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Original Articles

REPORT OF AN UNUSUAL COMPLICATION OF SMALL OVARIAN CYSTS.

By James F. W. Ross, M.D.,
Professor of Gynecology, University of Toronto;
AND
Arthur C. Hendrick, M.A., M.B.,
Demonstrator in Gynecology, University of Toronto.

The case to be reported was admitted to the Gynecological Department of Toronto General Hospital on February 20, 1911, complaining of pain across the lower abdomen, especially on the left side, and inside of left leg, and of great swelling of the left leg.

Personal History.—Mrs. E. C., aet. 41 years, married for 19 years. No children; no miscarriages.

Menstruation began at 12 years and ceased at 40 years; regular up to one year ago; interval normal, amount and duration normal until this last year. In November and December, 1910, there were no periods, but patient says she lost a little blood in January and February, 1911, but no discharge and no urinary symptoms.

Present Illness.—Patient was taken ill the first week in January. Says she was completely run down. Her physician treated her for anæmia. Was confined to her bed for five weeks. When patient got up she could hardly walk, and had much pain across the lower abdomen. Patient then noticed her left leg was commencing to swell. This swelling continued to increase; and her physician, in making a pelvic examination considered she should be sent to the Hospital, and she was accordingly admitted on February 20, 1911.

Examination in the hospital showed the left leg enormously congested and almost one-third larger than the right. The swelling extended from the toes right up to the groin. The condition seemed one of venous obstruction rather than lymphatic. There was also an absence of inflammatory reaction, such as one might expect in phlebitis or phlegmasia.

The question was: what was causing the venous obstruction? Now, in a patient aet. 41, with unilateral œdema of a leg, one always thinks of malignant disease in the pelvis causing obstruction by metostatic growths in the lymphatics causing pressure upon the iliac veins.

Bi-manual examination did not reveal any malignant growth of the uterus, but did reveal a tense, slightly fluctuating mass to the left of the uterus and well down in the pelvis. It was diagnosed as an incarcerated ovarian cyst and abdominal section was performed.

Operation.—The usual median, sub-umbilical incision. Here the great size of the superficial and the deep veins was remarked, and bleeding was so great from them that they required ligaturing. This enlargement was due to the established collateral circulation, much as one sees in hepatic cirrhosis. On putting the patient into the Trendelenburg posture and packing back the intestines, a tumor about the size of a large orange was revealed to the left of the uterus and lying deep in the pelvis. It was a sub-ligamentous ovarian cyst, tightly bound down to the rectum and latent pelvic wall by rather dense adhesions.

These adhesions held the tumor tightly against the lateral wall and so compressed the iliac veins, both internal and external, that action was much like a ball-valve or a Sprengel's air-pump.

The tumor was freed from its adhesions, being peeled up from within, keeping close to the uterus, and from below, keeping well away from the dilated pelvic veins.

The tumor proved to be a sub-ligamentous, unilocular ovarian cyst, containing a clear fluid, and being about 3 inches in diameter.

The usual ovariotomy was performed, the cyst was removed without rupture, and the abdomen closed, and the patient returned to the ward and kept very quiet, as there was some fear of embolism after freeing the pressure upon the veins. However, the patient made an uninterrupted recovery. The swelling in the leg gradually subsided, and at the end of two weeks was normal in size, though the patient was kept quietly in bed for another week and then allowed to go about the ward.

The chief interest in this case seems to me to be the symptom of swelling of one leg.

For an ovarian cyst about the size of an orange to cause so much obstruction from its presence in the pelvis seems unusual, especially when one remembers how fluctuating a cyst of that size usually is.

The explanation is purely mechanical, and the symptoms were due to the cyst being bound down in a most unusual manner by adhesions to the wall of the true pelvis.

The literature shows only a few cases of ovarian cysts causing the complication described above.

A SKIN ERUPTION IN SIX CONSECUTIVE CASES OF POLIOMYELITIS.*

By Dr. Alan G. Brown,
Sick Children's Hospital, Toronto.

This skin eruption which I am about to describe appeared in six consecutive cases in the H. S. C. during a period of one and a half weeks, and has followed the same course in each case. The cause and distribution and whether or not it is associated with the paralysis yet remains to be ascertained. In reviewing the different works on poliomyelitis, there appears to be no reference to such a lesion, but in looking over the New York report of 1907 of the epidemic there I find they have tabulated, but not fully described, different varieties of skin eruptions, as follows:

Erythema, 7; macular, 8; maculo papular, 3; papular, 18; pustular, 3; urticarial, 2; sudamina, 8; herpes, 2; petechial, 2; vesicular, 6.

The form of eruption which was most common in this epidemic was papular, and it was particularly mentioned in many instances that the eruption covered the entire body. In concluding, the article says: "Perhaps this eruption may have some significance, since it is not apt to be mistaken for anything else."

The character of the rash was fairly uniform, and the distribution seems to vary little. In all cases it appears as a small papule, quite shot-like in character, with a tiny inflammatory base. This may or may not go on to vesiculation. If it does, the vesicle is about the size of a pinhead, and looks not unlike a small chicken

*With the Consent of Drs. Baines and Machell and assistance of Dr. Goldie, I am permitted to make this report.

pock, containing a clear fluid. The vesicle also is quite hard, and those papules which terminate in a vesicle lose their inflammatory base. The rash may appear in all stages on the same patient; for example, in one area vesiculation may be present, while in another simply a papule; and then again, a small impalpable pigmented spot. The distribution is as yet indefinite, but in all cases they appear to be present and most abundant on the paralyzed limbs, and then again they seem to be scattered, but only sparsely, over the unaffected abdomen and chest, and occasionally on an unaffected upper extremity. They do not appear to follow any definite nerve segments, nor are they in the least painful to the touch.

Case 1.—The rash was present when the child was admitted, and the disease was then of four days' duration, and as far as could be noticed there was no further development of the vesicles. The temperature never rose above 99°, and fell the fourth day; and on the fifteenth day after admission the lesion had entirely disappeared. It was present on the outer side of the right and left leg, and on the external part of the dorsum of both feet, but more abundant on the right side.

Left leg completely paralyzed. Right leg had slight movement in every direction.

Case 2.—This patient's illness was of two days' duration, and when admitted the rash was easily discernible, but did not appear on any fresh areas, and could not be seen on the 18th day after admission. The temperature fell to normal on the second day, and never rose above 99°, except four days later, when it went to 101, then fell. This lesion showed a symmetrical distribution, viz., on the anterior and posterior surfaces of the right and left leg, and one or two on the dorsum of the feet; throughout, the rash was very feeble. Left leg was completely paralyzed. Right leg showed fair movement, but the reflexes were gone.

Case 3.—In this case, also, the disease had been present four days previous to admission, and at this stage presented the skin eruption, which did not show any further development. The temperature fell to normal on the third day, and never rose above 99°, but during the following weeks there was an occasional rise of temperature, attributed to intestinal disturbance. The rash showed typically and disappeared about the end of the second week after admission, being profuse over the dorsum of the right foot, tibial and calf surface. The right leg was completely paralyzed, the left leg feeble. Scattered papules were present over the trunk, while the rash also appeared on the right elbow and on the posterior

surface of the forearm. Only a discrete papule existed on the posterior surface of the left arm. Power in both arms quite normal.

Case 4.—On admission had been ill five days, and the rash was present from the beginning, and faded at the end of two weeks after admission. This case ran almost a continuous temperature p.m. remissions. The lesion was present only in the form of an occasional papule and vesicle on the calf and sole of the right foot. Right leg paralyzed. Left leg moved slightly, but reflexes gone.

Case 5.—Had also been ill five days previous to admission, with a rather pronounced rash, which did not appear to form in fresh places, and was entirely gone at the end of three weeks and a few days. The temperature on admission rose to 101°, but fell to normal on the 6th day, and in four days again rose to the same height, and likewise fell on about the 7th day, and from this on ran a rather irregular course. The rash was present on the anterior and posterior surfaces of both legs, chest, abdomen, and an occasional one on the upper extremities, but did not seem to be present more on one place than the other. Both upper extremities paralyzed and lower reflexes gone. Throughout the child showed mild brain symptoms.

Case 6.—Was ill six days before admission, and showed the rash from the first, disappearing at the end of the third week, not developing any more after patient's admission to the hospital. This temperature was also very irregular, with a.m. and p.m. remissions, not rising above 99°, and even up to date the temperature is not normal continuously. The rash was typical, being present more or less all over the body, papular and vesicular, more especially on the lower extremities, anterior and posterior surfaces, and on the dorsum of both feet, over the trunk and chest, and only an occasional one on the arms. Both lower extremities paralyzed, while the upper seem normal.

The lumbar punctures, smears and cultures from the serum of the vesicles have shown no uniform results, while sections through the vesicles show the latter not to be deep-seated, as one would imagine on palpating them, but on the contrary to be only superficial, *i.e.*, between the malpighian and corneous layers of the skin; and apart from a little peri-vascular infiltration there was no other pathological change to be found.

SALVARSAN (EHRLICH-HATA'S "606"; DIOXY-PARA-DIAMIDO-ARSENO-BENZOL.)

By Graham Chambers, B.A., M.B.

(Continued from February Number.)

Flexner and Fordyce, of New York, advocate the use of an alkaline solution injected intra-muscularly; but in dissolving the drug do not use as much caustic soda as required in preparing the drug for the intra-venous injection. This seems a rational procedure inasmuch as the greater the amount of alkali used the more intense the local reaction. It may be asked, How is it possible to form an alkaline solution for a subcutaneous or intra-muscular injection with less alkali than that required for an intra-venous injection? The answer is: that the greater the dilution, the more alkali required. For instance, 6 gram. of salvarsan in 250 c.c. of water require about 21 drops of a 15 per cent. solution of caustic soda, but the same amount of drug dissolved in 10 c.c. of water requires much less.

The Reaction.

The reaction produced by the administration of "606" may appear immediately. After a subcutaneous or intra-muscular injection pain appears at once, and in a few minutes swelling and induration are manifest. The intra-venous method does not cause any pain or swelling. These are the first symptoms and signs of the reaction. A little later, other symptoms and signs may appear, such as chill, fever, leucocytosis, vomiting, intestinal irritation, tenesmus, and loss of patellar reflexes. A chill occurred in three of my cases; fever and leucocytosis in all who were under observation; and vomiting in one. The chills occurred about forty minutes after the administration of the drug by the intra-venous method. They were followed by fever, which, however, disappeared in a few hours, and did not reappear. During the fever, leucocytosis was present. As to the cause of this type of fever, it is difficult to explain. Some think it is due to endotoxins liberated by the death and solution of the spirochætes. This may be true, but I have seen a similar chill and fever follow an intra-venous injection of normal saline. After a subcutaneous or intra-muscular injection of "606" the fever is

generally of a different kind. The temperature rises almost immediately, but as a rule the elevation is not marked. It lasts a few hours, and is followed by an apyritic interval of one or two days. Leucocytosis is usually present during the fever. Again, following the afebrile period, fever appears and may remain for several days. This "late" fever is probably due to endotoxins of the spirochætes. It should be mentioned that in a few cases a fall of temperature below normal has been observed at the time of the reaction.

The Contra-Indications and Indications.

In using "606" in the treatment of syphilis, it should be remembered that the treatment is no ordinary method of medication; and it cannot be too strongly urged that care be taken in the selection of cases. Before deciding on the treatment, a thorough examination of the patient should be made, special attention being directed to the kidneys, cardio-vascular system, central nervous system and eyes. Any grave visceral disease of non-syphilitic origin is, as a rule, a contra-indication to the use of "606," whereas, the presence of syphilis—primary, secondary or tertiary—is an indication. The following may be cited as the important contra-indications:

I. Nephritis.

II. Optic neuritis and optic atrophy.

III. Tabes dorsalis and general paresis, except in their incipiency.

IV. Advanced disease of the central nervous system.

V. In advanced myocardial disease and cardiac insufficiency.

Of course each case should be considered by itself. A contra-indication may exist with one method of administration but not with another. For instance, in the case of a patient with cardiac disease the drug may sometimes be given subcutaneously or intramuscularly when there is a contra-indication to its administration by the veins.

The Results.

Anyone using "606" in the cure of syphilis is soon convinced of the marvellous action of the drug and the brilliant results following its use. The action of mercury in syphilis is remarkable, but this is not to be compared with that which one sometimes sees after the administration of "606." This unfortunately is not always the case. In a small percentage of cases the remedy apparently fails to favorably influence the course of the disease. Again,

in some cases all the symptoms and signs disappear for a time, and then relapses occur. The percentage of relapses after a careful treatment has not been definitely determined.

The Wassermann Reaction.

This serum test occupies a very important position among the diagnostic methods used in studying syphilitic patients. In a patient recently infected the reaction may be absent, so that one should not wait for a positive reaction before instituting treatment, if one is convinced of the presence of syphilis. This negative phase does not last long, so that if the patient is untreated, the Wassermann reaction soon becomes positive, and remains so as long as the patient is actively syphilitic. Moreover, Boas, of Berlin, found in eleven cases of early and four cases of late latent syphilis which had been untreated that the Wassermann reaction was positive.

Ehrlich calls attention to the importance of watching the Wassermann reaction after the use of "606," for it is found that after a negative reaction has been obtained the blood may again become positive, which is an indication for another injection of the drug. Another type of case in which the Wassermann test is very valuable is to determine the presence or absence of active syphilis in a patient who presents none of the ordinary symptoms or signs of the disease. If such a patient has not received anti-syphilitic treatment a negative reaction practically excludes a diagnosis of syphilis. On the other hand, if the patient had been treated, a negative reaction does not determine whether or not syphilis is present.

MEMBRANOUS PERICOLITIS.

By J. P. Kennedy, M.D.
Surgeon to the Wingham General Hospital.

My attention was first vividly drawn to this condition during my annual visit to the Mayo Clinic, in July of last year, by Dr. W. J. Mayo. Dr. Jabez N. Jackson, who, I believe, was the first to describe the condition as a clinical entity (*Surgery, Gynecology and Obstetrics,* September, 1909), was visiting the clinic at the time, and gave us an address at the Surgical Club one afternoon on the pathology, symptomatology and treatment of the disease. Although I had previously read his article in *Surgery, Gynecology and Obstetrics,* his graphic description of his gradual elucidation of the symptomatology impressed itself upon my mind. For the benefit of any who may not have seen his original paper, I may quote him as follows:

"The transparent, vascularized veil appearance of the membrane strikes one's attention very forcibly, with the parallel bright red vessels, running with the long axis of the ascending colon. In some instances it appears as though the membrane came on to the colon from the lateral parietal wall just above the caecum and courses directly upward to disappear beneath the liver on the superior layer of the transverse mesocolon. In other instances it seems attached like an adhesion to the under surface of the liver wall anterior to the normal peritoneal reflection. Again in other cases it appears as though it had begun above and descended on the colon to its termination, usually just above the caecum. Again we have seen it pass across and upward to the transverse colon, which in one instance was apparently drawn down by the membrane practically paralleling the ascending colon to the level of the caecum. In this case the gastric symptoms were marked as a result of the mechanical gastroptosis thus produced. In one instance this membrane was so dense as to lose entirely its apparent vascularity and transparency, and looked like a solid sheet of organized fibrous tissue, beneath which the ascending colon was so lost that it could not be seen at all until the membrane was divided and brushed aside, when an apparently normal, though contracted, colon became evident. In no instance does this membrane resemble our ordinary conception of an adhesion. It is never adherent to

the abdominal wall, nor to any contiguous loops of small intestine. Instead it resembles more closely than anything we can describe a thin pterygium. In recent cases the membrane is quite free and produces but limited restriction to the underlying colon. In more advanced and characteristic cases it seems to bind the colon to the abdominal wall and produces such marked angulations and convolutions as to practically produce a stricture of its lumen. In fact, in one case seen in autopsy, when a stream of water was caused to flow into the caecum through the ileo-caecal valve, the caecum distended almost to bursting, and yet none of the fluid would pass through the ascending colon and past the hepatic flexure until it was milked through with the fingers. The angulation of the colon is generally most marked at the hepatic flexure. There is always a very loose space where the membrane can be easily picked up at the outer angle where it passes from the colon to the outer parietal wall."

On September 15th last I was called to see A. G., aged 20 years.

Family History.—Negative.

Personal History.—Previous illness, none, excepting mastoid disease, for which I operated on her five years ago. Complete recovery.

Present illness began last March, the first symptoms being the occasional passage of a few drops of blood in the stool. During the spring and summer she suffered at times from a dragging, drawing sensation, sometimes amounting to pain, along the right side of the abdomen. She was a stout, hearty, athletic girl, not given to complain unnecessarily, and did not consider her condition sufficiently serious to consult a physician. The first week in September she entered the training school in Victoria Hospital, London, to train as a nurse. She was there only a week when the pain became so bad that she was forced to give up the work, and her mother brought her home to Wingham.

When I called to see her I found her with a normal temperature, normal pulse, suffering severe pain along the right side of the abdomen. This pain radiated through to the loin behind; in fact she complained of about as much pain in the back as in front. The right side of the abdomen, too, was quite tender to the touch. During the next few days I found her temperature and pulse normal always. Her prominent, and in fact her only marked symptoms were pain and tenderness, which grew severer. One morning her mother remarked, "Doctor, do you think Annie has appendicitis?" I replied that she might have a chronic appendicitis, but that I was convinced that there was some further trouble in addition.

As I saw they were anxious to have something done and the indefiniteness cleared up, I had patient removed to the Hospital for operation. So certain was I that there was something further than appendicitis at the bottom of her trouble, although I did not expect to find the pericolic membrane, I opened the abdomen in the medium line. Upon opening I found the entire ascending and transverse colon covered with the bright red vascular veil described by Jackson, and beneath this cobweb, here and there, spots, tags of fat or enlarged lymph glands, as mentioned in his pathological description of the condition. At the lower part of the ascending colon, and enveloping the entire caecum and appendix this had developed into a membrane or apparent pseudo-peritoneum. I cut through this, grasped the base of the appendix, and tied it off. With a great deal of difficulty I then enucleated a very small sclerotic appendix, much as one would draw a finger out of a tight glove. I then loosened up the enveloping vascular veil, but as this was my first experience in operating on a case of this kind, and as the subsequent history of the case showed, I evidently failed to loosen up the membrane sufficiently at the time to give a permanent cure. The patient rallied nicely from the operation, wound healed in a week, and the patient left the hospital in two weeks. She was entirely free of her pain and distress for three weeks, when it began to return gradually, and on the 24th of October I had her again removed to the hospital, where she remained for four weeks. During this time we gave her rest cure, abdominal gymnastics, massage, vibratory and otherwise, anti-fermentative diet, and occasional catharsis. During this time her temperature never went higher than 99 1-5 degrees, excepting on November 13th, when for some unaccountable reason it reached 101 degrees. Most of the time, and sometimes for several successive days, temperature was normal or sub-normal.

Under this treatment pain and tenderness almost entirely disappeared, and she was allowed to go home on November 26th. She had only been home a day or two when the pain again returned with increased severity, and I had her again removed to the hospital on the 6th of December for further observation. The pain became more general, and there gradually developed exquisite tenderness all over the abdomen, more marked just to the right of the umbilicus. The whole abdomen was tender and sore as if it had been bruised by external violence. In fact, the way she expressed it herself was, she felt as if J. L., an acquaintance, and a very large, stout individual, had sat upon her abdomen, crushing and bruising everything inside.

She had for days a slight elevation of temperature, 99 degrees to 99 1-5 at 6 p.m., the remaining part of the 24 hours temperature being normal or sub-normal. She lost her appetite completely, and consequently failed in flesh The dominant symptom, however, was pain, a constant dragging, drawing, boring pain, almost altogether on the right side, but tenderness all over the abdomen on pressure.

She was brave and did not complain without good reason, but the pain became so severe that we had to resort to morphine hypodermically to give her rest at all. She now insisted upon my opening the abdomen again, which I did on December 29th. Opening the abdomen through the right rectus, with the aid of my assistant, Dr. Margaret C. Calder, I made a very careful exploration of the whole abdominal cavity, but could find no abnormality, excepting the vascular veil. I found the caecum quite free where I had divided the membrane previously to remove the appendix. I now divided the membrane towards the lower part of the ascending colon, and proceeded in a leisurely and orderly manner to strip off the membrane along the whole ascending colon. A large portion of the membrane I could strip off with gauze wipes. At a few points of its attachment a little oozing of blood demanded clamping and ligaturing, but most of the vessels stopped bleeding spontaneously with a little pressure. I then removed one of the fatty tags or enlarged lymph glands for microscopical examination. After the constricting membrane had been detached completely, the oozing points controlled, I washed off with hot normal salt solution, returned the bowel to the abdomen and closed as usual. The operation had been prolonged, and the patient suffered severely from shock for 48 hours. After this, however, she rallied nicely, wound healed by primary union. There was a little tenderness along the line of incision for two or three weeks, but not more, I think, than might be expected in any abdominal wound. Patient began to recuperate two days after operation, appetite returned, began to gain in flesh, and from that day to this the patient has not known an ache or pain. She is now the picture of health.

The symptoms of this condition as enumerated by Jackson are pain, tenderness, constipation, mucous discharge from rectum, gaseous distension of abdomen, particularly in exacerbations; loss of weight and tone, gastric symptoms and neurasthenia.

My patient had never been constipated up to the time she was admitted to the hospital. This was probably due to the fact that the pericolonic membrane had not yet contracted sufficiently to constrict the colonic circuit.

When the pain became worse towards the last, however, constipation set in. Jackson refers to the article by Arbuthnot Lane, of

London, on "The Surgical Treatment of Chronic Constipation" (*Surgery, Gynecology and Obstetrics,* February, 1908). He is of the opinion that Mr. Lane is dealing with much the same condition. Mr. Lane presents the symptoms of constipation as the eminent characteristic of the disease. Jackson claims pain as the predominant feature in his cases. Mr. Lane speaks simply of "adhesions." Mr. Lane advises ileosigmoidostomy after excision of the entire colon. I can readily believe, too, that this might become necessary in long-standing cases when, after the mechanical restraint of the membrane has been removed, the muscular walls of the colon are found to be so far atrophied, by continued interference with the peristalsis, as to be unable to regain their tone. Professor Duncan McKenzie, of Chicago, made the pathological examination of the lymph gland for me, and his report is as follows:

"The peritoneal lymph gland does not show any very great disturbance, slight hyperplasia and oedema, which is the result of defective nutrition and chronic peritoneal congestion. In all probability there is some obstruction to the venous circulation in the peritoneum."

So far as I know this is the first case of the kind to be described in any Canadian medical journal.

I am of the opinion that the continued symptoms in many cases of apparent chronic appendicitis, not relieved by appendectomy, may be due to membranous pericolitis.

VON MIKULICZ DISEASE.

William Luitz (*N.Y.S.J.M.*) states Von Mikulicz first described this affection in 1894, as a distinct and typical, well-defined, heretofore undescribed disease, although he had presented a case in 1888. There is present a characteristic and symmetrical enlargement of the lachrymal and salivary glands, chronic in character, non-painful, and not associated with any demonstrable systemic disease. The treatment employed is as follows: 1. X-ray treatment, twice weekly. 2. Inunctions of oleate of mercury. 3. Potassium iodide, 10 grains daily and increased one grain a day until 47 grains a day were taken. 4. Mercurial plasters to cheeks. 5. Intramuscular injections of salicylate of mercury. 6. Liquor potasii arsenitis 10 m., t.i.d, had to stop on account of vomiting. 7. Tinct. nucis vom. If these fail, operative interference is essential.

Reports of Societies

THE CANADIAN MEDICAL ASSOCIATION.

The Annual Meeting will be held in Montreal on June 7th, 8th and 9th. Meeting to be held in the building of the Medical Faculty of McGill University, by permission of the Dean and Faculty.

PROVISIONAL PROGRAMME.

First Day, June 7th, Wednesday.

9 a.m.—Registration, Fees, and Meeting of Executive Council.
10.30 a.m.—General Meeting.
Installation of President.
Address of welcome and response.
Report of Chairman of Committee of Arrangements.
Reading of minutes of last general session.
Report of General Secretary of last general meeting.
Election of the Association's Members to the Executive Council.
Meeting of Executive Council.
1 p.m.—Lunch in New Medical Building.
2 p.m.—Section of Medicine.
Section of Surgery.
Section of Obstetrics and Gynecology.
Section of Laboratory Workers.
Section of Ophthalmology and Oto-laryngology.
Section of Preventive Medicine.
9 p.m.—Smoker (in the Victoria Rifles Armory).

Second Day, June 8th, Thursday.

9 a.m.—Meetings of Sections.
2 p.m.—Combined Sections.
(1) President's Address.
(2) Address in Surgery, Alex. Primrose, Toronto, Ont.
(3) Paper, W. J. Mayo, Rochester, Minn.
8.30 p.m.—Address in Medicine in the Royal Victoria College. Sir James Barr, Liverpool.

Third Day, June 9th, Friday.

9 a.m.—Meetings of Sections.

2 p.m.—Sections.

3.30 p.m.—Visit to McDonald Agricultural College at Ste. Anne's.

SECTION OF SURGERY.

Papers have been promised as follows:

1. Diagnosis and Surgical Indications of Duodenal Ulcer—James Taft Pilcher, Brooklyn, New York.

2. Renal Calculus: a Consideration of the Newer Methods of Diagnosis and Operative Treatment (with lantern slides)—Paul M. Pilcher, A.M., Brooklyn, N.Y.

3. Tumors of the Bladder—Wm. Hutchinson, Montreal.

4. "606"—R. P. Campbell, Montreal.

5. Spinal Anesthesia—J. M. Elder, Montreal.

6. Paper—F. J. Shepherd, Montreal.

7. Surgical Treatment of Empyema and Abscess of the Lung—E. M. von Eberts, Montreal.

8. Paper—E. W. Archibald, Montreal.

9. Operative Myxedema in Monkeys—J. H. Halpenny, Winnipeg, Man.

10. Paper—E. MacKenzie Forbes, Montreal.

SECTION OF MEDICINE.

Papers have been promised as follows:

1. Treatment of Pulmonary Tuberculosis—J. Roddick Byers, Ste. Agathe des Monts, Que.

2. Tuberculosis—R. C. Paterson, Ste. Agathe des Monts, Que.

3. Prevention of Insanity—W. H. Hattie, Halifax, N.S.

4. Some Recent Work in the Diagnosis of Hemiplegia—Ernest Jones, Toronto, Ont.

5. Paper—D. A. Shirres, Montreal, Que.

6. Paper—C. A. Peters, Montreal, Que.

Symposium on Acute Poliomyelitis.

Conjoint session, with Section of Preventive Medicine, on Water Supply and Its Relation to Disease has beeen proposed.

OBSTETRICAL AND GYNECOLOGICAL SECTION.

Symposium—Temperature in the Puerperium.

(1) Etiology—H. M. Little.

(2) Diagnosis—E. A. E. de Cotret.
(3) Treatment.

Symposium—Uterine Displacements.
(1) Etiology and Pathology—F. A. Clelland.
(2) Symptoms and Complications—W. W. Chipman.
(3) Treatment—F. A. L. Lockhart.

Original Papers:
Common Mistakes in Gynecological Diagnosis—Wm. Gardner, Montreal.
Prolonged Pregnancy—Adam Wright, Toronto.

Paper—John Clarke, Philadelphia.
Paper—H. A. Kelly, Baltimore.
Paper—J. C. Webster, Chicago.
Tuberculosis of Urethra with Specimen—E. A. L. Lockhart, Montreal.
Advances in Obstetrics in the Last Twenty-five Years—A. Lapthorn Smith, Montreal.
Paper—H. M. Vineburg, New York.
Paper—E. S. Maynard, Burlington.
Practical Points in Abdominal and Pelvic Diagnosis—E. M. Hay, Toronto.
Sequelæ of Abortion from Gynecological Point of View—L. de L. Harwood, Montreal.
Paper—J. C. Goodall, Montreal.
Paper—F. W. Marlow, Toronto.

SECTION OF OPHTHALMOLOGY AND OTO-LARYNGOLOGY.

Papers have been promised as follows:
1. Glaucoma—Casey Wood, Chicago.
2. Paper—J. P. McKernon, New York.
3. Paper—W. G. M. Byers, Montreal.
4. Paper—G. H. Mathewson, Montreal.
5. (a) Possibilities of Infecting Intraocular Operations by Means of the Hair.
   (b) Inefficacy of Intraocular Use of Iodoform in Tuberculous Iritis.
   (c) Pathological Sections—F. T. Tooke, Montreal.
6. Paper—S. H. McKee, Montreal.
7. Living Cases—R. H. Craig, Montreal.
8. Treatment of Tinnitus Aurium—A. W. Mayberry, Toronto.
10. Paper—C. W. McCullough, Fort William.
11. Paper—H. S. Muckleston, Montreal.

SECTION OF LABORATORY WORKERS.

Announcement later.

SECTION OF PREVENTIVE MEDICINE.

Announcement later.

A large number of papers in addition to those announced in this provisional programme are expected within the next few weeks. A series of entertainments has been arranged, and a ladies' committee has been formed to look after the entertainment of the wives of members and other lady visitors.

Satisfactory arrangements have already been made for reduced rates on the various railway lines, of which more precise information will be published later. Inasmuch as the functions connected with McGill Convocation and the McGill Reunion take place on the two days preceding the meeting of the Association, it is expected that the attendance this year will break all previous records in numbers.

THERAPEUTIC TIPS

WHOOPING COUGH.

Henriquez (*N.Y.M.J.*) states his belief that, after two years of trial of compound syrup of squill and compound syrup of cocillana, it is specific. In a prescription of three drachms of the first and four ounces of the second he gives fifteen drops from one to two years; twenty-five drops from two to three years; forty from three to four years; over four years a teaspoonful; dose to be repeated every four hours.

VARICOSE VEINS.

Büdinger (*Weiner Klin Woch.*) takes cotton cloth 10 cm. wide and winds a few turns below the knee. Then he winds over this three or four turns of adhesive plaster about 4 cm. wide until the plaster forms a band 2½ inches wide. This just compresses the superficial veins and is applied with the leg elevated and blood in veins stroked back towards the trunk. When it works loose it is removed and a new one applied, generally necessary about once a week. Varicose ulcers heal rapidly below this garter.

Reviews

A Text-Book of Mental Diseases. By EUGENIO TANZI, Professor of Psychiatry in the Institute of Higher Studies of Florence. Authorized translation from the Italian by W. Ford Robertson, M.D., C.M., Pathologist to the Scottish Asylums, Edinburgh, and T. C. Mackenzie, M.D.. F.R,C.P., Medical Superintendent Inverness District Asylum. New York: Rebman Company, 1123 Broadway. Cloth, $7.50.

Italian medicine is well to the front in psychiatry, and this translation, which is stated to be exceedingly well done, by competent authorities, will be found to be an exceedingly readable book. Canadians will find it replete with the best knowledge on the subject, and be charmed by the easy, graceful style of the author. Every general practitioner will find it a book of the best value.

Canadian Red Cross Society. We acknowledge receipt of a copy of the Annual Report and the Charter, By-Laws, Regulations and Rules of the Canadian Red Cross Society, from Dr. Charles R. Dickson, Toronto, the General Secretary of this Society.

Medical Guide and Monograph Series—Golden Rules of Diagnosis and Treatment of Diseases. By HENRY A. CABLES, B.S., M.D., Professor of Medicine and Clinical Medicine of the College of Physicians and Surgeons, St. Louis, etc., etc. Price $2.50. St. Louis: C. V. Mosby Co.

To meet urgent instances for a ready reference book on diagnosis and treatment at times when the busy practitioner's time is limited is the reason given for the production of this volume. Books of this class certainly appeal to the medical student and the untried, inexperienced practitioner, but scarcely to the well qualified man. However, they serve to fasten and clinch those salient features which always must be promptly at our beck and call.

Dominion Medical Monthly

And Ontario Medical Journal

EDITED BY

Medicine: Graham Chambers, R. J. Dwyer, Goldwin Howland, Geo. W. Ross, Wm. D. Young.
Surgery: Walter McKeown, Herbert A. Bruce, W. J. O. Malloch, Wallace A. Scott, George Ewart Wilson.
Obstetrics: Chas. J. C. O. Hastings, Arthur C. Hendrick.
Pathology and Public Health: John A. Amyot, O. R. Mabee, Geo. Nasmyth.
Psychiatry: Ernest Jones, W. C. Herriman.
Ophthalmology: D. N. Maclennan, W. H. Lowry.
Rhinology, Laryngology and Otology: Geoffrey Boyd, Gilbert Royce.
Gynecology: F. W. Marlow, W. B Hendry.
Genito-Urinary Surgery: T. B. Richardson, W. Warner Jones.
Anesthetics: Samuel Johnston.

GEORGE ELLIOTT, MANAGING EDITOR

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COMMENT FROM MONTH TO MONTH.

Dr. James Bell, one of Canada's most able and skilful medical men and surgeons, died at the Royal Victoria Hospital, Montreal, at half-past ten o'clock on the morning of the 11th of April, after a short illness.

The deceased was in his usual good health up to a week ago, when he contracted a chill. No serious development was expected, but as a precaution Dr. Bell remained at his home, 409 Dorchester Street West, where his condition remained unchanged until Monday evening last, when it was found that he was suffering from pneumonia. He was removed to the Royal Victoria Hospital and died there.

Dr. Bell is survived by his wife and one son, Stuart, 12 years of age.

The medical men of Montreal are in sorrow over the loss of one who was an honor to the profession and a warm friend to all, especially to those who had just placed their foot on the first rung of the ladder of their career.

"By his death," said Dr. G. Trenholme, who was at the bedside at the time of his death, "Canada loses her greatest master of surgery. He was a man of few words, and of sterling worth. He was a king among physicians and surgeons."

Dr. Bell was the son of John Bell, and was born in North Gower, Carleton, Ont., on October 10, 1852. He was educated in the local schools, and in 1877 graduated from McGill University, winning the Holmes gold medal. He became house surgeon of the Montreal General Hospital in the same year, and was promoted to the office of medical superintendent of that institution in 1881. In 1885 he was elected to the staff of the hospital as assistant surgeon, becoming surgeon in 1886. He was elected consulting surgeon to the General Hospital on his appointment, in 1894, as surgeon to the Royal Victoria Hospital.

Dr. Bell was appointed associate professor of clinical surgery in his Alma Mater in 1888; assistant professor of surgery and clinical surgery, in 1890, and professor of clinical surgery in 1894, from which time he was surgeon-in-chief at the Royal Victoria Hospital.

He was for some years, up to 1888, surgeon of the 6th Batt. Fusiliers, and at the outbreak of the rebellion in the North-West, in 1885, accompanied General Middleton to the scene of operations as Surgeon-Major in charge of the Field Hospital Corps, being favorably mentioned in the despatches.

He married, in 1889, Edith Mary, eldest daughter of the late J. J. Arnton, of Montreal.

Deceased was a member of the St. James Club, the Mount Royal Club and the Montreal Hunt.

He was also a prominent member of the Canadian Medical Association, having at one time served as General Secretary, and was at the time of his death, Chairman of the Finance Committee.

"Women in Medicine" is the title of a strong and well-constructed article by Dr. Maude Abbott, Montreal, in the current—April—issue of *The University Magazine*. The title, to our mind, is a little misleading. It seems to us to be more concerned with women *and* medicine.

At first blush one expects to read a great deal about women doctors, what they have done, what they are doing, and what they are going to do. Instead we read what certain ladies have done, what some historic midwives have done and what some historic and celebrated nurses have done.

For instance, Lady Mary Wortley Montagu is accredited with having introduced the practice of inoculation against smallpox into England in 1718 (1722). Was Lady Montagu a doctor of medicine? And is it much to the credit of vaccination at the present

day to state that when "the Princess of Wales and other prominent ladies of the court submitted to the operation, its success was assured"? Were the then Princess of Wales and other prominent ladies of the court doctors of medicine? It is an historical fact that whilst "Lady Montagu influenced royalty, she failed to influence her own friends, and her own nephew and the very friend to whom she wrote from Turkey died of smallpox."

Great and revered as is the memory of the late Miss Florence Nightingale, her prestige belongs to the sister profession of nursing—not to "Women in Medicine." As well claim Madame Curie.

"The history of the great midwives of France" may hand down to us noble and brilliant examples of what midwives may have done in the past; but not in this day nor generation, not in this country nor clime, are midwives considered as "women in medicine."

All honor, all praise, to all women who have done good in all ages; but the cobbler should stick to his last and the preacher to his text. "Women in Medicine" cannot take credit to themselves for the good which other women have accomplished in other walks of life, even though those other walks of life may be cousin-german to " women in medicine."

As "to the work which is being done by women in medicine at the present day," Dr. Abbott gives many instances—all of a technical, scientific, research character. Practically all the best countries have established the open-door to medical degrees. In Canada and the United States medical education is now open to women upon the same terms as to men.

That much-criticized and resented bulletin—Bulletin No. 4—of the Carnegie Foundation for the Advancement of Teaching, tells us that woman may enter Johns Hopkins in medicine if she has an academic degree; that she may enter Toronto on the basis of a high school education; that, if she chooses to go to Meridian, Miss, U.S.A., she may enter " if she has no definable education at all."

All over Canada and the United States, freely admitted to the medical profession, year by year, the number of women graduates from both the purely women medical schools and the co-educational schools is declining—and this in the face of the fact that their opportunities have increased and not decreased. This shows that there is no strong demand for "women in medicine."

Men in medicine often wonder why the opposite sex should wish to become "women in medicine." 'Tis true, it is an attractive study, but the life-work is by no means ideal. Woman, with her finer sentiments, her spontaneous goodness and her spiritual affinity, could find a far better profession and a much better sphere —in the pulpit.

The Ontario Medical Association annual meeting we have announced several times before. The dates should be kept in mind—May 30th, 31st and June 1st. Niagara Falls, Ontario, is the spot; the Clifton Hotel the rendezvous.

Good advice is to the effect that this is going to be probably the best and largest meeting in the history of Ontario's medical organization. It should be and deserves to be well patronized this year on account of the courtesy of the officers last year joining with the Canadian Medical Association in the large meeting we had in Toronto.

Niagara Falls should prove an ideal spot for such a meeting; and large numbers will go from London, Hamilton and Toronto, as well as from the sister cities of Niagara Falls, N.Y., and Buffalo. The well-populated Niagara Peninsula will turn out to a man.

Never was there a better programme. Entertainments will be numerous and of a very enjoyable order.

The advantages socially and otherwise of meeting under one roof are rarely so satisfactory as on this occasion; and the Clifton Hotel management may be depended upon to look well to the comfort and enjoyment of its medical patrons at this time—May 30th and 31st, June 1st.

The Canadian Medical Association will this year hold its 44th annual meeting in the new McGill Medical Buildings, Montreal, on the 7th, 8th and 9th of June.

On another page we are privileged to publish a preliminary announcement, which shows the organization for the meeting is well in hand and that many excellent practical and scientific papers are already on the programme.

Every effort is being put forth by the profession in Montreal to eclipse the largest meeting ever held, that of Toronto last year; and good and loyal members of the C. M. A. even in Toronto will try to help in the attainment of the end desired.

It appears to us, however, very unwise to hold the annual meetings of the national medical body so closely following upon the meeting of a provincial medical body which rather rivals the former in point of attendance and quality and quantity of papers read and discussed. At least two or three months should intervene, one, say, being held at the beginning of the midsummer holidays and the other at the end thereof.

It is quite likely that the Canadian Medical Association wishes to draw from Ontario just as much as from any other province, so

there is need of great care being taken not to antagonize any provincial interests. It is the same in the Maritime Provinces and in Manitoba. It would seem to us to be somewhat incongruous for a meeting of the Maritime Medical Association to be held one week in Halifax, and the next week the Canadian Medical Association foregather at St. John.

The name of this journal stamps it as provincial and national. Therefore, while we loyally support our own provincial medical association, we are never unready nor unwilling to say a good word for all the other provincial associations. And as we thoroughly believe in Canada for Canadians, so we say, God-speed to the Canadian Medical Association.

Smallpox and Vaccination in the Philippine Islands is the subject of a bulletin sent out from the Public Health and Marine Hospital Service of the United States.

The introductory paragraph reads as follows: "At probably no time in the world's history has the efficiency of vaccination as a preventive of smallpox been so conclusively and successfully demonstrated as in the Philippine Islands since American occupation."

"Prior to 1905, between 3,000 and 4,000 deaths from smallpox were reported each year in the Province of Cabu. In 1905 and 1906 the systematic vaccination of the 650,000 inhabitants was undertaken. In 1907 there were only 94 deaths, and in 1908, 84 deaths from the disease."

When it is considered that from time immemorial there were annually 6,000 deaths from smallpox in the six provinces near Manilla, with a population of 1,000,000, and that now, since 1907, when systematic vaccination was completed, not one person has died of smallpox who had been successfully vaccinated, and that this information is from an authentic government source, it surely proves that the evidence of the value of vaccination as a preventive measure is incontestable.

News Items

DR. J. L. TODD, Montreal has gone to West Africa to study sleeping-sickness.

DR. J. G. FITZGERALD leaves Toronto University for the University of California.

DR. J. N. ELLIOTT BROWN, late Superintendent of the Toronto General Hospital, has sailed for Europe.

DR. A. H. CAULFIELD won the gold-headed cane donated by the ex-house surgeons of Toronto General Hospital.

THE death is announced of Dr. William Warren Potter, for many years editor of the *Buffalo Medical Journal.*

DR. T. B. RICHARDSON, Toronto, is now in command of No. 10 Field Ambulance, Dr. Fred Fenton having resigned.

THE name of Dr. A. E. Garrow has been mentioned as successor to the late Dr. James Bell, as Surgeon-in-Chief to the Royal Victoria Hospital, Montreal.

A NICE two thousand medical practice and property is for sale in Western Ontario; unopposed. Further particulars may be secured by applying to this office.

SPLENDID medical practice, with small property, for sale in New Ontario. Five hundred cash only required. Box 102, DOMINION MEDICAL MONTHLY.

DR. N. H. ALCOCK, lecturer in physiology, St. Mary's Hospital Medical School, London, Eng., since 1904, and Vice-Dean of the School, has been appointed professor of physiology in McGill University, Montreal.

MISS BOWN, late of London, England, and who has done a great deal of literary work for Rissian Russell and other notable medical men abroad, is at 19 North Street, Toronto, prepared to do translating, epitomizing, shorthand, typewriting and reporting for members of the profession.

QUEEN'S MEDICAL GRADUATES.—DEGREE OF DOCTOR OF MEDICINE AND MASTER OF SURGERY.—W. R. Bateman, Thomasburg; M. R. Bow, Regina; F. C. Boyd, Kingston; F. C. Bracken, Seely's Bay; J. E. Carmichael, Strathcona, Alta.; S. G. Chown, Kingston; W. Y. Cook, Allandale; L. J. Corrigan, Kingston; C. M. Crawford, Kingston; R. A. Dick, Bolton; M. J. Gibson, Kingston; F. W. Gravelle, Portsmouth; W. R. Hambly, Napanee; P. H. Huyck, Kingston; J. V. Jordan, Smith's Falls; G. B. Hendricks, Regina; P. J. Kennedy, Portsmouth; A. Lipman, Kingston; G. B. McCarthy, Thorold; A. W. Macbeth, Lumsden, Sask.; E. F. J. Matthews, Orangeville; H. Mohan, Liverpool, England; N. E. MacDougall, Cana, Sask.; M. A. Mackay, Lemberg, Sask.; J. G. McCannon, Gananoque; R. V. McCarley, Edmonton; C. E. McCutcheon, Seely's Bay; J. J. McDermott, Kingston; J. P. Dermott, Eganville; M. H. McDonald, Sudbury; A. C. McGlennon, Colborne, J. McKenzie, Unity, Sask.; L. H. O'Meara, Fallowfield; J. O'Rielly, Humboldt, Sask.; B. C. Pamerson, Hallville; R. R. Paul, Fort William; G. W. Pringle, Madoc; G. A. Puglow, Kingston; A. J. Randall, Seely's Bay; J. M. Ravary, St. Amour; A. G. Scott, Eden, Man.; R. A. Simpson, Chapman, N.B.; E. E. Steele, Grenada, B.W.I.; G. E. Thwaites, Trinidad, B.W.I.; S. E. Thompson, Kingston; H. C. Wallace, Lumsden, Sask.; W. E. Wilkins, Verona.

The prize of the Chancellor, Sir Sandford Fleming, $70, for the highest percentage on the four years' work, was won by F. C. Boyd, Kingston.

The medalists are: In medicine, F. C. Boyd; in surgery, R. V. McCarley, Edmonton.

A COMPLIMENTARY banquet was tendered Dr. J. N. E. Brown Saturday night, April 8th, at the York Club by the members of the medical staff of the Toronto General Hospital, on the occasion of his retiring from the Superintendency of that institution. Dr. Bingham was chairman, and Dr. Brown was presented with an illuminated address, which was read by Dr. Wishart.

The address told of the six years of successful administration of Dr. Brown at the hospital, of his excellent equipment for the post, and assured him that a wonderful degree of harmony in the working of the whole complicated machinery of the hospital had been effected under his management. Dr. Brown was especially commended for faithfulness in the discharge of duty, for constancy to his post, late and early, and for never-varying courtesy, sympathy and good temper in dealing with the difficult and hetero-

geneous situations which occur daily in hospital management. Reference was made to the fact that he had added prestige to the hospital abroad by his mastery of the technique of hospital administration and by his publications thereon.

Dr. Brown replied, expressing gratitude for the honor tendered him, and gave to the members of the hospital staff much credit for the success of the institution.

Dr. R. A. Reeve presented Dr. Brown with a beautiful silver salver, and spoke in a very laudatory and kindly manner of Dr. Brown's sterling qualities and the splendid work he had done as Superintendent of the hospital. Dr. Bruce, Dr. Cameron, Dr. Temple, Dr. Grasett, Dr. Adam Wright, Dr. Baines and Dr. Ross also spoke in a similar strain, and expressed their deep regret at the loss the General Hospital would sustain in Dr. Brown's departure.

The following members of the staff attended the dinner: Drs. McPhedran, W. P. Caven, Chambers, Primrose, McIlwraith, Fotheringham, Thistle, D. C. Meyers, Johnston, Gordon, Trow, C. L. Starr, F. Starr, Marlowe, MacLennan, Malloch, Harold Parsons, Goldie, Joseph Graham, O. R. Mabee, Geoffrey Boyd, King Smith, Richardson, G. W. Ross, Colin Campbell, Goldsmith, Kinnear, Howland, Hendry, Royce, Burson, Lowry, McMillan, Strathy, A. A. Beatty, W. Jones, J. A. Roberts, Gallie, Shenstone, Cole, Hendrick, John McCollum, Arthur Wright, W. Mabee, and Robertson.

The eleventh annual meeting of the Canadian Association for the Prevention of Tuberculosis will be held in the Hygienic Institute, London, Ont., on Victoria Hospital grounds, Wednesday, Thursday and Friday, May 17, 18 and 19, 1911, beginning on Wednesday at 2 p.m. Evening meetings will be held in the Y.M.C.A. Auditorium. F. G. Adami, M.D., F.R.S., President; Geo. D. Porter, M.B., Secretary. This is the provisional programme:

Wednesday, May 17th, Hygienic Institute.—Reports from Secretary and Treasurer; Reports from Affiliated Societies; Appointment of Special Committees. Y.M.C.A. Auditorium.—Address of Welcome, Mayor Beattie; President's Address, J. Geo. Adami, M.D., F.R.S.; Address, "The Present Outlook in the Compaign Against Tuberculosis," Dr. Livingston Farrand, of New York.

Thursday, 18th, Hygienic Institute.—"Tuberculosis Among Children," Dr. J. H. Holbrook; "The Tuberculosis Clinic," Dr.

Harold Parsons; General Discussion, led by Dr. J. H. Elliott; "Sanatorium Treatment," Dr. C. D. Parfitt; "Women's Work Against Tuberculosis," Mrs. P. D. Crerar. Y.M.C.A. Auditorium.—Address, "Relation of Bovine Tuberculosis to Public Health," Dr. E. C. Schroeder, of Washington, D.C.; Addresses, Hon. Sydney Fisher, Minister of Agriculture, Hon. Adam Beck.

Friday, 19th, Hygienic Institute.—"Municipal Sanatoria," Dr. J. W. McCullough, Chief Health Officer of Ontario; "Prevention and Treatment of Tuberculosis in Rural Municipalities," Dr. Wm. C. White, Pittsburg; Business and Election of Officers; Reception at the Queen Alexandra Sanatorium.

MEDICAL REUNION.—A programme has been prepared for the reunion of graduates in medicine of McGill University, which takes place in June.

Monday, June 5th.—Informal luncheon at the McGill Union by members of teaching staff of the Medical Department to the graduates in medicine. Afternoon—Convocation in Royal Victoria College. Evening—Opening of new building; conversazione given by the governors of the university.

Tuesday, June 6th.—Morning and afternoon—Clinics and demonstrations in hospitals and laboratories; private entertainments. Evening—Banquet tendered by the members of teaching staff of the Medical Department to the graduates in medicine.

Class reunions.

Headquarters, for information, registration, letters, invitations, etc., at McGill Union. Open Monday, 9 a.m.

The Central Block and East Wing of the new medical building have been in use during the past session, while the West Wing is now rapidly nearing completion and will be ready for occupation at the time of the reunion, so that the formal opening of the whole building will take place. His Excellency the Governor-General has again consented to be present.

During the latter part of the week in which the reunion will be held the Canadian Medical Association will meet in Montreal. Dr. F. G. Finley is chairman of the Reception Committee, which is dealing with the special arrangements in regard to hotel accommodation, etc.

This reunion of graduates in Medicine should not be confused with the general reunion of all graduates of the university which is being planned for 1913.

Correspondence

Dear Mr. Editor,—

We are writing the Editors of our Dominion asking their co-operation in securing help for the famine-stricken Province of Anhui and Kiangsu in China, where nearly three million people are destitute and perishing.

The conditions there are appalling. The harvest was all destroyed by the terrible flood, and no food can be had from the soil until June or later. Many villages were entirely swept away, and the people left homeless and in dire distress. Multitudes gather together in great camps; those who are strong enough wander over the hills, pulling up roots of weeds for fuel in cooking the pittance of rice they may receive from the relief agencies. The suffering is terrible. Thousands of tottering babies, boys and girls clad in rags—if clad at all—are about everywhere; old men and women hobble about leaning on sticks for support, or lie by the wayside, their eyes staring up in mute appeal. Many thousands have perished, and it is estimated that over a million will die unless help is *immediately* sent.

The Chinese Consul-General at Ottawa writes that the distress is indescribable. The Honorary Secretary of the Distributing Committee in Shanghai cables that the famine area is larger than at first believed. Bishop White, of Honan, cables an urgent appeal for help.

The one hundred thousand dollars asked from Canada to help meet this awful situation should be *easily and immediately secured.* ONE DOLLAR AND FIFTY CENTS WILL SAVE A HUMAN LIFE. How many lives will your readers save?

The Editors of our country can do more than any other class to assist in this work. We ask you to make a strong appeal through your paper, making use of this letter as you may think necessary, noting that His Excellency Earl Grey, His Honor the Lieutenant-Governor, J. M. Gibson, and the Hon. Sir James Whitney are giving this movement their hearty support. We suggest that in making the appeal you give your readers the alternative of sending contributions direct to the Treasurer of the Central Committee, Mr. S. J. Moore, 445 King Street West, Toronto, or sending to you; and that in the latter case you acknowledge all such contributions

through your columns and remit weekly to the Treasurer, Mr. Moore.

Trusting that in response to this cry of suffering humanity you will do all you can, and that we may receive a reply from you and a copy of the paper containing your first appeal.

On behalf of the Committee, we are,

Yours sincerely,

W. A. CHARLTON, Chairman.

J. H. GUNDY, Secretary.

Publishers' Department

MODERN MARTIAL THERAPY.—Amid a veritable swarm of new medicinal agents of all varieties that have been introduced to the therapist during the last twenty years, and in spite of the great advances in general medicine during the same period, there has not as yet been proposed any remedy which can successfully compete with iron in the treatment of anemic and generally devitalized conditions. This metallic element, in one form or another, is still the sheet anchor in such cases, and when intelligently administered in proper form and dosage can be depended upon to bring about marked improvement, provided serious incurable organic disease is not the operative cause of the existing blood impoverishment. The form in which to administer iron is, however, very important. The old, irritant, astringent martial medication has had its day, and properly so. Probably the most generally acceptable of all iron products is Pepto-Mangan (Gude), an organic combination of iron and manganese with assimilable peptones. This preparation is palatable, readily tolerable, promptly absorbable, non-irritant and still distinctly potent as a blood builder and general tonic and reconstructive.

PROPER MEDICATION AND CHEERFUL COMPANY.—During the past two months we have met with more la grippe than anything else, and the number of cases in which the pulmonary and bronchial organs have been very slightly or not at all involved has been greater than we have noted in former invasions. On the contrary, grippal neuralgia, rheumatism and hepatitis have been of far greater frequency, while the nervous system has also been most seriously depressed.

With each succeeding visitation of this trouble we have found it more and more necessary to watch out for the disease in disguise, and to treat these abnormal manifestations; consequently, we have relied upon mild nerve sedatives, anodynes and tonics rather than upon any specific line of treatment. Most cases will improve by being made to rest in bed and encouraging skin and kidney action, with possibly minute doses of blue pill or calomel. We have found

much benefit from the use of antikamnia and salol tablets, two every three hours, in the stage of pyrexia and muscular painfulness, and later on, when there was fever and bronchial cough and expectoration, from an antikamnia & codeine tablet every three hours. Throughout the attack and after its intensity is over, the patient will require nerve and vascular tonics and reconstructives for some time. In addition to these therapeutic agents, the mental condition plays an important part, and the practitioner must not lose sight of its value. Cheerful company, change of scene and pleasant occupation are all not only helpful, but actually necessary in curing the patient.

THE Canadian Medical Exchange, conducted by Dr. Hamill, 75 Yonge Street, besides arranging the sale of medical practices and properties between vendors and vendees, also is in a position to furnish locum tenens work and assistanceships especially to Council graduates at all times. The Exchange also has at present a number of applications from different villages where there is no doctor, and where they want one to locate, and the size of the villages and surrounding country would warrant one believing that a practice of at least from $2,000 to $3,000 a year could be done. Anyone interested in any of the above can secure full particulars by dropping Dr. Hamill a request. In fact the Medical Exchange endeavors to act as a central depot to secure a short cut to the goal desired by physicians. Offers of practices for sale will be found among our advertising columns.

THE BUGBEAR OF "INDIGESTION"—"It is often said that ours is 'a nation of dyspeptics.' Medical men appreciate how apt this statement is, and never was there a time when it was more true. Only yesterday one of them remarked, with a touch of humor, that 'people are living so fast to-day that they do not stop to masticate their food'—a wise observation, we must admit.

"And besides—in the matter of eating—have we not, as a race, departed from the so-termed simple life? Have we not in more than one way become denatured rather than civilized? It seems that the things people eat to-day are censored to tickle the palate rather than nourish and upbuild the body, and the consequence of such pleasurable and improper eating is a disordered stomach."
—*From a Brochure on Taka-Diastase.*

One is tempted to quote further from this booklet, so interesting is the story in subject-matter and in the manner of its telling. To do so, though, were to defeat the present writer's object, which is to insure a wider audience for the booklet itself—a booklet which is well worth having, whether or not one expects to avail himself of its therapeutic suggestions.

As the quoted paragraph attests, the brochure is well written. Its literary flavor, however, is but half its charm. In its physical make-up the booklet is a distinct novelty, its quaint cover design, its fitting inner embellishments, and its oriental suggestiveness lifting it well out of the casual and commonplace.

The brochure tells how Taka-Diastase came to be; tells how it is made, and in the language of the distinguished chemist and scientist who evolved and gave to the world this valuable ferment. It explains, in attractive, readable form, how Taka-Diastase acts in defective starch-digestion, in gastritis, in diarrhœa and constipation, in wasting diseases, and in the diet of infants. It contains a full list of Taka-Diastase products, and gives hints as to dosage. Altogether, it is an important little work, and one that readers of DOMINION MEDICAL MONTHLY are advised to send for. A copy may be obtained by any physician by addressing a request for the "Taka-Diastase Brochure" to the publishers, Parke, Davis & Co., Walkerville, Ontario, providing, of course, the edition has not previously been exhausted.

LAYING aside all sentiment concerning the practice of medicine that has been handed down from the past, when physicians made no charge, but accepted honorariums, the fact remains that the physician, like the business man, must keep his income equal to or above his expenditures in order to maintain his credit. The business man from whom he buys expects to be paid; so why should not physicians also expect to be paid for their services? If a physician collects a good share of his accounts each year, it not only enables him to keep his family comfortable, but it also enables him to buy journals, books, instruments and other accessories, that make it possible to render better services to his patients. Physicians should endeavor to collect from all who are able to pay, even invoking the aid of the law when necessary; but always remembering to take care of those who are unable to pay. It is better to do less business at a proper remuneration than twice the work at half-pay. The income will be the same, and there will be more time for study and recreation. The physician's worst enemies are those who

have old, unsettled accounts; and these enemies can be changed into friends if they can be made to settle their indebtedness. A person who owes the physician money and does not intend to pay will be one of the first to knock him. "Short accounts make long friends." By accustoming all classes of patients to an early rendering of accounts, while the amount is small and the service is fresh in memory and appreciation, the satisfaction of both patient and physician will be better assured, collection facilitated, and a better financial morale promoted. The regular collection of accounts has several good effects on a doctor's patients; it teaches them that he expects to be paid for his services; it prevents the bill becoming so large that they are unable to pay it; it weeds out bad payers early, and it avoids many losses due to removals and deaths. To avoid payment people go elsewhere. A good rule to follow is never to allow an account to get larger than a family can comfortably afford to pay. It is unquestionably easier for patients to pay and for a physician to collect $10 twelve times a year than $125 once a year—or even $30 four times a year. Soon after services are rendered a statement should be rendered, and on the first or fifteenth of each month thereafter. In long-continued cases, the physician should try to collect something while attending the patient. Some men never present a bill, but wait the patient's pleasure to pay. This is demoralizing, as it puts the physician in a wrong light. The patient gets the idea that the physician does not need the money, and can wait, and he is then often forgotten. Others present bills only once a year, which plan is also open to objection, for the patient accidentally or intentionally forgets the circumstances surrounding a case or the items of the account, and disputes the bill. After sending two or three statements and receiving no response, nothing gives such good results as personal visits. The accounts may be given to an attorney or a local collector. It is important that a physician keep his word with his debtor. If the physician states that he will sue after a certain date, if the individual fails to make a satisfactory arrangement about his account, then he must do it. The moral effect of a successful collection is of more value than the costs. Having people say, "Dr. Blank is a good doctor, but he expects his pay," is worth hundreds of dollars, and the reputation can be acquired by a couple of years of close collecting. The income from a medical practice rarely equals the income obtained by men of equal ability, whose education and capital are invested in commercial pursuits, notwithstanding the great responsibilities physicians carry which laymen escape. The principal reason for this is that physicians have a constant tendency

to settle down to a level—and that the lowest level of professional fees—from which they find it difficult to rise. There is too much tendency to dull routine in charges. There should exist a wide range of charges for medical services, depending on several factors, such as the severity of the case, time given to it, the dangers to the physician and his practice, and the ability of the patient to pay. People should be impressed with the fact that the fee bill represents the minimum fee for ordinary services only, and that when special attention is required a fee in accordance with it should be expected. This is done in surgical cases; why not in medical cases? The price of a visit does not necessarily pay for services rendered. When, therefore, physicians try to collect something for extra services they are invariably confronted with the settled price of a visit. Such a procedure by no means compensates the physician under all circumstances. A rich man will have his life saved for a thousandth part of what he will pay a lawyer to save his business, and then he will object to the physician's bill. The lawyer long ago learned to value and to charge for special services according to their value and according to the ability of the client to pay; he no longer charges so much a visit or consultation. When a physician has saved a patient from death or from poisoning he should charge for a major operation, which is what has really been performed, and he should not send a bill for $2 for a night call. It is the medical profession's duty to educate the unthinking public to appreciation of the fact that it takes more skill and a finer quality of judgment to carry a patient through a long period of critical expectancy terminating in a successful accouchement, than to amputate an arm or leg, and that physicians should be paid accordingly. In attending contagious diseases, physicians incur danger to themselves, their family and their practice. They should be compensated for the risk and the loss sustained by a reward at least double that received in ordinary cases. There is no need of rendering an itemized account to patients. In making out a bill, medical men should take into consideration time, ability and service; nothing less than this will insure the justice that they deserve. Unless physicians come to some understanding of this kind with themselves, unless they ask for a professional fee in proportion to their service and without fixed rates, they will never be paid for what they do. For example, during certain stages of a case of pneumonia or diphtheria, it is important that they be able to watch the case very closely and adapt treatment to the varying conditions, instead of making a regular visit and going back to the office to await further summons. If a lump charge be made, they will feel

at liberty to call as often as necessary. The dead-level fee—the same price for everybody—for all kinds of cases—should have no place in medicine. It certainly pays to dispense: First, the patient has his treatment at once; second, he will return if he needs more medicine, and the physician can see the effect of the medication and change, continue, or discontinue it as necessary; third, the patient cannot pass the prescription to his friends who are "just as he was." A physician who habitually writes prescriptions, or prescribes proprietary preparations, simply hands over to the public a part of his income. Hit or miss, the laity will essay to treat themselves and even their friends and neighbors by the name or number on the bottle or box. At times, when the physician has not the appropriate medicine, it will be necessary to write a prescription, but this will not happen often, if he learns thoroughly the action of the most important drugs, and carries them in his case. Let physicians have printed on their prescription blanks, "Do not repeat," or "*Ne repetatur.*" The New York Board of Health undertook to ascertain the extent to which substitution was being practiced in New York City, and sent out 373 prescriptions for phenacetin, with the result that only 58 were found to be pure phenacetin; in 315 there was substitution. To sum up: Let physicians collect while bills are small; educate the people that the fee schedule is only a minimum one; present bills in lump sums, and keep guard over prescriptions.—Charles Haase, M.D., Elmira, N.Y., in *J.A.M.A.*

The Doctor's Wife.—A good wife is one of the best assets of a physician, and is "rather to be chosen than great riches." All women are not fitted to be doctors' wives, only about one in a thousand. When a boy I used to be sent after our old family doctor when someone was ill in the family. How well I can remember how the doctor's wife met me at the door with a pleasant smile and a warm grasp of the hand. She had a sweet face, and it made a great impression on my boyish mind. She would inquire all about the family, and feel just as much interested in our family as if it were her own. I did not care much for the old doctor's drugs, but I learned to have a great respect for his wife. Thus it is that a doctor's wife, with a little tact and kindness, can help her husband to get business and hold it. But unfortunately women are not all alike, and most women, when they marry a man, think that he belongs to them soul and body. As soon as the marriage takes

place they proceed to hang out a sign: "Keep off the grass. This man belongs to me." It is a well-known fact that the doctor is a sort of "father confessor." Most of the doctor's patients are ladies and they go to him with all their troubles. If Charlie gets gay and kicks over the traces sometimes the old family physician is sure to hear about it. If he is a successful physician he gets the confidence of the ladies. They believe in him, and of course they feel that they can go to him, tell him just how they feel, for they feel that they can trust him with the greatest secrets. If a doctor's wife is at all inclined to be "jealous," when she sees a lady enter the office and is closeted with him for over ten or fifteen minutes, she begins to imagine something wrong. When the lady comes out of the office the doctor's wife greets her with a sour face that has driven many a lady patient away. When she meets her husband, he is liable to get "all that is coming to him." In my experience as a practical man I have seen some queer things. Deliver me from a jealous woman! She has no business to be a doctor's wife. She is out of her place. Many a doctor's business has been ruined by a jealous wife. Many of them will not allow their husband to attend a confinement case. They peep through the key-holes, listen at the door of his office, spy over the transom, open the door and walk in unannounced when he is consulting with one of his lady patients, and in many other ways make themselves a general nuisance. There is another class of doctors' wives with long tongues, who talk too much. They tell everybody who will listen to them about the doctor's patients. Many a good doctor's business has been ruined by his wife's tongue. A doctor's wife, of all women, must be discreet and never talk about her husband's patients. As her husband, he naturally confides a good deal to her about his practice, but she should learn to respect his confidence at all times and in all places. She can do a whole lot for her husband if she will: see that his office and reception-rooms are cheerful and tidy, have his meals at regular times, and see that he gets the food he likes and ought to have. Many a doctor's health has been ruined by overwork. Many doctors' wives, not fully realizing the work their husbands have to do—exposure to all kinds of weather, loss of sleep, the constant care and worry of his profession will in time break down the strongest constitution. It is then that he needs a wife's best care, her sympathy, her sweet womanly love. She should watch over him to see that he gets a proper amount of sleep and that he does not work at his profession when sick and full of pain. Many a good doctor might have been saved for many years of usefulness in his profession if his wife had only seen and realized the fact that her