Stomach compressed closely under diaphragm. It showed only signs of slight chronic gastritis. Pancreas, spleen

and kidneys appeared healthy. Colon showed nothing internally but chronic mucous catarrh; it was, however, kinked and pressed on by the adhesions and the omentum lying athwart it. Mesenteric glands caseous. Sigmoid showed collection of larger tubercles on it, forming a patch of some little size (this was apparently the tender point noticed to the left of uterus during life). Uterus moderately enlarged, lining showed caseous patches, as did the tubes and ovaries. Left pleura showed a few miliary tubercles; its cavity was half full of turbid serum, and the lung was partially collapsed. The lung was not tuberculous. Right pleura a few old adhesions. No tubercle in right lung. Heart somewhat dilated and fatty. The tubercle bacillus was demonstrated in scanty numbers.

Consideration of the conditions above noted lead one to infer that a two-inch incision would in all probability have evacuated the fluid and prolonged (for a little at any rate) the patient's life. Her age, the pleural involvement, and the extensive adhesions in the upper abdominal zone, seemed to almost prohibit a final recovery. The primary source of infection seemed clearly to be the pleura and dated probably from the old so-called pneumonic attack.

I venture to add a few remarks on the diagnosis of these cases. In the first place we evidently cannot depend greatly upon temperature and pulse. Subnormal temperatures have been frequently recorded, and are not at all uncommon in all forms of tuberculosis in the chronic insane. I have personally noted this more than once in demented patients, found at autopsy to be suffering from tuberculous peritonitis. It may occur also in elderly patients whose reactive powers are on the wane. In the present case the absolutely normal pulse and temperature, persisting until quite late on in the disease, were interesting. The explanation seemed to be:—(a) small doses of toxin (few bacilli), or (b) defective reaction to them in degenerating tissues.

The exclusion of malignant disease in the stomach is, of course, important, but this can be secured by careful palpation, inflation and the appropriate chemical tests. Pancreatic disease might give rise to doubts, especially in the early stage of a case like this, where there is no free fluid in the greater peritoneum and the distension and resistance appear first in the upper zone, and

where no portal of tuberculous infection is evident. Its comparative rarity must be borne in mind, and, also, the unreliability of fatty stools and glucosuria as proof of its presence or absence.

Before evidence of general involvement of the peritoneum is present, the possible existence of carcinoma of the large intestine has to be considered. Morris, of London, and Fried. Crämer have recently called attention to the stealthy advance and anomalous symptoms of this condition. Of these latter, attacks of colic, intestinal rigidity, stenotic murmurs, persistent tenesmus, with small, repeated, bright hæmorrhages seem to be the most reliable. In my case there was considerable difficulty in eliminating this condition at one stage of the diagnosis. As soon as it is evident that the general peritoneum is involved, the diagnosis narrows down practically to a separation of tuberculous from malignant disease of that membrane. In this relation the detection of a primary tuberculous, or probably tuberculous, focus in pleura, genital tract, or elsewhere, is all important; and the history gives valuable suggestions. The omental tumor is common to both conditions, and its vagaries are decidedly puzzling. It may form\*—(a) A solid cake-like structure lying on the intestines, and be mistaken for an enlarged liver. (b) Be drawn up, thickened and adherent to abdominal wall. (c) Be quite drawn up and form a hard ridge attached to transverse colon. This occurs in some cases of diffuse malignant disease of the abdomen.

The doughy feeling of the abdominal wall in tuberculosis is very suggestive when it occurs. After all, some cases must remain for a while in doubt. In malignant disease the rapid accumulation of free fluid and the detection of large umbilicated nodules with glandular enlargements, is more common. In either cases the fluid may be sanguineous and characteristic elements wanting. F. P. Henry considers that a peri-umbilical erythema is diagnostic of tuberculous peritonitis, when present.

Into the diagnosis between the acute cases of this disease and typhoid fever, and between the encysted cases and ovarian tumor, I do not propose to enter; the latter is classic, and described in all the text-books, so that it is sufficient to remind you how often the mistake has been made and in what skilled hands. I recently

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\* Gibson and Russell "Physical Diagnosis," 1902.

was told by a friend of a case that was operated upon for acute appendicitis, in which tuberculous peritonitis became the diagnosis on inspection.

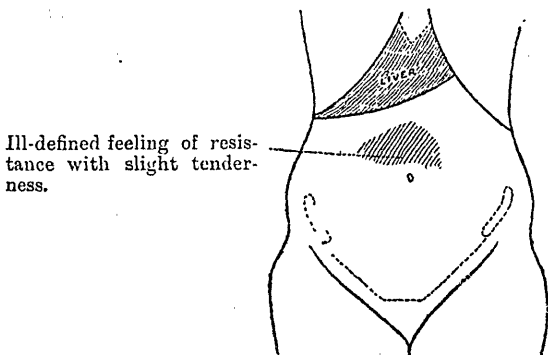
I am aware that within the last year or so there has been a considerable reaction amongst the surgeons with regard to operating on these tuberculous cases.\* Some go so far as to hand back all of them to the physician. I think, however, that the bulk of us are agreed, that in the cases with free fluid, no probable adhesions, and fever, drainage by a limited laparotomy is the best treatment. It is such cases as the one I have reported, and those with multiple loculi filled with fluid, in short, the ones that are hard to diagnose and hard to drain, that I would like some of my surgical confreres to advise us on.

At the same time it would be interesting to hear suggestions as to diagnosis or treatment from those who, like myself, have been nonplussed at times by the protean forms of this common but always important disease.

In conclusion, I would like to acknowledge my indebtedness to my able consultant, Dr. Stewart, whose diagnostic acumen and sound judgment were most welcome in the handling of the case.

N.B.—Appended are rough diagrams to illustrate three stages of the case.

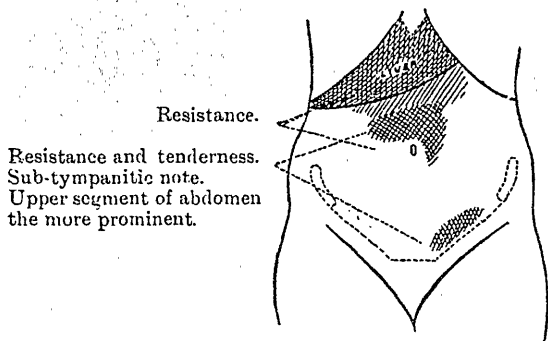
#### STAGE I. ATTEMPTED DIAGNOSIS BY EXCLUSION.



*Symptoms.*—Pains in abdomen; looseness of bowels; anorexia; slight loss of weight. Temperature, pulse and respiration, normal.

*Signs.*—Contour normal; abdomen tympanitic all over; ill-defined feeling of resistance and slight tenderness over region of transverse colon as indicated; no sign of fluid.

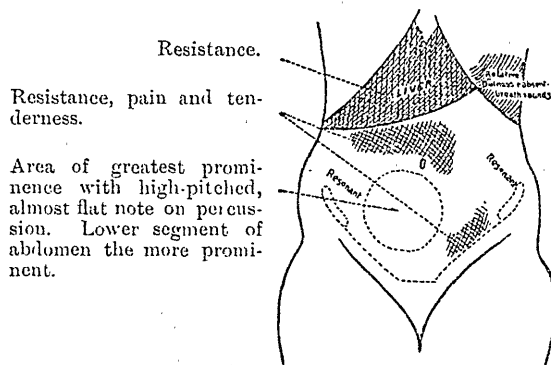
## STAGE II. TENTATIVE DIAGNOSIS TUBERCULAR PERITONITIS.



*Symptoms.*—Pain more marked, especially on movement or defæcation; tenesmus; alternate attacks diarrhœa and constipation; slow but steady emaciation. Pulse, 85—90; respiration normal; temperature normal.

*Signs.*—Distension more marked, but still only slight; contour not much altered; breathing costo-abdominal; marked tenderness and resistance as indicated (Fig. 2); the upper segment of abdomen being more prominent than normal; lower end of liver can be sharply differentiated above the mass; tender thickening in left iliac region to left of retroverted uterus; no sign of free fluid.

## STAGE III. POSITIVE DIAGNOSIS—ENCYSTED DROPSY OF PERITONEUM (TUBERCULOUS) WITH OMENTAL TUMOUR.



*Symptoms.* Marked emaciation, except of abdominal wall; pain more marked and more continuous, especially over tumor and in groins, tenesmus at times; continual regurgitation of food and bile, difficult urination and constipation.

*Signs.*—Dullness and absent breath sounds at lower base; abdomen greatly distended, greatest prominence below umbilicus and to right (vide figure); over this area percussion sound is nearly flat, with a suggestion of very high-pitched tympany on very light percussio; there is a vague sense of fluctuation over this area, but no real thrill; flanks more resonant, especially the right; marked œdema lower limbs and sacrum rocar midway between pubes and umbilicus failed to withdraw fluid.

## A CASE OF NEURALGIA OF BRACHIAL PLEXUS AS FIRST SECONDARY SYMPTOM OF SYPHILIS.

By J. J. DOYLE, M. D., Halifax, N. S.

In April, 1902, I was consulted by a well nourished young man who complained of pain in right shoulder radiating down the arm.

The pain set in the week before and had been gradually getting worse and was so severe at night as to prevent sleep. There was no history of injury. Examination of chest and urine was negative. There was no wasting of muscles, no restriction of movement, no definite points of tenderness. Temperature, normal.

I tried phenacetin and salicylates without giving any relief and had to resort to morphia hypodermically. A series of small blisters along the course of the various nerves gave but temporary relief.

I sent the patient to Dr. Weaver to have him try the effect of static electricity. This, also, gave no permanent relief. Several weeks afterwards, Dr. Weaver wrote to me that he had found a copper coloured rash on chest and back and a hard chancre on penis. The patient was then placed on specific treatment, and within a week all pain had disappeared and there has been no return.

[G. Gordon Campbell, of Montreal, reports a somewhat similar case — "Severe Facial Neuralgia as First Secondary Symptom of Syphilis," Montreal Medical Journal, Aug., 1901.]

## Correspondence.

### A VISIT TO PARKE, DAVIS & CO'S. LABORATORIES AT DETROIT AND WALKERVILLE.

*To the Editor, Maritime Medical News.*

Dear Sir:—It was my good fortune by the kind invitation of Mr. E. G. Swift, general manager of the Canadian branch at Walkerville, that I visited the extensive laboratory at Detroit, which is so well known not only in Canada, but throughout the United States, and in many parts of the world.

On my arrival I was most cordially received by Mr Swift and the heads of the different departments, and after spending a very pleasant conversation, there being present Mr. Barker, of St. John, N. B., and Mr. Johnson, of Prince Edward Island, and others, I was placed in the hands of Mr. Harold B. Boulden, who conducted me and explained completely the full details of the different workings of the several departments, and I must here convey my thanks and appreciation for the valuable and instructive information he imparted, and his kind attention paid me while in the city.

Our first visit was to that part of the laboratory which is especially and exclusively used for the storing of crude drugs. Here will be found hundreds upon hundreds of original packages of drugs, as imported direct from different parts of the globe; and it was most particularly interesting to examine the different shapes and kinds of packages in which they are imported. Then proceeding to the next floor we came to the grinding and sifting department where the drugs are prepared to be submitted to the different stages of manufacture. From there we made our way to the basement where the fluid extracts are stored after completion and ready to be bottled, it being estimated that over eight hundred thousand pints were stored and ready for the market.

Our visit to the pill and tablet department was most interesting. It was really wonderful to witness the thousands of pills, tablets and triturates that are daily manufactured; the different kinds of ma-

# LACOTOPEPTINE TABLETS.

Same formula as Lactopeptine Powder. Issued in this form for convenience of patient—who can carry his medicine in his pocket, and so be enabled to take it at regularly prescribed periods without trouble.

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—*The Medical Times and Hospital Gazette.*

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

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

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**HALIFAX, N. S.**

chinery used in the manufacturing of these forms of medicine; the hundreds of girls employed in coating, and the complete and great accuracy in which every pill and tablet is examined before they are sent to the bottling and labeling department. It was estimated that about eighty thousand were made daily.

This establishment covers an area of six city squares, or about fifteen acres, independent of their manufacturing department. They have their own fire protection, printing and editorial departments, box manufacturing, machine shop, reading and circulating library for the use of their employes which number about fifteen hundred, so one can form an idea of the facilities and extensiveness of this establishment.

This does not include the Canadian branch at Walkerville, in which the same accuracy and precision is carried out, only not quite on as an extensive scale. I was informed that seventeen truck loads are shipped daily from this laboratory.

Their travellers are about two hundred and fifty who are constantly on the road bringing to the notice of the medical profession the virtues and merits of the products of their firm.

In connection with their main building, they have under construction a large four story brick building termed as a Research Laboratory, being fitted up with the most modern improvements and equipped with the latest and modern appliances, to thoroughly carry out bacteriological work. The cost of the building alone will be about two hundred thousand dollars.

A visit was also made to their large commodious stables which have recently been completed at the cost of nearly twenty-five thousand dollars, built of iron and steel, not a particle of wood in the whole structure, with concrete floors and fitted up with the latest improvements. Here are stabled a large number of horses and calves, who are under the supervision of competent veterinary surgeons, and where they prepare their antitoxin and vaccine. These stables are daily washed out by turning on a hose. In connection with these stables is an operating room under the charge of physicians.

Having spent the best part of two days in examining this establishment, I was much impressed with the large number of young men employed at, which appeared to me, the most important point in the laboratory, and that is analysing and testing the different products after they are completed, and which are submitted to them for final

examination to ascertain if they come up to the required standard before they are given to the public. I asked my friend, Mr. Boulden, what qualifications were necessary for these young men to fill these important positions? He informed me that all of them have had a thorough college training and are graduates as chemists, pharmacists and physicians from the best schools in America and abroad.

Finding my time had about expired and wishing to be present at the Canadian Medical Association at Montreal, I had to shorten my visit which to me was of much interest and profit, but before doing so I beg to thank Mr. Swift for this unexpected and pleasant visit, and also to Mr. Boulden for his kindness in showing me the beauties of Detroit which shall long be remembered by me.

CHARLES E. PUTTNER, PH. M.

Victoria General Hospital.



THE  
MARITIME MEDICAL NEWS.

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

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VOL. XIV. HALIFAX, N. S., NOVEMBER, 1902. No. 11.

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**Editorial.**

**OUR RELATION TO INSURANCE COMPANIES.**

Life insurance has of late years become such an important factor, that the relation to it of medical men is well worth serious consideration. While a number of companies, Canadian, British and American, are most honorable in their dealings with their medical examiners, paying them adequate fees, relying upon their decisions, and retaining them in office unless some grave reason arises for a change, there is a large and ever increasing class of insurance companies whose agents prey upon the doctors. The *modus operandi* is quite well known to medical men residing in the larger towns—at any rate to such as have been in practice for a few years, but it is for those who are entering or have recently joined the profession that we wish to sound a note of warning. They will be wise to take heed of what has happened to their predecessors.

Firstly, they should take heed lest they be induced to go on the bond of an insurance agent. These bonds, apparently innocent guarantees of an agent's honesty, are in many cases guarantees of his earning capacity, being security for advances which are made to him to carry on the business of his company. No ordinary guarantee company will give these bonds, so frequently the medical examiners with the prospect of examination fees are induced to sign them.

Next comes the question of taking insurance. Dr. A. is a young

and energetic practitioner, full of enthusiasm, and with a great capacity for work. He is approached by the agent of a second or third rate company who, introducing himself and his business, offers to make the doctor an examiner for the company conditionally on his taking a policy, assuring him that the examination fees will more than pay his annual premium. Dr. A thinks the scheme a good one, and pictures himself working for twenty years for the company, at the end of which time he will have the capital amount of his insurance to his credit. These hopes are, however, doomed to disappointment. During the first twelve months, Dr. A, by assiduous attention to his work, and by being at the beck and call of the agent at all hours, succeeds in earning a considerable proportion of his premium in fees, probably paying fifty per cent. in cash. In the following year the doctor is surprised to find a great falling off in his work, and on inquiry discovers that Dr. B is now doing the company's examining, the new appointment having been made at the request of the agent, who has doubtless held out to Dr. B the same inducements that worked on Dr. A's credulity. Dr. A has no redress; he must either carry the insurance for cash payments or drop it, losing his cash and his year's work. As the insurance is usually taken without great necessity for it, it is dropped, and having no surrender value, a year's examining and a considerable amount of cash is wasted.

The change of examiners is sometimes more excusable when it occurs with a change of local management, but even then it is liable to abuse.

The company which lightly changes its examiner loses the guarantee against bad or indifferent risks which a continuity of examiner-ship secures. Such a company should also lose the support and recommendation of the medical profession. We should advise our friends against taking insurance in companies which, unfair in small things, cannot be trusted to act honestly in greater affairs.

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ARTICULAR RHEUMATISM.—Dr. F. W. Stewart, late assistant physician to Milwaukee County Hospital, reports excellent results from the use of Lambert's Lithiated Hydrangea in the treatment of two cases of complicated articular rheumatism due to excess of uric acid in the system, and which had resisted the remedies usually prescribed in such cases. The lithiated hydrangea was administered in one dram doses three times daily; the effects were prompt and satisfactory, a complete recovery resulting after two weeks' medication and diet.—*Peoria Medical Monthly*.

## Society Meetings.

### NOVA SCOTIA BRANCH BRITISH MEDICAL ASSOCIATION.

The annual meeting of the Nova Scotia Branch of the British Medical Association was held at the Halifax Hotel on Wednesday evening, October 15th the President, Dr. T. W. Walsh, in the chair.

The minutes of last meeting and report of council were read and adopted. The average attendance of members for the session of 1901-1902, in which there were eleven meetings, was over seventeen. The report proved conclusively that the past year was the most successful in the history of the branch, not only in attendance but in the merit of the papers and discussions which took place.

The election of officers for 1902-03 resulted as follows:

*President*—Dr. G. M. Campbell.

*Vice-President*—Dr. F. W. Goodwin.

*Treasurer*—Dr. A. I. Mader.

*Secretary*—Dr. C. D. Murray, (re-elected.)

*Council*—Drs. Ross, Murphy, Kirkpatrick, Trenaman, Hattie, Jones and Major Peeke.

*Representative on the General Council of the Association*—Surgeon-General O'Dwyer, A. M. S. (re-elected.)

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### MEDICAL COUNCIL OF YUKON TERRITORY.

The election of members for the Medical Council of the Yukon Territory took place in July last.

After a keen and close contest, the following were elected officers:

*President*—Dr. McLeod.

*Vice-President*—Dr. Barrett.

*Registrar and Secretary*—Dr. Edwards.

*Executive*—Drs. Barrett, Sutherland, and Alfred Thompson with the President and Registrar as *ex-officio* members.

Dr. McLeod is a native of Prince Edward Island. Dr. Thompson is a Nova Scotian and a graduate of Dalhousie University.

## Personals.

Dr. D. H. Muir, of Truro, who has been seriously ill for some weeks, is reported slightly improved.

Dr. S. E. Shaw, of Waterville, was married last month to Miss Crispo of the same place.

Dr. M. T. McLean, of North Sydney, and Miss Lehigh were united in marriage last month. The bride was formerly the efficient teacher of elocution at the Halifax Ladies' College.

Dr. C. P. P. Cameron, (Dalhousie, 1902), is practising at Broad Cove, C. B.

Dr. M. A. O'Brien, (Dalhousie, 1902), of Noel, arrived at the Victoria General Hospital on the 10th instant suffering from strangulated inguinal hernia. He was successfully operated on by Dr. N. E. McKay the same day.

Dr. H. E. Kendall, of Sydney, has gone to New York to take a course in electro-therapeutics and will provide himself with an X-ray outfit.

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## Notes.

IN THE SICK ROOM.—As before mentioned, Bovril is a builder up of the system after wasting illness. So palatable, so thoroughly digestible is it, that the most fastidious can take Bovril when other foods, either liquid or solid, are rejected. Bovril administered to the enfeebled under these conditions maintains strength and vitality, gradually invigorating the system until convalescence leads to complete recovery.

### HYPERTROPHIED PROSTATE WITH DIFFICULT MICTURITION.

For an old gentleman, seventy-four years of age, who was suffering from hypertrophied prostate with difficult micturition, I prescribed Sanmetto. The results were favorable, and after taking two bottles of Sanmetto, he was so much improved as not to require the use of the catheter, which he had been compelled to use for several months previous at least once in twenty-four hours. I have since prescribed Sanmetto in five similar cases with equally good results.

KEITH, OHIO.

E. C. CULBERTSON, M. D.

### MEMBRANOUS COMPLICATIONS.

(Throat, Bronchi and Lungs.)

Under the above heading we find the following by Walter M. Fleming, A. M., M. D., New York City, in the September number of *The Medical Era*: "With all the experience of more than a quarter of a century, in the treatment of winter cough, and its complications of laryngeal, bronchial and pulmonary irritability, also dyspnoea, asthmatic

spasms, and finally whooping cough—usually the most persistent and tenacious of all of these membranous maladies—I find no one remedy more strongly indicated, or which yields more prompt and satisfactory results than Antikamnia and Heroin Tablets, composed of antikamnia 5 grains and heroin hydrochloride 1/12 grain. The purpose of this combination is manifest at once, for it provides primarily, a respiratory stimulant; secondly, a soothing sedative to the irritable mucous membrane and thirdly, an antipyretic and analgesic. Result:—A prompt and efficient expectorant, which at once relaxes the harsh and rasping cough, and releases the tenacious, sticky and gelatinous mucus, while its soothing influence is at once manifested, greatly to the comfort and contentment of the patient.”

**HOT HOUSE PLANTS.**—Refinement in matters of social life proceeds hand in hand with refinement in other lines as civilization advances. From the standpoint of the physician and of the anthropologist, it is a question whether the physical side of mankind is improving or degenerating.

The method of bringing up children, especially in the families of the well-to-do, is too often a serious menace to the child's health and development. Too much indoor life, too much supervision, too little freedom of motion and of will is undoubtedly the cause of the many weaklings seen in the families of the wealthy. Such children have the characteristics of hot house plants.

The remedy is, of course, to do away with the surplus care and attention bestowed on the child, to let the child do more for itself, have more freedom, more fresh air, more play with other children. Foods and medicines are only temporary helps for child weakness. Such a medicine as Scott's Emulsion of Cod Liver Oil, or the hypophosphites, or some of the beef preparations, may be needed to give new strength and restore flesh—but nature is its own best doctor and in the end can take care of “hot house children” if fond parents will only give nature a chance.

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**BLOOD FOR BABIES.**—In the course of the second year there comes a time when the milk diet begins to be insufficient for the growing child, and Nature calls for a change, while yet the system is in many cases unprepared for solid food. This kind of deadlock results in diarrhœa or constipation, anemia, restlessness, fretfulness, etc. In such cases the fit and radical remedy will be found in the administration of say ten drops of bovine in a little milk, at intervals of three hours.

Little Robert Valverdie, a patient who came under my care in the condition of malnutrition above described (after trying all the usual medical helps with no benefit), was immediately restored by the direct blood treatment. On the second day of taking bovine, the constipation and other trouble began to be relieved, and on the third day all signs of ill health had disappeared as if by magic. This simple treatment was continued for three weeks, the child thriving beautifully.—Case reported by Dr. T. J. Biggs.

## HOW TO ASSIST YOUNG GIRLS TO WOMANHOOD.

BY EDWARD C. HILL, M. D.,  
DENVER, COLORADO.

The primary establishment and the menopausal cessation of menstruation are the two crucial physical epochs of woman's life. The change from maidenhood to womanhood is one that involves the whole body, and manifests itself alike in the form, the voice and the sexual and nervous phenomena. In an ideal state of perfect health this transition into puberty should be as natural and uneventful as gliding from sleep into consciousness. Owing, however, to the present civilized modes of living, the cerebral development of young girls is fostered and forced to a degree that deprives the remaining tissues and organs of their necessary nutrition, and too often we are called to treat delicate girls that are like buds blasted in the blossoming. Many a woman traces back



a prolonged existence of semi-invalidism to exposure and lack of care at the early menstrual periods. Tight lacing also predisposes to pelvic disorders by interfering with circulation and exciting uterine displacements. The strain of puberty upon the nervous and blood-forming structures may be too great in a subject hereditarily deficient in vital resistance and adaptability. So we may count among the morbid incidents more or less peculiar to puberty, chlorosis and anemias, general debility, neurasthenia and hysteria, acute pneumonic phthisis, chorea and hebephrenia.

According to Emmet, more than half of all women who have suffered at puberty from menstrual derangements are sterile and delicate in after life. Skene has stated that his observations showed that the vast majority of incurable diseases peculiar to women originate in imperfect development and consequent derangement of function. This development is either primary, during the embryonic stage, or secondary, at puberty. Defects in the former are irremediable, whereas secondary deviations from the normal standard are both preventable and curable in most instances.

It is important in connection with the subject under consideration to bear in mind the essential reciprocal relations of the reproductive system and the general organization. As V. Chow says, all the specific properties of woman's body and all her sexual development is natural and complete and in line with a healthy general organization. A beautiful illustration of sexual dimorphism has been furnished by Prof. Max Weber (quoted by Skene), who presented the case of a chaffinch in which the left side of the body had the female coloration and the right side that of the male bird, the two colors being sharply limited at the middle line. The bird was hermaphrodite with a well developed ovary on the side of the female plumage, and a testicle on the opposite side. The phenomena of menstruation offer the most palpable evidence of the onset of puberty. The precise nature of this rhythmic cycle is overshadowed by a jungle of theories, and, as Millikin well says, we can do no better in the present state of our knowledge than accept menstruation as a habit which has been nailed upon our race by heredity, and which is for us an ultimate biologic fact.

Normal menstruation in temperate climates generally begins in the fifteenth year. In the tropics it appears much earlier, so that in Mexico one may see a grandmother of only twenty years. Within the Arctic Circle Eskimo girls do not generally arrive at puberty until the eighteenth year. City girls usually have the menstrual flow earlier than do hard working country girls, in whom muscular exercise has the same derivative effect on the pelvic blood supply as too intense devotion to study. The time, amount and character of the menstrual flow vary normally within wide limits. The menstrual cycle for different individuals ranges in perfect health from two to six weeks. The average duration in the temperate zone is about four days. Soaking more than three napkins daily is considered abnormal. Anemic girls, as a rule, tend to menorrhagia; chlorotic ones, to scanty menstruation. Clots are present when the amount of blood is great, or the mucus and fatty acids scanty. A periodic white menstruation, from supersecretion of the uterine glands, is not infrequently noticed in the intervals midway of menstruation.

Menstruation is or should be a perfectly physiologic process. In the virgin disorders of menstruation (if whatever nature are nearly always dependent upon the defective nutrition of the reproductive organs, and this in turn upon a blood supply insufficient in quality or in quantity. In the great majority of cases, therefore, our efforts to aid nature in effecting the transformation of the girl into a woman, should be in the line of a happy balance of nutrition between the special female organs and the body as a whole.

Hygienic measures are of the first importance. Fresh air and sunshine are always in order. Exercise is especially indicated for the fat and flabby chlorotic girl, and her diet should be restricted in sugars and starches. The highly active, intelligent girl must rest from her studies and try to become a little lazy. Proper precautions should be taken in regard to reasonable care of the person at the time of the monthly periods. Yet the physician should beware of unduly alarming his little patient, and so bringing about a condition of hypochondriacal valetudinarianism. Simple cleanliness is certain to do no harm, but good. The conservation of the general health and vigor is the chief factor in maintaining safe and easy menstruation.

In spite of hereditary defects, if the physician could have full control of the diet, clothing, hygiene and environments of the little girls in his clientele up to the date of puberty, but little if any medication would be then required. Unfortunately, however, the lack of harmonious development in the preadolescent period necessitates consider-

able medical attention to secure a normal course for the critical metamorphosis of puberty, whose influences, as Dudley remarks, are fundamental, not only in the reproductive organs, but in the entire woman. Actual pain at the menstrual period in the young virgin may be considered always pathologic, and the same is true of menorrhagia or very scanty menstruation. Such abnormalities of function should direct our attention to the state of nutrition especially. The obese, chlorotic girl must take more exercise; the thin, delicate, sensitive girl, more rest. Fresh air and sunshine are needed in every instance. Red meat, eggs and other blood-forming foods should be taken in such quantities as can be well borne. The appetite for wholesome nutriment should be encouraged, if need be, by stomachic stimulants, such as the official elixir of strychnin, pepsin and bismuth. The use of bromides, coal-tar analgesics and diffusible stimulants at the menstrual periods can be regarded only as a temporary makeshift.

The most constant and positive clinical sign of imperfect puberty is deficiency of the blood in red corpuscles and hemoglobin, the chlorotic type being perhaps more common than the simple anemic in relation to menstrual disorders. Hemic defects and malnutrition act reciprocally as cause and effect. The oxidizing life of the blood is in the iron it contains, with about one-twentieth as much manganese. The total iron of the adult body amounts to but 2.5 or 3.5 grams, chiefly in the form of hemoglobin. The normal daily content of iron in the food of an average diet, is, according to Stockman, from five to ten milligrams. When absorbed, as in health, this food-iron replaces the metal continually lost by disintegration of blood corpuscles and excretion. The round of iron in the body seems to be from the duodenum to the mesenteric glands, thence to the thoracic duct, the general blood current and the spleen, from where it passes to the liver to be synthesized into hemoglobin for the red cells, on the breaking down of which the dissociated iron is eliminated by way of the large intestine.

The use of iron in anemic and chlorotic conditions is, of course, a cardinal principle in the therapeutics. In girls becoming women, to supply a deficiency of erythrocytes or hemoglobin, one might infer at first thought that the best method would be to administer hemoglobin, that is, blood in some form. Chemistry proves, however, that when hemoglobin is taken into the stomach it is changed by the acid there to hematicin (causing the coffee-ground color of small gastric hemorrhages), which, according to Cloetta, passes down the alimentary tract without being absorbed.

Most authorities conclude that inorganic compounds of iron in order to be absorbed must first be changed to albuminates by combining with food matters. All albuminous substances are hydrolyzed to peptons before they are capable of absorption. Hence it follows that peptonate of iron is the preparation most likely to be readily and completely absorbed and assimilated. The best remedy of this composition, I think, is Gule's Pepto-Mangan, which I have used for the past ten years with great satisfaction, particularly in the hemic and nutritive disorders of female puberty.

This neutral solution contains three grains of iron and one grain of manganese in each tablespoonful. The latter ingredient is doubtless to be credited with a large part of the nearly specific effect of the remedy in functional menstrual derangements. The preparation is pleasant to the eye, agreeable to the palate and has the great advantage over inorganic iron compounds of not corroding the teeth, deranging digestion nor inducing constipation. According to the nature and severity of the case, the dose varies from a teaspoonful to a tablespoonful. It is well taken in milk or sherry just after meals.

The following brief clinical notes may serve to illustrate the facts above stated. The blood count in each instance was made with the Thoma-Zeiss hemacytometer; hemoglobin was calculated by the Hammerschlag specific gravity method. I need hardly remark that the blood findings at the altitude of Denver are normally higher than at points near sea level.

CASE 1. Jose K., 15 years, thin, delicate and somewhat strumous, had menstruated irregularly and intermittently for 16 months; erythrocytes 3,600,000, hemoglobin 58 per cent. She was taken out of school, put on a diet largely protein, given aloin, strychnin and belladonna pills for her bowels, and for her blood, Pepto-Mangan (Gule), a dessert-spoonful four times daily after eating. Under this treatment she made an average weekly gain of 1½ pounds in weight, about 150,000 red cells and 3½ per cent. hemoglobin, and was discharged cured in ten weeks.

CASE 2. Alice R., 18 years, rather stout but pale, with greenish tinge; complained of palpitation and breathlessness on slight exertion; menstruation barely begun and scanty. She was made to take gradually increasing exercise on her bicycle, a cool

bath every morning, less carbohydrates and more proteins in her diet, and Pepto-Mangan (Gude) in the dose above mentioned. She recovered from all her morbid symptoms within four months, and has since married and given birth to two healthy children.

CASE 3. Amelia B., 23 years old, an overworked servant girl, had suffered since the periods first began, nine years before, with marked dysmenorrhoea, the flow being prolonged and scanty. The red blood cells numbered 3,800,000 per cu. m. m., with proportionate oligochromia. She was induced to rest at home and take six eggs daily, along with other nourishing food and Pepto-Mangan (Gude), a dessertspoonful four times daily an hour after food. She made a very rapid recovery, the red cells running up to 4,900,000 within two months and the menstrual periods becoming quite normal. By exercising proper care she has remained well for the past eight years.

CASE 4. Olive M., 13 years, blonde, thin, active, sensitive, a hard student, just beginning to menstruate, the flow being scanty and accompanied with pain. The blood count was 63 per cent. of normal, the color index 57 per cent. Under treatment similar to that mentioned in the first case, she became round and rosy, menstruated freely and easily, took on 17 pounds in weight and raised the blood findings above the normal at sea level, all within eight months.

CASE 5. Fannie R., 17 years, active, ambitious, intelligent, had such excruciating pain all through her menstrual periods for two years as to cause actual wasting. Physical examination revealed nothing abnormal except an undersized uterus. She was given Pepto-Mangan in tablespoonful doses three times a day, and was told to lie with the head lower than the hips. After three months' treatment the periods became quite painless, and have remained so for five years.

CASE 6. Flora J., 16 years old, began to menstruate profusely a year before, since which time she has been always ailing; erythrocytes 3,100,000 hemoglobin 63 per cent. She was given cool baths and massage, a bitter tonic, laxatives and Gude's Pepto-Mangan in dessertspoonful doses. When discharged cured, five months later, the blood count was 4,700,000, hemoglobin 95 per cent.

CASE 7. Maggie W., age 15, clerk in a department store, was extremely chlorotic (hemoglobin 28 per cent.), with a soft, systolic basic murmur and some symptoms of gastric ulcer; menstrual molimina but no flow. She was kept in bed at home, fed largely on meat, fish and eggs, and was given Pepto-Mangan (Gude) thrice daily, a tablespoonful at a time. The functional murmur soon disappeared, the iron in the blood came gradually up to normal, the patient lost in weight as she gained in health, and menstruation appeared regularly.

CASE 8. Nora R., 14 years, healthy in appearance, but neurasthenic; no trouble with menstruation, except at this time she became more nervous and developed a rapid pulse and some swelling of the thyroid gland. For this incipient exophthalmic goiter she was kept in bed with a cold pack over the thyroid at the menstrual period, and was given Pepto-Mangan (Gude) steadily for six months in dessertspoonful doses. She has been quite well and free from the symptoms mentioned for over a year.

In conclusion the writer would like to emphasize the peculiar physiologic efficacy of Pepto-Mangan (Gude) in aiding young girls to a normal womanhood, when the crisis of puberty is complicated with any defect in blood-making and nutrition. Its action is prompt and pleasant, and the clinical benefits derived from its use are readily apparent to all concerned. In curable cases it is as nearly specific as any combination of drugs could be.



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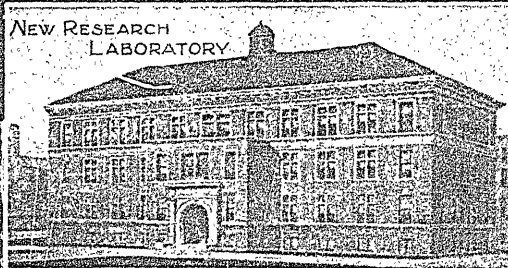
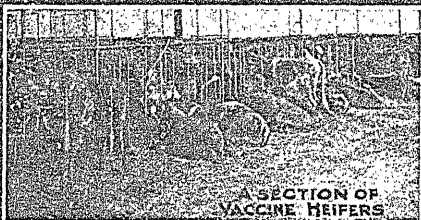
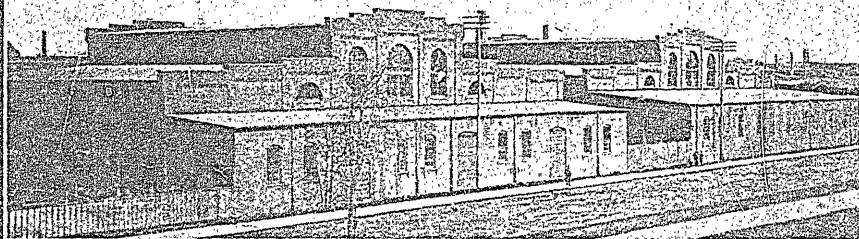
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