

# Dominion Medical Monthly

And Ontario Medical Journal

VOL. XXVII. TORONTO, DECEMBER, 1906.

No. 6.

## Original Articles.

### THE EVOLUTION OF MEDICINE IN ONTARIO.\*

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In assuming the duties of President of the Toronto Clinical Society for the coming year, I wish to express to you my deep appreciation of the honor. To be elected to the chief office in a society which represents so much of the medical life of a great city is something of which any man might be proud. Limited though it is in numbers, within the membership of this Society are found many of those whose eminence as clinicians has gained for the medical profession of Toronto the place it now holds in the confidence and esteem of the community, and whose ability as teachers and wisdom as counsellors has contributed largely to mould the medical thought and direct the policy of our profession during one of the most important periods in its history. While appreciating the honor, equally do I realize the responsibilities which the position involves, and how much one lacks the qualifications to properly discharge them. I shall continue, however, to rely on that personal kindness and friendship which has been one of the most valued assets of my professional life, and shall ask of you and my associates in office the same sympathetic and loyal support so freely accorded my predecessors in the chair. During my tenure of office I can assure you that my best efforts will be devoted to maintaining the high character which has distinguished the work of this

\*Presidential address, delivered before the Toronto Clinical Society, Oct. 10th, 1906.

Society since its organization, and which has made the meetings so valuable to us all.

It is not my intention to occupy much of your time this evening with any introductory remarks. Not that the present is an inopportune time, nor that a Clinical Society is an unsuitable place to discuss many matters of importance to the profession of our country—matters which the rapid evolution of events will force upon our consideration in the near future, and in the solution of which a society of the standing and influence of this must play a considerable part.

The epoch-making nature of the events which have been taking place around us since the organization of the Clinical Society in 1893 must have occurred to all of us, not in the medical profession alone, but in every line of intellectual, industrial, commercial and political activity in our country. After long years of waiting and hope deferred we are privileged to live at the beginning of the century which by common opinion belongs to Canada,—an era which is to witness the transformation of an obscure colony into one of the great nations of the world. Our illimitable natural resources and opportunities are attracting attention from all quarters of the globe. Ever alert, financial, commercial and industrial interests have quickly grasped the situation, so that on every side we see an extension of enterprise, a broadening of foundations and a perfecting of organization to meet rapidly growing requirements, and to take advantage of the golden opportunities which the future has in store.

It therefore appears a fitting time to glance at our own profession,—its past history, present condition and future prospects. As an index to our hopes it is instructive to recall the transformation which a century has produced in the country which is so frequently compared to our own. At the beginning of the last century the United States had a population of about 4,000,000. The first medical school in that country, now the Medical Faculty of the University of Pennsylvania, had been established only thirty-five years; the Medical Department of King's College, N.Y., now Columbia, thirty-three years; Harvard seventeen years, and the Medico-Chirurgical Faculty of Maryland eleven years,—all struggling institutions, whose influence at that time had produced no effect on the medical world at large. In the whole country there were but two general hospitals, one medical journal (*The Medical Repository*, New York, 1797), and the only medical libraries were one each in connection with the hospitals of New York and Philadelphia. For the education of

medical students the old apprentice system was still largely in vogue.

Reflection on the position of the profession in our own country, our medical laws and institutions, at a corresponding period in national development, is indeed reassuring, and must impress us with a deep sense of the gratitude we owe those worthy pioneers, the military surgeons, who at the beginning of the last century were laying the foundations of the profession in this province. We, of the present generation, are reaping the advantages of the high ideals by which they were actuated, and of the strenuous efforts they put forth to establish and maintain in a struggling colony the honorable character and traditions of the profession of the motherland. From the view-point of the present it would be not only instructive but inspiring to look back and consider for a moment what manner of men they were, these pioneer surgeons, the difficulties they encountered, what they accomplished, and to trace their influence on the evolution of the profession in the province; but the time at my disposal will permit of only a brief reference to them. They were men socially of high rank; and certainly well abreast with the advancement of medicine at that time, thoroughly trained in the schools of London, Edinburgh and Dublin at a period made brilliant by the labors of the Hunters, Edward Jenner, Percival Pott, Benjamin Bell, John Bell and other great teachers. They possessed a wide experience, not only of medicine, but of men and affairs, gained by active service during the wars of that period. The influence of these early military surgeons had been indelibly stamped on the medical profession of the province, and has been an important factor in giving character to our clinical teaching and practice. To their efforts we are indebted for the first efficient legislative control of the practice of medicine, obtained by the Medical Act of 1818, under which the Medical Board of Upper Canada was created. From that time until its last meeting in 1865, immediately before the formation of the College of Physicians and Surgeons of Ontario, this Medical Board guarded the entrance to the profession and practically controlled the medical affairs of the province. Up until 1830 the influence of the military element in relation to the medical profession was practically supreme and undisputed. In the very nature of things they were in close touch and sympathy, and evidently possessed the confidence of the Governors and the Executive, which, in the period preceding the Mackenzie Rebellion, administered as they deemed best the affairs of the province. This intimate association of the founders of our profession with the

all-powerful Family Compact was a potent factor in securing the sympathetic co-operation and often active assistance of the early Governors and other branches of the Administration in establishing the profession on a proper basis. In this connection it is pleasant to note, in parenthesis, that the profession in the early days had a warm friend and able advocate in the Rev. Dr. Strachan. In all ages, the true followers of Aesculapius have had to deplore the ease with which too frequently clerical support has been enlisted on behalf of their enemies, the rapacious irregulars and quacks who fatten on the ignorance of the laity in matters medical, but the prevalent quackery of the days prior to the Medical Board got no quarter from this strenuous ecclesiastic.

It was through the efforts of the military surgeons that the General Hospital was established in 1819, at a time when the population of Toronto was less than 1,200. The outstanding figure among them, who for thirty-five years was chairman of the Medical Board and the recognized leader of the profession, was Dr. Christopher Widmer. Resigning his commission in the service, and undertaking civil practice in York in 1815, at a time when the medical needs of the population could no longer be properly cared for by the surgeons attached to the garrison, for many years he had practically a monopoly of the practice of the town, and until his death in 1858 his name appears in connection with every movement for advancing the welfare of the profession. When Dr. Widmer began practice there were only about forty regularly qualified doctors in the province. He was one of the founders and first President of the Medico-Chirurgical Society of Upper Canada, established in 1833. A perusal of the minutes of the Medical Board during his thirty-five years as president indicates his broad grasp of medical politics and illustrates with what constancy, courage and military precision he directed its proceedings. In speaking of him, Dr. Osler says, "One picture on the canvas of those early days lingers in the memory, illustrating all the most attractive features of a race which has done much to make this country what it is to-day. Widmer was the type of the dignified old army surgeon, scrupulously punctilious, and in every detail regardful of the proprieties of life." Dr. Christopher Widmer has therefore justly been called the Father of Medicine in Ontario. He and his associates on the Medical Board were early and vigorous advocates of the necessity of providing for the medical education of those desiring to enter the profession in the province, and they were largely instrumental in securing the establishment of a medical

department in King's College when that institution began operations in 1844. Tories by instinct and association, they had an antipathy to everything American, born, no doubt, of the Revolutionary War, perpetuated by the influence of the United Empire Loyalists on the politics of Upper Canada, and intensified by the experiences and memories of the War of 1812. This ever-present fear of American influence was one of the chief reasons continually urged on the Government of the importance of establishing a medical school in Upper Canada, so that our students might be educated at home, without their loyalty being exposed to the possibly too democratic atmosphere of New York and Philadelphia. Between 1830 and 1840, however, with the gradually increasing population, another element became prominent in the medical as well as in the political affairs of the province. They were not of the military type, nor were they the favorites of the Family Compact; consequently they soon came into opposition alike with the Government and the dominant medical faction. Much dissatisfaction arose from the composition of the Medical Board, the control of the examinations for license to practise, the administration of the General Hospital and other public medical institutions. This discontent culminated in the calling of a public meeting in 1836, at which these grievances were ventilated, and resolutions adopted for transmission to the Government, embodying many suggestions for reform. Resolution No. 4 reads as follows: "That it is the opinion of this meeting that over the Hospital of this city a veil of obscurity impends which it is highly advantageous to have removed. No appointed days await the attendance of medical men in connection with the institution; no published reports inform the public of the number of those who have been restored to their friends, cured of their infirmities; the passing bier alone affords a melancholy proof that the institution still exists in active operation." The clouds of discontent were evidently deepening over the medical as well as the political institutions of the province. The struggle for responsible government was being bitterly prosecuted, and in the movement no class of the community took a more prominent part than a section of the medical profession, of whom Drs. John Rolph, William Warren Baldwin, Thomas David Morrison and Charles Duncombe were the leading spirits. It therefore appears how inevitably a breach in the medical profession occurred between the adherents and intimates of the administration and those who espoused the cause of reform. Of the latter, Dr. Rolph was for many years such a conspicuous figure in the medical affairs of the province that to us his career

is of unusual interest. He was a student of Guy's and St. Thomas' Hospitals, and a pupil of Sir Astley Cooper's; at the same time he studied law and became a member of the Inner Temple. He first devoted himself to the practice of law, being called to the Bar of Upper Canada in 1821. By his great intellectual endowment and eloquence he soon acquired a large practice and became one of the leaders of the profession. Early at variance with the judiciary, owing to his political views, in 1828, dissatisfied with a decision of Justice Sherwood, he with Dr. William Warren Baldwin (who also practised dual professions), threw off his gown and left the court. He thenceforward devoted himself to politics and medicine, passing the examination of the Medical Board in 1829. He was then nearly forty years old, and his subsequent career is a brilliant example of a man's capabilities in medicine after that age. He soon attained a position in the medical profession as eminent as the one he had forsaken in law. He was appointed a member of the Medical Board in 1832, and for some years was an active advocate of a medical department in the projected King's College. Of the part he played in the struggle for responsible government, his association with the Rebellion, and his six years' exile in Rochester I shall say nothing. Returning to Toronto in 1843, out of touch and sympathy with the newly created medical faculty of King's College, he established a private school in rivalry with that institution, which afterwards became known as the Toronto School of Medicine. These details are given to show that in the beginning political disagreement at that period was responsible for producing school divisions and rivalries, which affected the profession of the province long years after the original cause was forgotten.

In 1850, after the ascendancy of the Reform party, King's College passed from under the control of the Anglican Church and became a secular institution under the name of the University of Toronto. Through the efforts of Rev. Bishop Strachan, Trinity University was then established in connection with the Anglican Church, and the Upper Canada School of Medicine was constituted its medical faculty, with Drs. Hodder, Bovell, Bethune, Hallowell and Melville as lecturers. This school, however, lasted only a few years. Owing, it is said, to the influence of Dr. Rolph in the Reform Government of Sir Francis Hincks, the Medical Faculty of the University of Toronto was disestablished in 1853.

In 1856 a disagreement arose between Dr. Rolph and his colleagues, Drs. Aikins, Workman, Langstaff, H. H. Wright and

Morrison, of the Toronto School of Medicine, a separation occurred, and after some litigation Dr. Rolph established a school in Yorkville, which became the Medical Faculty of Victoria University. As such, due largely to his wonderful powers as a teacher, this school had a prosperous career until Dr. Rolph's death in 1870.

The resuscitation of the old Trinity School shortly after this time by Drs. Geikie, Hodder and others, the reorganization of the University of Toronto in 1887 with the Toronto School of Medicine as its medical faculty, with the subsequent events leading up to the amalgamation of Trinity in 1903 are matters so familiar to all as to require no reference to them.

Kingston was early an important centre, medically speaking. The Kingston General Hospital was completed in 1835, with a capacity of 120 beds, Dr. James Sampson being its first physician. The Medical Faculty of Queen's College, Kingston, was organized in 1854, chiefly through the exertions of Dr. J. R. Dickson and Dr. Horatio Yates, with the able support of the late Sir John A. Macdonald.

We are thus able to trace the influences which led to the formation of the various medical schools in Ontario between 1843 and 1856.

Of Dr. Rolph, it is difficult even yet to estimate the value of the service he rendered the profession in this province. He represented a strong independent sentiment which won many adherents. He apparently commanded the admiration and affection of his friends as much as he aroused the bitterness of his enemies, but all had to respect his ability. An unprejudiced judgment must acknowledge him as a great teacher whose view of medical affairs was at times biassed by his strong political convictions. Dent says of him: "He possessed talents which under favorable circumstances would have made him a marked man in either political or public life in any country. Chief among his qualifications may be mentioned a comprehensive, subtle intellect, high scholastic and professional attainment, a style of eloquence at once ornate and logical, a noble and handsome countenance, a voice of silvery sweetness and great power of modulation, and an address at once impressive, dignified and ingratiating.

For us of the present day, forgetting the differences of the past and the causes which produced them, we cannot look back on the history of the profession in this province without a feeling of admiration for the ability, courage and foresight which characterized those who labored so earnestly to establish its founda-

tions on a basis which enables us to begin the century free from the difficulties with which they had to contend. The founders of our profession were men of whom we may well be proud, not alone for their achievements in medicine, but for the important part they played in the social and political development of the province. Widmer, Rolph, Baldwin, Bovell, Hodder, Workman, King, Gwynne, Bethune, and later Aikins, Ross, Fulton and Graham, are representatives of a group of men who must always command our respectful admiration and regard. A few of the same type still remain with us. Some have retired from active work, others still in the harness distinguish their calling. These doctors of the old school furnish many examples of all that is implied in the best sense of the term gentleman, high in ideals, scrupulous in honor, dignified in bearing, broad in culture and courageous in their adherence to principles. In this age of material prosperity, and lacking much of the environment which developed their characters, it will be no easy task for their successors to maintain the standards they set as citizens as well as physicians.

In the evolution of our system of medical education, the traditions and methods of the London schools, of which most of the early members of the profession were graduates, exerted the greatest influence. The schools of Edinburgh, Glasgow and Dublin furnished many able representatives, but on the whole they played a secondary role; in fact, until 1839 their graduates were not recognized by the Medical Board on an equality with those of the London schools,—a cause of much dissatisfaction in the early days of the province.

It is interesting to note here certain causes which have helped to determine differences between the educational and clinical methods of the American profession as compared with our own. The important influence of the military element has already been alluded to. Another potent factor arose from the estrangement between the United States and the mother country following the Revolution, on account of which American students went to Paris instead of to London. There, at the beginning of the last century, they came under the influence of the great teachers who laid the foundations of modern clinical medicine—Bichat, Laennec, Corvisart, Louis and others. The scientific and clinical awakening of the French Pathologico-Anatomical school did not reach Great Britain until about the thirties, at the time of John Cheyne, Graves, Stokes, Bright, Addison, Latham, and others, all of whom came under its influence. Through their students it extended



to Canada between 1830 and 1840. The French school maintained its position until the time of Trousseau (1866), when the German influence began to dominate medical thought and progress. Vienna and Berlin then became the centres of attraction for American students. The American profession then passed under the dominating influence of Virchow and his followers, where they have remained until the present time. In contrast to ourselves, during the greater part of the past century, French and German methods have been much more powerful than British in moulding the medical thought of the American profession. That we have been affected by French and German scientific methods, especially in later years through our close association with Johns Hopkins, goes without saying, but they have been modified by passage through English channels. The majority of our students still go to London rather than the Continent. Whether this has been a misfortune or not is a debatable question. If we missed the direct quickening influence of the scientific awakening of the French and German schools, we have avoided the therapeutic nihilism which followed in its wake. If our medical horizon has thereby been narrowed, if we have remained too much under the thralldom of authority, having accomplished little in the way of original investigations, we have avoided the tendency which in some schools has made the study of medicine an accumulation of dry scientific facts obtained by the observation and research into the phenomena of disease as exhibited by plants, animals and man in the aggregate, rather than of an art which has for its main purpose the prevention or relief of pain and suffering as it affects the individual. Moreover, what Osler says of the American profession applies equally to our own: "Justice compels us to acknowledge that while winning an empire from the backwoods, the people of this land had more urgent needs than laboratories of research." Medicine with us, as with the English-speaking people in general, has been essentially utilitarian and practical, exalting the art rather than the science. "Sydenham, not Lineacre or Harvey, is the model English physician in whom was concentrated all those practical instincts upon which we lay much stress in the Anglo-Saxon character" (Osler). As the result of this practical trend our race may lay claim to most of the great discoveries which have lessened the suffering of mankind. Sydenham introduced the treatment of malaria by quinine, Jenner discovered vaccination, Simpson and Morton general anæsthesia, and Lister the use of antiseptics in surgery.

There is apparently a movement at the present time to pursue

scientific work along lines of more immediate value to the clinician, as exemplified by the revival of interest in the study of therapeutics, and the brilliant researches of Sir A. E. Wright. This closer association of the science with the art of medicine will more strongly appeal to men of our race. The maxim of Sir Astley Cooper still reflects the attitude of the majority of our profession: "Profound erudition is good for a man of means—useful and practical knowledge for the physician and surgeon."

The outlook in all branches of medicine was never so bright as at the present time, and in the progress that is bound to take place during the twentieth century no country is more favorably circumstanced than our own for playing an important part. That Canadians are possessed of the intellectual capacity, the energy and the zeal, has been amply demonstrated by what our countrymen have already accomplished, and it should be a source of no small degree of pride to a country so young that Dr William Osler, a fellow-citizen, should be the greatest living exponent of internal medicine. As for Toronto, the most favorably located city on the continent, medically speaking, with a great university, one of the largest medical schools in the world, with the assurance in the near future of the best hospital facilities and abundance of clinical material, with a medical profession unsurpassed in the average of attainment, and supported by a country of unlimited resources, if we avail ourselves of the opportunities presented, and fulfil our stewardship to posterity as faithfully as the Fathers of Medicine in the province did for us, we may indulge the most sanguine hopes of its future as a centre of medical activity.

**THE INDICATIONS FOR CYSTOSCOPY.\***

BY DR. MILLETT (of the Mayo Clinic).

*Mr. President and Gentlemen,*—In a way, you might say that the indications for cystoscopy would be any case which had pain or a feeling of weight in the region of the bladder, and to a great extent I believe that is true in very nearly every such case which comes to us. I believe every such case should be cystoscoped. I have not much sympathy with the notion that the cystoscope ought to be one of the last things employed. I believe it is a more satisfactory thing to do, especially in a badly diseased bladder, than sounding with a catheter. I have seen bad results from a catheter, and I have sometimes seen bad results from a cystoscope, but not very often. But with the exception of acute cystitis, all cases which have these symptoms are almost always cystoscopic cases. I do not believe it is necessary, in the face of a good history, which has come on within a week or ten days, to subject your case to the discomfort of a cystoscopic examination, because your clinical history is generally such that you can make a safe diagnosis, providing that you don't allow a case of acute cystitis to go drifting along until it becomes chronic before doing anything. These are the cases which, after ten days or two weeks, if not getting better, should be cystoscoped without delay. To enlarge upon some of the conditions which especially call for cystoscopic examination, will be the main subject of my talk. To begin with, those of you who do surgery, especially prostatic surgery, have been struck with the conditions that we find two times out of ten, in which, after taking the personal history of the case, you will have your mind made up that it is a prostatic case, and you make an examination, and are surprised to find that there is very little evidence that prostatic hypertrophy is the cause. Sometimes one of these old fellows won't have much hypertrophy; still he may be drawing his urine with a catheter. Now, what would you advise? Would you advise an operation upon the prostate? You cannot do that unless you can find some evidence that the prostate is the cause of the symptoms.

For instance, stone in the bladder, a tumor, and various other conditions might produce much the same symptoms that a hypertrophied prostate would, and the only way of finding out what

\* Delivered before the Surgeons Club of Rochester, Minn.

the trouble is is to use the cystoscope. Then you can find out if there is one stone or more. Sometimes when on account of fat you could not feel anything, there are little lobes which may be no bigger than the end of your finger which act like ball valves and cause the difficulty in micturition. They may be quite large and still you may not be able to feel them at all with the fingers, but very often they are small lobes that tip up toward the front of the bladder: a condition which you could not make out in any other way. It would be absolutely impossible. In every case of prostatic hypertrophy which you expect to operate upon the cystoscope should be used. We don't always do it. We ought to do it more than we do.

Suppose your case is complaining of a little more pain than you would expect in prostatic hypertrophy. You won't be satisfied in your own mind whether or not it is prostatitis or stone in the bladder, and you may put a sounder in and feel a stone. As often you won't find it is there. But the most important thing is not exactly to know that there is a stone there, but if it is a large prostate it is of quite as much importance to know, not only whether there is a stone there, but how many stones there are. You know it is impossible to get the finger through the perineal opening into the bladder. You cannot get into the bladder with your finger at all. If they know there is a stone there they have to fish around until they can get at it. But suppose there are four or five stones in the bladder, and the operator does not know how many there are. He removes the prostate, puts in his forceps and pulls the stone out, and don't feel any more stones. That is the end of it. But we have had it happen here that afterwards the case has had much pain, and they have found that the operator left a stone, or two, or three, or four, or five. One stone is enough to cause the man's pain. The operator takes out a stone, and he don't feel any more with a pair of forceps. Often you will find but one stone when there are a good many there. I have seen a bladder that had eight or ten stones in it. So it is impossible to know how many there are. You see how easy it would be to leave a stone or two there where there are multiple stones, because you cannot feel with your finger, and you are just as bad off as we used to be with the sounder: if we did not feel it we could not say. Put the cystoscope into a man, and when you have finished, and said there is no stone, you can stake your reputation on it. You cannot always be absolutely certain of the exact number, but you can come nearer than without a cystoscope. One stone may be behind another, and you may miss it. If there is an area of the bladder you can-

not get to, and a stone is located there, another may be behind it. If you have been all over the area of the bladder with a cystoscope you can say there are three or four or five, as the case may be. This is a pretty hard proposition. So much for the prostatic cases. I want to emphasize the point I made first: that is, in cases where you cannot feel anything with the finger. It is impossible to get these remnants of the prostate out through the perineal opening, there almost always being a certain amount of shrinkage. We have had it happen in cases where a fair-sized opening remained, but these little remnants stuck up. These cases often would have much trouble; even with a great, big orifice they would have to use instruments to take the urine, because these little lobes were sticking up there yet. I could take old men out of bed and use the cystoscope; and often if I let them alone they will get well anyway, and these lobes will shrink up so that they can micturate all right.

Now, there is a class of cases which are not very satisfactory to anybody. These classes complain bitterly of pain in micturition. Of course, a man doing general practice will sometimes make a correct diagnosis without, but the only way to be sure is to look in and see, and we make it a fairly uniform practice to cystoscope these cases. It is the safest thing to do, and it does not take long to find out. It is the very bad cases that take longer. It is the safest thing to examine these cases and see if there is anything in the bladder or not. In connection with this, don't be deceived by certain conditions which are quite often met with; that is, red spots in a woman's bladder. I think they are sometimes a congestion or a red area produced by straining. They may have been making the urine every five minutes for a day or two, and if they come to you about that time you are apt to find a red area up near the posterior orifice. It is the part which receives the most pressure, and it is very easy to conceive that it should become red. I do not think that this is ever the cause of the trouble, but simply one of the effects of the frequent micturition. I don't think it amounts to much, but I simply mention it to prevent you from making a diagnosis of something bad. Don't make a bad prognosis of it.

There is another large class of cases which come to us complaining of pain in one side or the other, the most frequent, of course, being those which complain of pain in the right side. Some are cases of gall-stones; some are classical cases of duodenal ulcer. They are so distinct from kidney trouble that they don't need a cystoscopic examination. Between these classical cases and cases which show cystitis on the face of them there is a number

of cases that have a certain amount of conflicting elements. In how many cases, you just happen to think of it, and ask him about his bladder, and he tells you about spells he has had and in some cases you find the urine looked like blood. You cannot turn your case right off and say there is nothing the matter with that right kidney. The only way to find out is to look and see. Then there is a class of cases which come to you with tumor in the side which may appear to be a gall bladder and may appear to be like a kidney. How are you going to determine which it is? It may be any one of three or four things. It may be a moving kidney. It is pretty hard sometimes, and the only way I know of is to go to the bladder and see if there is healthy urine. If so, you can be reasonably safe in saying the tumor is not a kidney. There are very few exceptions when you get healthy urine from a tumor of the kidney. Hypernephrosis may produce blood. It is another thing when there is not enough kidney left to produce blood. A tumor in the side, in connection with this, is another thing in which the clinical history would be of more value than anything else. Most kidney tumors are movable, so if there is pain in the side and healthy urine you can make up your mind that this tumor is not of the kidney. It is a lot of satisfaction to be able to say that, lots of times.

Sometimes hypertrophy of the kidney is caused by a tubercular condition in the other kidney. In many cases of a tubercular kidney, there is an absolutely healthy bladder. The great majority of the cases have something in the bladder to indicate the trouble. Then what do you find? In the first place, there are small red spots which are circumscribed, and the healthy mucous membrane comes right up to the spot, very different from the spots in the neurotic woman's bladder. They blend out to the natural color of the mucous membrane. Now, this condition may be a sort of lupus, like that on the skin, which never gets any farther. I am inclined to think that these spots are the same things that produce ulcers. I have never had a case in which I could observe the different steps. I see the different conditions in different cases. When the ulcer comes it is clear-cut. The ulcers are red or gray. Most of the cases I have seen have been red, although the doctors say they are gray. Nothing else will produce anything like that kind of an ulcer. The ulcer appears red, and if you touch it it bleeds: rubbing will produce a hemorrhage. These ulcers may be at the spot where the dropping of the urine leaves a sediment. There may be trouble in the urethral meatus, but I do not know of as many cases of this as of vesical ulcer. Sometimes there is a stiff wall over

the ureter, which stands open like a gaspipe. You stick a catheter into it. There may be a whole lot of room beside the catheter. It don't mean a tubular ureter. I have seen it in ureteritis from stone. Then there is another condition that is almost pathologically like this. It is shrinking of the ureter. When the ureter shortens it pulls the bladder out. You look it over and see the funnelled appearance of the bladder, and you cannot see any ulcer. That means a tubercular condition ninety-nine times out of a hundred. These are some of the special conditions found in the bladder which indicate tubercular disease. Of course, the bacilli in the urine is the proof positive. But you cannot always find it if it is there. It is not always there. That is in cases where there are old, dead kidneys. Then you do not find the bacilli in the bladder. It runs from seven to eight out of ten cases that we do find it. In every one of these cases the diagnosis has been made as tubercular by the bladder appearance, together with the history of the case. If you get the history you will find that frequently urination is the only symptom. At one time I looked it over—I have not lately—and at that time I found that thirty per cent. of our cases never had a pain or an ache of any description. Sometimes the neurotic cases complain of pain. If they have no pain don't exclude tuberculosis, and don't expect them to be emaciated, hectic, etc. In these cases the bad kidney is dead, and the other kidney has taken up the work until it is a great, big kidney. Don't think because it is a tumor of the kidney even that it is too large. Many of these cases will come in complaining of frequent making in water, and they have a big kidney. There is every reason to suppose that the other kidney has ceased to be a kidney years ago. It is nothing but a shell, and you have a great, big, hypertrophied kidney on the other side doing the work of two. We have learned a great deal in the past few years about operating on these cases. The time was, in certain cases of extra-uterine hemorrhage, that a woman was sent off to the hospital and immediately operated upon. Now we know that not one of five hundred will bleed to death. Of course they may get pretty anæmic and lose a whole lot of blood, but they generally come out all right. It is seldom that they die. And, speaking of tubercular kidney, we don't believe it is necessary to operate in every case of tubercular kidney. There is no reason to believe that tuberculosis of the kidney has not been cured, but the point I want to impress upon you is: don't spend too much time trying to cure kidney tuberculosis, but keep track of it. Know about how much urine and what kind of urine there is, and

whether there are bladder involvements. At the first indication of bladder involvement it is time to act. But where you find that the large kidney is making healthy urine, are you going to take out the other and leave all the work to that kidney to do, or will you leave it to gradually prepare to do the whole work? There are cases that have come here within the last year. They have a tubercular kidney and a good kidney. The tubercular kidney may not be much use, but it is a kidney. If the patient is healthy, especially if a young woman, she may get well. You don't know. The thing to do is to wait, and if there is no bladder involvement the other kidney will slowly take up the work, and it is a whole lot better than to take the tubercular kidney out and at once put all the work on the other good kidney.

The stone cases are usually pretty plain. A good radiograph which will show the bone structures of the transverse processes will show a stone. If you can get that kind of a radiograph and you don't have any stones show on the plate, you cannot say but there is something that can be done with the cystoscope. That may lead to a correct diagnosis. You may find that there is nothing coming from there but a little pussy urine, and perhaps nothing but pus. You don't know whether it is a stone case or not. You know it is a dead kidney. Nothing else will produce it. If there was any healthy tissue the pus would be diluted. So when the thick stuff comes down there is no kidney left. I have sometimes seen a stone stuck halfway into the bladder. In one instance it stuck into the urethra and ulcerated through the bladder and formed another passage. If you fail to pass the catheter through, there may or may not be obstructions. One indication is not proof. Your catheter may have struck a fold of membrane. You may put it back and repeat it four or five times, with the same result. It is suggestive, but it is not proof. There may be a stone and the stone may slip by the catheter. Even Kelly's practice of waxing may be of assistance. The middle of the tube might strike it, and if you failed to find a scratch on the wax you would not be any the wiser. Urine may come down where the catheter will not go up, and sometimes urine will not come where the catheter will pass through. Of course, a stone in the urethra can just as well be radiographed. There is this much about the use of the cystoscope: if there is a stone of any kind in the urethral opening you can always draw it out with a pair of forceps.

In one case, the case of a woman, with one finger in the vagina and another in the bladder I had the stone between my two fingers and envaginated the bladder well into the urethra.



My idea of the two fingers was to squeeze it out. I could not. By using the cystoscope I was able to work it into the bladder.

There is one other special point that I want to speak of; that is, hydronephrosis. Just a few words and I am through. Sometimes they have a tumor in the colon and symptoms of obstruction of the bowels, vomiting, chills, etc.

We had a little boy here, ten years old, who since he was three years old had had frequent attacks of pain, vomiting and absolute inability to get the bowels to move. With such conditions he had been treated almost invariably for obstruction of the bowels. These spells would last three or four days. It seemed to be obstruction of the bowels, but we were at a loss to diagnose it, as there was no bloating, and obstruction of the bowels will always produce bloating. He happened to have one of those spells here in town. They called me down to the house to see him. He had a very large kidney. In twenty minutes he was opened up and a quart of fluid taken from his kidney. On account of a kink in the ureter he had been suffering all that time.

Then there is the class of cases that are neurotic. They have symptoms of hypernephrosis. I don't really understand much about them yet. Some of them we have here in town. We have been very prone to send them home without operating. Ten or twelve years ago they were operating for moving kidney everywhere. A woman came in and you told her she had a movable kidney and must have an operation, and lots of times she had it and the same symptoms came back, so that the operation fell into disrepute, and they would go home and not get well. But where there is no improvement, these cases should be operated upon, even if they have neurotic symptoms.

## Clinical Department.

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### **A Study of Two Unusual Brain Tumours.** GORDINER AND CAREY, in *Journal of Nervous and Mental Diseases*, 1906, p. 1.

CASE I. Multiple cylindroma involving the 2nd, 3rd, 4th and 8th cranial nerves, and producing symptoms closely simulating a tumor of the quadrigeminal bodies.

Eight months before his death a laborer of 49 commenced to suffer from headaches and dizziness, then from noises in each ear. A few weeks later he became deaf, first in the right, then in the left ear, and in the course of three months developed a markedly unsteady gait. An examination showed: Pupils unequally dilated, left the larger, sluggish to light and accommodation; eyeballs fixed, moderate divergence, the only movement in a slightly upward direction; double ptosis and optic neuritis with failing sight; muscles of face, tongue and palate unaffected; sensation of face normal, no rigidity of neck; smell and taste unimpaired; marked deafness in both ears to bone and air conduction; patellar reflexes lively, others normal; no tactile or stereognostic symptoms; cerebellar gait; memory failing and cerebation slow; a slight degree of arterial sclerosis and emphysema. Death from exhaustion. The order of occurrence of focal signs, viz., tinnitus aurium, deafness, cerebellar gait and ophthalmoplegia, suggested a growth in the region of the quadrigeminal bodies. The authors explained the ophthalmoplegia by a ventral extension of the growth, the tinnitus and deafness by irritation and destruction of the central auditory tracts, "lateral fillets," and the inco-ordination to a compression either of the central part of the median worm or the ventral peduncles of the cerebellum. Iodides and mercurial inunction were tried without benefit.

*Autopsy.*—A tumor, 3 by 2.5 cm., occupied the inter-peduncular space involving the optic nerves and commissure, and also the 3rd and 4th nerves; about 15 other tumors, varying in size from 0.5—0.2 cm., were scattered asymmetrically mainly over the surface of the brain, brain-stem and cerebellum and in the angle between the caudate nuclei and corpus callosum in the lateral ventricles. Both 8th nerves were involved in the cerebello-pontine angles, and at their exits from the internal auditory meatus. The smaller tumors stripped off with the visceral layer

of the pia, but the larger tumors infiltrated the cortex. They were grey and like soft cartilage.

*Microscopically*, the tumors consisted chiefly of a homogeneous, refractive, hyaline-like material, the basement substance occasionally showing striations or fibrillæ, and enclosing cells in spaces which were more numerous in the region bordering the cortex and grew more scarce as the pia was approached. The looser portion of the basement material bordering the cells stained like mucus, and the denser portions like the hyalin of cartilage. The cells form "irregular masses of multinucleated protoplasm often vacuolated and containing droplets of fluid" like syncytium, but elsewhere the matrix was denser and resembled hyaline cartilage. It was not hyaline cartilage, however, because there was no connective-tissue from which it could be formed, the endo- or peri-thelial cells which originated the growth being a differentiated form of mesoblastic origin, but not true connective-tissue. These cells in their growth manufactured the ground substance, as was seen by the droplets. At the periphery the method of growth was seen, the syncytial masses being here elongated occasionally with rudimentary vascular channels enclosed and surrounded by the mucinous material and the masses of cells so described above; these latter eventually obliterated the rudimentary vessels. Swollen endothelial cells of the pia at the border of the smaller growths gradually disappeared as the central portion was being atrophied by pressure.

The growths, therefore, start neither from the pia nor from the cortical tissues, inasmuch as they could not be traced to any of the fixed tissues. The authors think that they sprang from vasoformative, mucinogenous cells included in the brain during its early development. The tumors were not very malignant, owing to scanty blood supply. That they were of this developmental nature is shown by their appearance at the base near the line of closure of the cerebral vesicle, by their syncytial appearance and by the multiplicity of growths which are not metastases. Bilroth called such growths cylindroma, and the authors class their case as a hæmangio-perithelioma cylindromatosum. They say that though multiple endothelial tumors of the brain are not infrequent, such an extent of hyaline degeneration as occurred in this case has not been previously described.

CASE II. A neuro-epithelioma of the choroid plexus of the 4th ventricle growing dorsally; symptoms of a tumor of the median lobe of the cerebellum.

A boy of 10, with symptoms of cerebellar tumor (median

lobe), viz., headache, optic neuritis, marked dizziness, swaying to the right, slight nystagmus, with lively knee-jerk on one side and later tenderness over occipital and parietal bones with rigidity of neck muscles. During the last week of the illness, which ended fatally in four months, attacks of dyspnoea, dysphagia and hiccough with rapid and feeble pulse supervened. Two months before death he had an attack of transient unconsciousness.

The autopsy revealed a vascular tumor 3.5 by 2.75 cm., springing from the choroid plexus of the 4th ventricle and penetrating the velum to invade the vermis cerebelli. There was a marked degree of hydrocephalus.

*Microscopically*, there were two types of cell, one like a lymphocyte and the other an irregular cell giving off branching fibres glia fashion. These cells are often grouped with nuclei peripheral and protoplasm central, but with no lumen. In the centre of the tumor, however, where the capillaries are numerous, are many "rosettes," consisting of a central small vessel surrounded by layers of cells, the innermost having nuclei peripheral and protoplasm centrally disposed and sending out towards the capillary wall fibres. These cell masses occasionally undergo hyaline degeneration which commences in the vessel wall and spreads outwards. The ependymal cells lining the interior wall of the velum are normal, but as they approach the border of the tumor they are flattened and reflected over the outer surface of the growth and gradually emerge into the glial-like cells of the growth—a metaplasia or metamorphosis into embryonic form, the authors think.

Flexner named this form of tumor neuro-epithelioma, and described one arising from the external nuclear layer of the retina. They have also been called ependymal gliomata, but wrongly, as the growth arises from epithelium and not from glia. Ependymal tumors are uncommon. Flexner described two, Mallory three, and Neuthmann has collected fourteen from the literature. In one of Mallory's cases the growth, the size of an orange, was located in the mid-line of the coccyx.

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DURING the performance of a hernia operation it is often helpful for the anesthetist to allow the patient to react sufficiently to strain into view a sac that has slipped back into the abdomen.  
—*American Journal of Surgery*.

IN the presence of large masses of glands in the epigastrium, especially on the right side, examine the testicles for new growth.  
—*American Journal of Surgery*.

**Fracture of the External Condyle of the Humerus.** W. E.

HOME, M.D. Edin., Fleet Surgeon, R.N., in *The Lancet*.

Fracture of the external condyle of the humerus is so uncommon an accident that it may be well to put a case on record.

On July 28th a stoker on H.M.S. *Exmouth* caught his right elbow under the cross-head of a hydraulic engine. So violent was the blow that his arm bent the rim of a cast-brass lubricating cup. On examination he was found to have a lacerated wound on each side of the elbow. From the inner wound the finger passed through lacerated tissues down to the front of the humerus. Within the outer wound the muscles were slightly lacerated, the skin was partially separated even where not ruptured, and about an inch of the external condyle and supracondylar ridge was found lying free. No arteries bled. The loose piece of bone was fixed by a suture through its adherent soft parts. The wounds were drained and sutured (one deep silk-worm gut suture of relaxation, the others catgut continuous), and the elbow was put up in cotton wadding with elastic bandage over all. The drain was removed from the inner wound on the second and from the outer on the third day. The after-history was uneventful. The wound is now under cyanide gauze and collodion.

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**Raynaud's Disease.** ROBERT ABRAHAMS, M.D., Instructor in Medicine, New York Post-Graduate Medical School and Hospital; District Physician Mt. Sinai Hospital; Adjunct Dermatologist Lebanon Hospital, in *The Post-Graduate*.

Israel K— is fifty-nine years old. Family history negative. Personal history: Has always been in good health. Never suffered from an infectious or contagious disease. Never had gonorrhoea or syphilis. His lungs, heart and kidneys are in good condition. The arterial system so far as could be ascertained is normal. He gives a history of exposure to cold, dating back nine months ago. Shortly after the exposure he noticed "blue spots" on the instep of the right foot. Coincident with the appearance of the spots he began to experience pain in the last phalanx of the great toe. The nail of the toe underwent some atrophic changes. His physician advised him to remove the nail. The latter was removed, but the pain remained.

Two months after the onset of the affection the left foot became similarly involved. At present, around the borders and

extending to the middle of the back of each foot, there are areas of dull red and bluish discoloration. These areas are not of equal size; they come and go, etc.; at times they occupy almost the entire dorsum of each foot, and then the color is distinctly violaceous.

The occurrence of such total asphyxia is quite frequent, every week or ten days.

The subjective symptoms are pain and heat. The pain is continuous and aggravated during a paroxysm, that is when the feet become all blue. The character of the pain is sometimes dull and sometimes lancinating. The sensation of heat is always present, even when there is marked cyanosis.

I regard this case as Raynaud's Disease belonging to the type which is characterized by local asphyxia. The treatment in this case consists in the application of a thirty per cent. ichthyol ointment twice a day. This ointment affords the patient more relief than any other remedy that was tried, both internally and externally.

#### DISCUSSION.

PROFESSOR LUSK.—This case was under my care in the dispensary. I did not regard it as anything more serious than chronic chilblain, for which I treated him. The patient being a Russian and speaking no English, I could not understand him, consequently the history obtained of the case amounted to nothing. He is doing much better, however, than when he came into the dispensary. It is an interesting case.

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#### **A Case of Primary Epithelioma of the Urethra.** J. E. PLATT, M.S., (LOND.), F.R.C.S., Honorary Surgeon to the Manchester Royal Infirmary, in *The Medical Chronicle*.

Epithelioma arising primarily in the urethra is of exceedingly rare occurrence, although it is not very uncommon to have extension of cancer to the urethra from the end of the penis, the prostate, the bladder, or the rectum.

The following case was under my care at the Manchester Royal Infirmary some little time ago.

R. M., aged fifty-nine, was admitted to the Infirmary on September 18th, 1905, complaining of old-standing urethral trouble. He stated that in the year 1860, when he was thirteen years of age, he injured his urethra by a fall upon the edge of a table, but it was not until two years later (1862) that he suffered from

“stricture.” He had trouble with his water for a period of three or four years (1862—66), during which period catheters often had to be passed on account of retention. From that time for a period of thirty-five years (1866 to 1902) he had no trouble with his water. In 1902 he was again obliged to pass catheters at intervals of a few days. The difficulty in micturition became more marked, and about twelve months previous to his admission he was in the habit of leaving the catheters in the urethra in order to dilate the passage. For the preceding twelve months he had had to use the catheters almost daily. About nine months previously a medical man, under whose care he was, had incised a swelling on the under surface of the penis, about 1 1-2 inches from the meatus. The patient says that it was a “cyst,” and that some blood and dark matter escaped when it was incised. This operation was followed by the formation of a fistula, which had never closed up. Six months previously (March, 1905) the patient had first noticed that his penis was becoming indurated. No history of venereal disease could be obtained.

When the patient first came under my care I found a urinary fistula on the under surface of the penis about 1 1-2 inches from the meatus. The penis generally was indurated. There was an offensive discharge from the fistula, and some urine dribbled from it on micturition. There was what appeared to be an almost continuous stricture commencing about one inch from the meatus and extending backwards as far as the bulb. •

On September 30th, 1905, the patient was placed under chloroform, when, with some difficulty, I managed to pass a staff along the urethra into the bladder, and made a perineal section. A perineal tube was tied in the bladder. The operation was followed by a rigor, and for the first few days the temperature remained high. The tube was kept in the perineal opening for some days, and the urine discharged itself more or less completely through that opening until the patient left the Infirmary.

At that time I did not suspect that I had to deal with anything more than a bad stricture of the urethra, complicated by urinary fistulæ. The patient went home on October 25th, refusing to have any further treatment. He very soon returned, and begged to be re-admitted, and consequently he was again admitted under my care on November 27th, 1905. He stated that from the time he left the Infirmary the penile fistula had caused a constant offensive discharge, and that he had suffered very greatly from pain. When I examined him I found that a con-

siderable growth had taken place from the edges of the fistula, which were now greatly thickened and markedly everted. The penis generally had become very much more indurated. Micturition had to be performed very frequently, and gave rise to great suffering. The induration of the penis could be felt extending backwards through the base of the scrotum to the perineum. There was still a small fistula at the site of the perineal operation, and another small fistula opening just in front of the scrotum. The inguinal glands on each side were slightly enlarged.

At this time I came to the conclusion that the patient was undoubtedly suffering from epithelioma, and I therefore asked my colleague, Mr. J. W. Smith, to see the case with me. He agreed with my diagnosis and with the treatment which I had proposed, viz., complete removal of the penis with the crura and the bulb.

This operation was performed on December 6th, 1905. The patient having been placed in the lithotomy position, an incision was made around the base of the penis, and was then carried backwards along the middle line of the scrotum and the perineum to within half an inch of the perineal fistula. The two halves of the scrotum were separated, the attachments of the penis to the pubic arch were divided, the crura were freed from their attachments to the pubic and ischial rami, and the urethra was divided immediately behind the bulb. The cut end of the urethra was fixed by sutures in the perineal wound, and the bladder was drained by a perineal tube. The rest of the wound was closed by interrupted sutures.

On the day following the operation the temperature was 102.6 deg., but after that it remained normal. The wound was dressed daily and healed by first intention. The perineal tube was removed on December 13th.

The patient was inspected from time to time after his discharge from the Infirmary. When I last saw him, about three months after the operation, he was quite well, and, with the exception of a tendency to contraction of the urethral orifice in the perineum, he had no trouble at all. The contraction was overcome by dilatation.

Before the last operation I noticed a slight enlargement of the lymphatic glands in the groins. I was very doubtful whether this was due to any secondary infection, and I did not think it advisable to add to the shock of the operation I have already described by further operation upon the groins. I have exam-



ined these glands from time to time subsequently, and have found that they are quite unaltered.

The malignant disease in this case was rather advanced before the diagnosis was made, and I cannot hope that the man will have any very long period of freedom from recurrence. It is not improbable that before long we shall have a return of the malignant growth, either in the perineum or in the pelvic lymphatic glands, and this has influenced me in deciding not to undertake any further operation upon the inguinal glands, which after all are only very doubtfully affected by the cancerous growth.

By microscopic examination the growth was proved to be a typical squamous epithelioma.

The literature upon the subject of primary epithelioma of the urethra is by no means extensive. The first paper of importance is one which was published by the late Mr. Marcus Beck, in *Internat. Clinics*, 1892. Mr. Beck collected ten cases from medical literature. In this paper he refers to the difficulty of explaining its infrequency, both according to Cohnheim's theory and according to the persistent irritation theory of the origin of cancer.

After 1892 we find isolated cases in medical literature, including one published by Mr. W. P. Montgomery in the *Medical Chronicle*, for June, 1901. The most complete paper on the subject is one by Mr. J. Basil Hall, of Bradford, in the *Annals of Surgery*, Vol. 38, 1904. Mr. Basil Hall collected twenty-one cases in which the diagnosis had been confirmed by microscopic examination. He also collected five other cases in which no microscopic examination had been made, and in which, therefore, there must be doubt about the diagnosis. Since Mr. Hall's paper I have only been able to find references to two isolated cases, and I regret that in both cases I have not been able to consult the original paper.

The chief points which are brought out by an examination of the cases now on record are as follows:

*Cause.*—In a considerable proportion of the cases the patient has been the subject of old-standing stricture of the urethra. In my own patient there would appear to have been some injury to the urethra during boyhood, but I am unable to state definitely that there was a stricture dating from that time. Later, however, the patient undoubtedly had stricture, and it is probable that the malignant disease in his case was a result of the irritation produced in that way. In a few of the recorded cases there was no history of any urethral trouble prior to the origin of the malignant disease.

*Symptoms.*—Beck states that the chief symptoms to which malignant disease of the urethra gives rise are pain, hemorrhage, induration, and at a later stage induration of the lymphatic glands and cachexia. Hall, as a result of an analysis of the larger number of cases collected by him, states that Beck's account of the symptoms requires considerable modification. He states that in four of the cases which he collected there was a marked absence of pain and hemorrhage, and that in two cases instruments could be introduced into the bladder with great ease.

*Diagnosis.*—The diagnosis in these cases appears to be especially difficult, and in a large number of the recorded cases has not been made until any radical operation was out of the question. Stricture of the urethra, especially if associated with urinary fistulæ, is often accompanied with much induration, and in many cases the induration resulting from the growth has been for a time mistaken for inflammatory conditions resulting from stricture. The difficulties of diagnosis are especially marked in the early stages of the disease. It is possible that in certain cases early diagnosis may be facilitated by the use of the urethroscope.

*Prognosis.*—The prognosis in these cases must be regarded as most unfavorable. Much depends, however, upon the stage at which the diagnosis is made, and it is quite possible that if complete removal were effected early in the disease there would be a long period of freedom from recurrence, and perhaps absence of any recurrence in the future.

*Treatment.*—The only effective treatment lies in complete removal of the penis, with the bulb and crura. In cases where a radical operation is out of the question it is possible that relief may be afforded by means of perineal section.

*Results.*—It is worth while to give the results in the twenty-one cases which were collected by Mr. Basil Hall. In one case no treatment could be adopted, and in ten cases the treatment was merely palliative—simple incision or perineal section. All these patients died within nine months, except one who lived for eighteen months. In ten cases a radical operation was attempted, the results being as follows: In one the result was unrecorded; In four death took place within nine months; In one there was recurrence within six months. In the four remaining cases the patient was free from recurrence at the time of report, this period being twenty-one months, eleven months, ten months and four months respectively from the time of operation.

## Therapeutics.

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**Some of the Many  
Uses and the Method  
of Administering  
Normal Salt Solution.**

While this is not a new subject, normal salt solution having been in use for many years, its value has become widely recognized and it is being more and more used every day. Its value should not be underestimated in either surgery or medicine. How could the surgeon do without it? It is practically out of the question, for many hundreds of lives are saved every year that unquestionably would be lost if it were not for the use of salt solution.

The administration of normal salt solution supplies fluid to the body exhausted from loss of fluid through excessive purging, as in cholera, or in case of hemorrhage. It may be used to wash from the body various impurities circulating in the blood and lymph channels and to flush out the kidneys. In other instances it may be used to supply the body with fluid when liquids cannot be swallowed or retained.

As is well known, a quantity of liquid equal to four times the normal amount of blood may be passed directly into the veins without producing a rise of blood pressure, and experiments have shown that usually within fifteen minutes after the fluid flows into the subcutaneous tissue an increased flow from the kidneys takes place.

It is not safe to infuse into the intercellular spaces a greater quantity of liquid than one drachm to each pound of body weight in each fifteen minutes, for if this amount is exceeded the tissues become thoroughly saturated, drowned, so to speak, kidneys and skin being unable to excrete the liquid fast enough. (Hare.)

There is no excuse for not using it, since boiled water can be had almost anywhere. One teaspoonful of common table salt added to a pint of water will make about the right proportion, at least near enough for all practical purposes. Of course, where there is plenty of time, it should be made up with distilled water and should be six-tenths of one per cent. in strength. If it is not possible to get distilled water, filtered boiled water will answer every purpose, and this is most generally used. One should not hesitate, if the sodium chloride cannot be had, to use plain boiled water in case of extreme emergency.

The temperature should be from 112 to 115 deg. Fahrenheit. If in a hurry, the temperature can be estimated by pouring some of the solution over the hand. It should feel comfortably hot,

for some allowance must be made for the loss of heat in passing through the apparatus.

While many contrivances can be used for infusion or transfusion, the most satisfactory is Kelley's infusion apparatus, which is well known, simple and easily sterilized by boiling.

The best method of administering saline solution is by the rectum, and an untrained person can administer the solution in this way: The ordinary rectal tube and the irrigating can are generally used, but a male catheter, enema point or piece of gum tubing inserted well up into the rectum will answer every purpose. The fluid should be allowed to flow in slowly. A pint to a pint and a half, or even two pints, may be considered the proper amount of the solution. It is well to turn the patient on the left side and elevate the hips, causing the fluid to run up into the sigmoid. On the operating table the Trendelenburg position is most favorable, allowing the fluid to run well up in the colon. If the patient is restless and cannot retain an enema, or when an enema cannot be given, the infusion should be resorted to.

It is better to infuse than to transfuse, for the reason that when we infuse, or give solutions by rectum, the fluid is taken up by the lymphatics and has to pass through the lymphatic channels, becoming truly a part of the body fluids, while in transfusion the fluid is thrown directly into the blood and undergoes no physiologic change. Transfusion should be done in preference to infusion only when the pulse is very weak and we want immediate results. Then a vein should be opened and the saline solution allowed to flow in slowly. It is usual to open the median basilic, but on several occasions I have opened the brachial vein, which is larger, and, on that account, more convenient.

I have twice seen ill effects following an infusion. In one a nurse infused a strong salt solution under a child's breast, which resulted in a large slough. In the second instance a small vessel was punctured and a large clot of blood formed in the right sub-clavicular space, requiring evacuation by an incision.

Bisch warns against subcutaneous use of saline solution from experiences with it in Doderlein's clinic. He says it is quite harmless when injected into a vein or into the peritoneal cavity, but under the skin he thinks it is liable to produce gangrene. This, he claims, occurred in six cases under Doderlein. In one of these cases a fatal termination resulted from secondary infection. I cannot understand this if the right percentage and right temperature of the solution were used, and, most of all, if the solutions were sterile.

Following is the history of a case of typhoid fever in which I found saline solution very useful:

The young man, aged about twenty, had a very severe attack of typhoid. I saw him on the fourth day of his disease. His temperature at that time was 104 deg., pulse 102. He was in a semi-conscious condition and a very unpromising case. During the first nineteen days his temperature remained most of the time above 104 deg., going frequently above 105 deg., and on one occasion reaching 106 deg. His temperature after this gradually subsided and reached normal on the twenty-seventh day, but then rose and did not reach normal again until the fifty-fourth day. Tubbing had little or no effect upon the temperature. Ice-water enemas, one pint every two hours, seemed to have little or no effect. His toxic condition was very grave. This patient got 700 cubic centimeters of normal salt solution subcutaneously twice a day. He got thirty infusions in all—two every day for two weeks, and on two of the days when he was most ill an extra one, making thirty infusions in fourteen days.

These infusions were given under the pectoral muscles, except four, which were given in the flanks. There was no bad local effect, except a little stiffness and soreness, which lasted for a few days after the infusions were stopped. Before I began the infusions his mouth and tongue were parched and dry. Shortly after the infusions began these conditions were greatly improved. He secreted large quantities of urine and had to be catheterized frequently. I feel confident that the salt solution saved this man's life. I have seen similar good results from the salt solution in cases of pneumonia.

While I will not attempt to enumerate the conditions which loudly call for the normal salt solution, the most important ones are excessive hemorrhages, toxemia arising from various forms of infection, as in septicemia, uremia, the comatose state of diabetes mellitus, in cholera and in threatened eclampsia. It is also very useful in severe burns to overcome shock and toxemia.

The best place to give an infusion is under the mammary gland in women, lifting the gland well up and inserting the needle beneath the lower outer quadrant, pointing upward, and allowing the solution to flow in slowly through a needle about two millimeters in diameter. The needle should be inserted while the solution is flowing so no air can be introduced.

The loose cellular tissue and the breast quickly begin to distend; even a flatly atrophied organ will reach the size of a puerperal breast. The amount that can be easily put under a breast is about 700 cubic centimeters. It is more satisfactory in the

male, and in emaciated individuals, to lift the pectoral muscles, directing the needle upward and inward so that the fluid will infiltrate the subclavicular and axillary spaces.

The proper temperature of the fluid can be maintained by letting the tube carrying the saline solution lie immersed in a pan of hot water, about 115 deg. Fahrenheit. The saline enemas, which are often preferable, are best given in the way adopted by Murphy and the Mayos, that is, by inserting a small rectal tube and allowing a small stream of hot saline solution to flow into the rectum continuously. A large amount of the solution is thus taken up in the course of a day. The flow can be regulated by the elevation of the vessel above the individual, or, better, by a clamp on the tubing, limiting the flow to a very small stream, not more than a pint an hour. In surgical cases under anesthesia, it is well to give a pint by rectum before the patient awakens, for if given while awakening from the anesthetic the patient will nearly always expel it.

I have spoken of transfusion, and only recommend that it be used in very exceptional cases. It is a well-known clinical fact that some cases of shock are not much benefited by intravenous infusions of saline solution.

A series of sixty experiments on dogs was undertaken by George W. Crile, which he reported in the *Medical Record*, April 19, 1902, to determine the effect of the solution at varying temperatures, the cause of death from excessive infusions, dilution of blood, effect on respiration and other topics. The conclusions he arrived at were that if the blood pressure had been lowered by moderate hemorrhage alone infusion promptly restored it. If it had been lowered by exhaustion of the vasomotor system by afferent impulses from an injury of the cerebro-spinal or sympathetic nervous system, infusion restored the pressure in inverse proportion to the vasomotor exhaustion, that is to say, it is effectual in shock in inverse proportion to the impairment of the vasomotor mechanism. If the matter be greatly impaired or abolished, infusion has no certain effect, although if the impairment is considerable, but not of extreme degree, it will probably restore the pressure.

Blood pressure is re-established but little, if any, above the normal, because of the rapid escape of fluid from the tissue and of the automatic centre in the medulla, which, when the pressure rises above normal, slows the heart and lessens vaso-constriction in the area of peripheral resistance. If the peripheral resistance is lost (fatal shock) no amount of fluid can do more than temporarily and partially restore the blood pressure, and death is

inevitable. If the shock is much increased by regional accumulation of blood, as in operation affecting the splanchnic area, infusion may be effective, because the vasomotor mechanism has not gone into resolution.

Murphy says the above deduction explains why some cases of shock are but little, if at all, benefited by infusions. In almost every case an artificial pulse may be procured, even of considerable volume, but without resistance. It will disappear almost as quickly as it came and no amount of infusion will sustain the circulation, for the vasomotor mechanism has gone into resolution, abolishing the peripheral resistance.—*A. Aldridge Matthews, M.D., in Maryland Med. Jour.*

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## Physician's Library.

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*A Text-Book of Obstetrics.* By BARTON COOKE HIRST, M.D., Professor of Obstetrics in the University of Pennsylvania. Fifth revised edition. Octavo of 915 pages, with 753 illustrations, 39 of them in colors. Philadelphia and London: W. B. Saunders Company, 1906. Cloth, \$5.00 net; half morocco, \$6.00 net. Canadian agents, J. A. Carveth & Co., Toronto, Ont.

One would almost consider it enough to say this is the fifth edition of Hirst's Text-Book of Obstetrics, as that certainly establishes its popularity. The author himself has carefully revised this edition, and particular attention has been paid to new information on puerperal infection and gestational toxæmia. There are 767 illustrations, 40 being in colors.

*Diet in Health and Disease.* By JULIUS FRIEDENWALD, M.D., Clinical Professor of Diseases of the Stomach in the College of Physicians and Surgeons, Baltimore; and JOHN RUHRAH, M.D., Clinical Professor of Diseases of Children in the College of Physicians and Surgeons, Baltimore. Second revised edition. Octavo of 728 pages. Philadelphia and London: W. B. Saunders Company, 1906. Cloth, \$4.00 net; half morocco, \$5.00 net. Canadian agents, J. A. Carveth & Co., Toronto, Ont.

This is the second edition of this book. It is dedicated to Dr. William Osler. The chief change and improvement over the first edition is the fact that the section on the Salts has been re-written and enlarged, with particular attention to the work of

Professor Chittenden. There are many useful recipes and diet lists, and the book will now be found to fully meet the requirements which first brought it forth, namely, the needs of the general practitioner, hospital interne, medical student, and nurse at the training-school.

*Saunders' Pocket Medical Formulary.* By WILLIAM M. POWELL, M.D., Author of "Essentials of Diseases of Children"; Member of Philadelphia Pathologic Society. Containing 1,831 formulas from the best-known authorities. With an appendix containing Posologic Tables, Formulas and Doses for Hypodermic Medication, Poisons and their Antidotes, Diameters of the Female Pelvis and Fetal Head, Obstetric Table, Diet Lists, Materials and Drugs used in Antiseptic Surgery, Treatment of Asphyxia from Drowning, Surgical Remembrancer, Tables of Incompatibles, Eruptive Fevers, etc., etc. Eighth edition, adapted to the new (1905) Pharmacopeia. Philadelphia and London: W. B. Saunders Company, 1906. In flexible morocco, with side index, wallet and flap, \$1.75 net. Canadian agents, J. A. Carveth & Co., Toronto Ont.

Those who have been in the habit of keeping this formulary by them will find many obsolete formulæ omitted from this, the eighth edition; but they will find benefit from over 400 new and up-to-date ones. The beginner will find here good helps, the student good studies.

*A Treatise on Surgery.* In two volumes. By GEORGE R. FOWLER, M.D., Examiner in Surgery, Board of Medical Examiners of the Regents of the University of the State of New York; Emeritus Professor of Surgery in the New York Polyclinic, etc. Two imperial octavos of 725 pages each, with 888 text illustrations and 4 colored plates, all original. Philadelphia and London: W. B. Saunders Company, 1906. Per set: cloth, \$15.00 net; half morocco, \$17.00 net. Canadian agents, J. A. Carveth & Co., Toronto, Ont.

On a former occasion we drew attention to the first volume of this work, and we desire to record our appreciation of the second volume, just received. In this volume the same care and thoroughness are manifested in the discussion and illustration of the various subjects, as in the former volume. Special mention should be made of the excellent and numerous illustrations, and remarkably clear text. This volume deals with the surgery of the dorsal and lumbar vertebrae, of the abdominal and pelvic



region (with excellent chapters devoted to the surgery of the female pelvic organs), and Sections XX. and XXI. devoted to the surgery of the upper and lower extremities respectively.

The profession will undoubtedly reap a large measure of benefit from the work Professor Fowler has left as a legacy to us all.

*Prevalent Diseases of the Eye.* By SAMUEL THEOBALD, M.D., Clinical Professor of Ophthalmology and Otology, Johns Hopkins University. Octavo of 551 pages, with 219 text illustrations and 10 colored plates. Philadelphia and London: W. B. Saunders Company, 1906. Cloth, \$4.50 net; half morocco, \$5.50 net. Canadian agents, J. A. Carveth & Co., Toronto, Ont.

This book is essentially one written for the general practitioner; and on that account it deals with those affections of the eye he can readily treat, and, if not, can readily qualify himself to treat. It has been the aim of the author to set forth definite information in a clear form and not to burden the reader with unnecessary detail. On treatment the author is unambiguous and as specific as he is practical.

*Abdominal Operations.* By B. G. A. MOYNIHAN, M.S., (London), F.R.C.S., Senior Assistant Surgeon at Leeds General Infirmary, England. Second revised edition, greatly enlarged. Octavo of 815 pages, with 305 original illustrations. Philadelphia and London: W. B. Saunders Company, 1906. Cloth, \$7.00 net; half morocco, \$8.00 net. Canadian agents, J. A. Carveth & Co., Toronto, Ont.

The fact that only a few months have passed since the first edition of this work appeared, and that it has been found necessary to bring out a second edition, must be a source of satisfaction to both the author and the publishers. Mr. Moynihan has found it necessary to make a large number of additions to both text and illustrations, while two of the chapters have been entirely re-written.

The work is divided into five sections, dealing with the following subjects: 1. General Considerations. 2. Operations upon the Stomach. 3. Operations upon the Intestines. 4. Operations upon the Liver. 5. Operations upon the Spleen and Pancreas.

Space will not permit us to enter upon a minute or even a casual review of each of the forty-nine chapters which form the subdivisions of the work. Suffice it to say the work is most

exhaustive in its discussion of the various subjects, and, of course, most thoroughly up-to-date. The author expresses his indebtedness to such well-known authorities as Dr. W. J. Mayo, Dr. J. B. Murphy, and Mr. Mayo Robson, for help derived from their work. He has confined his discussions only to those operations which are common to the two sexes. No gynecological operations are described. The surgery of organs such as the kidney and the bladder, which are partly intraperitoneal and partly extra-peritoneal, is not included, neither are the various operations for hernia described.

While the work is more especially of interest to abdominal surgeons, it should be of great value to the general practitioner, enabling him to gain a world of information on subjects with which he should be familiar, even though he be not actively engaged in doing the various operations. In view of this fact, and because we feel it to be such a thoroughly satisfactory work, we have great pleasure in unhesitatingly recommending it to our readers.

*Surgery, Its Principles and Practice.* By various authors. Edited by WILLIAM WILLIAMS KEEN, M.D., LL.D., Professor of the Principles of Surgery and of Clinical Surgery, Jefferson Medical College, Philadelphia. Vol. I. With 261 text illustrations and 17 colored plates. Philadelphia and London: W. B. Saunders Company. Canadian agents, J. A. Carveth & Co., Toronto.

That which is before us is the first volume of a new system of surgery which is to be written by the great men of medicine in the medical world of to-day. It is to comprise 4,000 pages in five volumes; and the fact that it is edited by the distinguished American surgeon, Dr. Keen, bespeaks for it originality, ability and breadth of scope. In fact, nearly fourscore eminent scientists, medical solons, surgeons are engaged in the preparation of the text. At the present time this is the only volume off the press, and it is a typical example of the excellent matter issued by the well-known house of W. B. Saunders Company. The succeeding four volumes will follow and be issued just as fast as the editor and his staff of masters can produce them. In looking over the contributors to the work, whilst we are gratified to find the names of J. George Adami, George E. Armstrong and William Osler, we confess to some little disappointment that two or three others are not incorporated therein, as we believe in other sections of Canada (not particularly in Toronto) outside Montreal, there could be found men who could at least from their

experience and knowledge have dealt with such subjects as the surgery of the thyroid, intussusception, and septic peritonitis in a bright and continuous light. No one is better qualified to deal with the subject of Inflammation than Professor Adami; indeed, he has already contributed to the medical press the best ever written on the subject. Dr. Armstrong is a surgeon of the first rank, one in whom Canadians, even outside of Montreal, take a great deal of pride. Professor Osler is the first of Canadian physicians, although domiciled in the homeland; indeed, he is the best-known physician in the world to-day. To the book itself, the first volume, however, let us turn. The first chapter of 78 pages is an exceedingly interesting historical sketch, embellished with portraits of Lord Lister, Billroth, Bernard Langenbeck, Sir Astley Cooper, Samuel D. Gross, Warren, McDowell, Physick, John Hunter, Von Haller, Ambrose Paré and Vesalius. Following this are twenty-one chapters dealing with the following subjects: Surgical Physiology; Examination of the Blood; Infection and Immunity; Inflammation; Suppuration, Abscess and Fistula; Ulceration and Ulcers; Mortification or Gangrene; Process of Repair; Thrombosis and Embolism; Erysipelas; Tetanus; Diseases caused by Special Infections; Diseases derived directly from Animals, Insects and Reptiles; the Traumatic Fevers; Scurvy; Rickets; Surgical Tuberculosis; Chancroid; Syphilis; Tumors and Wounds and Contusions. The illustrations are nice, fresh and new; the text all that could be desired; the general make-up first-class.

*Atlas and Text-Book of Human Anatomy.* Vol. I. By Professor J. PLAYFAIR McMURRICH, A.M., Ph.D., Professor of Anatomy at the University of Michigan, Ann Arbor. Quarto volume of 258 pages, containing 320 illustrations, mostly all in colors. Philadelphia and London: W. B. Saunders Company, 1906. Cloth, \$6.00 net; half morocco, \$7.00 net. Canadian agents, J. A. Carveth & Co, Toronto, Ont.

If the splendid start made be kept up in the second volume, then students of anatomy will have a new and decidedly interesting work. This anatomy is distinguished by three things: 1, the beautiful illustrations; 2, the concise and pointed text; 3, the anatomical nomenclature. The latter, we are told, is essentially that of the Basle committee, and is such that it will at once appeal to students. The work will as well prove one of decided advantage to practitioners. In that it is so finely illustrated, and the text so pointed, it is essentially a very practical anatomy.

*A Text-Book on the Practice of Gynecology.* For Practitioners and Students. By W. EASTERLY ASHTON, M.D., LL.D., Professor of Gynecology in the Medico-Chirurgical College of Philadelphia. Third edition. Thoroughly revised. Octavo of 1,096 pages, with 1,057 original line drawings. Philadelphia and London: W. B. Saunders Company, 1906. Cloth, \$6.50 net; half morocco, \$7.50 net. Canadian agents, J. A. Carveth & Co., Toronto, Ont.

This well-known work makes its revised appearance in the third edition before us. The author has evolved a work of which he may justly be proud, and with which the profession may well be satisfied. Prof. Ashton has given us, what many of us prize not a little, a treatise which is not so much a compilation of what other men have thought and done, but rather his own thought and experience. The alterations have been somewhat extensive, and much new and valuable material has been added. The work is exceedingly comprehensive—as a work with such a title should be—and will, we feel sure, be a welcome addition to the physician's library.

*The American Illustrated Medical Dictionary.* New (4th) edition. All the terms used in Medicine, Surgery, Dentistry, Pharmacy, Chemistry and kindred branches; with over 100 new tables and 2,000 new words. By W. A. NEWMAN DORLAND, M.D. Octavo of 836 pages, with 293 illustrations, 119 of them in colors. Philadelphia and London: W. B. Saunders Company, 1906. Flexible morocco, \$4.50 net; thumb indexed, \$5.00 net. Canadian agents, J. A. Carveth & Co., Toronto, Ont.

This splendid work has become so well known to students and practitioners through its former editions that it would almost seem unnecessary to draw attention to this last (4th) edition—1906. Personally, however, we cannot refrain from expressing our thorough satisfaction with the work, in this its last and most complete form. For years it has been our rule to recommend this work to our clinical classes; indeed, we do not know of any one book which is so all-important to the student (and that term does not necessarily mean simply the undergraduate) as a good dictionary, and of such we know of no better all-round work than this one. In addition to the host of new words that have been added—over 2,000—one might mention such improvements as: considerable amplification of each table, and the addition of six new colored plates illustrating the subjects of Appendicitis, Diph-

theria, Gall-stones, Leishman-Donovan bodies (found in the spleen and liver of patients suffering with a peculiar tropical fever and cachexia, and thought to be a new species of parasite), Measles and Nephritis. In short it may be summed up as a most exhaustive work, put up in a most attractive and convenient form, and worthy of a place *on the desk* of every student and practitioner.

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In the presence of a breast infection that fails to heal within a reasonable time after appropriate incision and dressings, it is well to think of local tuberculosis.

It is wrong to perform any radical operation for an ulcer of the tongue without preliminary microscopical examination. Clinical symptoms, no matter how typical, are often misleading.

The perinephric space is a frequent site of metastatic inflammation after furunculosis or other septic infection.

In exploring for tumors of the brain, the best guide for determining an isolated hardness is the finger; the use of a needle is very deceptive.

When palpating the common bile duct for stone, make sure that a suspected calculus is not a gland.

In the progress of a cholecystectomy, if a stone slips away after cutting through the cystic duct and cannot be found, no great anxiety need be felt, for the stone usually comes away spontaneously in the subsequent discharge.

As a final cleansing step after curettage of the uterus it is well to introduce, and at once withdraw, a packing of gauze. This brings out with it fragments of tissue not washed out by the irrigation.

In cases of fracture where an end of the bone lies close beneath the skin do not place a pad or any pressure whatever over this point.

In cases of pain in the hip of doubtful origin, examination of the kidney region may discover the cause.—*American Journal of Surgery*.

# The Canadian Medical Protective Association

ORGANIZED AT WINNIPEG, 1901

Under the Auspices of the Canadian Medical Association

THE objects of this Association are to unite the profession of the Dominion for mutual help and protection against unjust, improper, or harassing cases of malpractice brought against a member who is not guilty of wrong-doing, and who frequently suffers owing to want of assistance at the right time; and rather than submit to exposure in the courts, and thus gain unenviable notoriety, he is forced to endure blackmailing.

The Association affords a ready channel where even those who feel that they are perfectly safe (which no one is) can for a small fee enrol themselves and so assist a professional brother in distress.

Experience has abundantly shown how useful the Association has been since its organization.

The Association has not lost a single case that it has agreed to defend. The annual fee is only \$2.50 at present, payable in January of each year.

The Association expects and hopes for the united support of the profession.

We have a bright and useful future if the profession will unite and join our ranks.

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# Dominion Medical Monthly

And Ontario Medical Journal

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Published on the 15th of each month. Address all Communications and make all Cheques, Post Office Orders and Postal Notes payable to the Publisher, GEORGE ELLIOTT, 203 Beverley St., Toronto, Canada.

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VOL. XXVII.

TORONTO, DECEMBER, 1906.

No. 6.

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## COMMENT FROM MONTH TO MONTH.

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The Toronto Board of Education will soon have to take up the question of the medical inspection of schools; other Canadian cities will follow, if they do not precede. Montreal is experimenting; the results there will be watched with keen interest.

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Never before, it might be safely ventured, has the child, and all which pertains thereto, been so prominently in the public eye of the United States and Canada; even in Great Britain and on the Continent. The illuminative writings of Mr. Edwin Markham on "The Hoe-Man in the Making," child labor, the new thing in human affairs, have attracted widespread attention, more particularly in the American Union, where, in a certain section of that mighty republic, "Christian civilization" (?) tacitly looks on seventeen hundred thousand children at work, all day long, and often far into the dark and silent watches of the night.

Whilst the American nation is becoming keenly alive to the evils of the child at work, in certain cities thereof it has been alive to the evils surrounding the child at school, for several years. In New York City, for instance, since March of 1897, some sort of medical inspection of schools has been in vogue. That system which is now in use was adopted in 1901.

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It may be asked: Why should schools be inspected by medical men regularly? The most potent reason which will appeal to parents will be the early diagnosis of infectious and contagious diseases, and the consequent prevention of cases of these amongst other members of the school. As is well known, many of these, particularly measles, mumps, whooping cough, chicken pox, are often never treated by a physician, with the almost sure result that there is a widespread field of infection, and subsequent development of dangerous cases. Even scarlet fever has been treated at home from so-called "doctor's books," "home physicians," etc. Consequently unwise parents allow their children to appear at school before all chances of infection are eliminated. It is a well-established fact that those neuroses of childhood such as St. Vitus' dance, hysteria, enuresis, etc., are contracted from school life, often the result of over-work and nervous strain. Add to these the prevalence of undetected pediculi, growths in the nose and naso-pharynx, defective eyesight, crooked spines, and we have a whole host of reasons for the adoption of the system of medical inspection.

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Let us now give some opinions from eminent pediatricists: Dr. L. Emmett Holt, New York, who is looked upon as probably the best specialist in this branch of medicine, says that the medical profession have been rather forgetful of this matter, and they should be the first to teach the mother how to bring up her offspring with the best physical results; that the care of the child was in a great deal a nutritional one; that children as infants required careful feeding. The medical man should teach the mother as to feeding, school hours and play hours. All children should be taken to their physicians at least twice a year for thorough physical examination. Dr. A. Jacobi says that no child should be sent to school under six years of age; seven years of age was the proper time. They should be well trained physically first. It was contrary to physiology and anatomy that a child should be at school before seven years of age. Dr. Wm. P.



Northrup considers that medical inspection is essential, as it finds out what eyes, noses, throats, and teeth need correction. Dr. Henry Dwight Chapin thinks that higher education is largely at fault, as it places a strain upon growing children. Add to this bad housing and bad food, and the results were all against the school child.

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A systematic inspection of school children would largely tend to correct these evils. Dr. R. J. Freeman, New York, in the *Archives of Pediatrics*, gives these essentials in the preservation of health of children: 1. A proper diet, all meals to be eaten slowly and well masticated. 2. Ample rest; ten to twelve hours in bed at night, and often with advantage a nap after the mid-day meal. 3. Fresh air. 4. Freedom from dust and exposure to disease. 5. Freedom from worry and fatigue.

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New York in 1897 started this work with 150 medical inspectors at \$30 per month, and their duty was to make a morning visit to the school to examine all children suspected of being sick with some contagious or infectious disease. In the fall of 1901 fewer inspectors were employed, and their pay increased to \$100 per month. Each man had four or five schools under his charge, with an aggregate attendance of 5,000 pupils. Morning inspection was made from nine until twelve. Morning inspection concerned: 1. Those isolated on account of suspected contagious diseases; 2. Those who had been absent for several days; 3. Those excluded from school. When this was performed each day, the inspector returned to some school and made a routine examination of each pupil.

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Montreal set apart \$3,000 for experimenting with this work; and for the last three months of this year forty medical inspectors have been working at \$25 per month. That it is a question of preventive medicine urgently needed is seen from the following: Out of 43,241 children examined, 20,622 were found suffering from some affection more or less necessitating medical treatment. One thousand six hundred and ninety-nine had inflammation of glands; 1,023 had defect of vision; 9,393 had decayed teeth; 2,107 had enlarged tonsils; 1,091 had pediculi. Of infectious and contagious diseases, five had diphtheria; two scarlet fever; seven measles; seven whooping-cough; eight mumps; one chicken-pox, and twelve erysipelas. There were a host of minor complaints and diseases.

From time to time some subscriber sends us in a circular or "dodger" bearing the names of medical men who are recommending and using a certain remedy. Just recently we have received one of these "dodgers," bearing on the subject of piles and the cure thereof. Strange it is that pile-curing is such an attractive field to the ordinary, every-day quack, but stranger still is it that medical practitioners will subscribe to such a thing as a "positive cure." On this dodger referred to are the names of medical men who live and practise not a thousand miles from a city in Western Ontario which supports two large breweries. This may account for the prevalence of piles in their midst; and then, of course, any such thing as a "positive cure" would be a positive gain financially. We would respectfully suggest to these gentlemen that, in order to spread broadcast this "positive cure" throughout the length and breadth of their beautiful city, that signs bearing these words be hung in their office windows:

#### PILES CURED WHILE YOU WAIT.

Business would certainly boom when it was known the application was painless and easy, and that the relief was immediate.

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The manner of conducting the elections of the Ontario Medical Council is said by many to be unsatisfactory, and needs to be remodelled. A system should be devised whereby neither returning officer nor anyone else would know the candidate any elector votes for. This will be something for the new Council to consider.

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The Sixth International Dermatological Congress will meet in New York City from the 9th to the 14th of September, 1907. Dr. James C. White, Boston, is the president, and Dr. John A. Fordyce, New York, the General Secretary. Drs. Gordon Campbell, Montreal, and Graham Chambers, Toronto, are the secretaries for Canada.

## News Items.

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"MCGILL UNION" has been organized at McGill University, Montreal.

THE Anti-Expectoration By-law of Montreal is being enforced.

REGINA, Sask., will endeavor to erect a \$100,000 municipal hospital.

DR. PEARSON, M.H.O., Brantford, suggests a municipal sanatorium for that city.

THE Muskoka Cottage Sanatorium treated 236 patients during its last official year.

THE Home for Incurables, Toronto, cared for 171 patients during its last hospital year.

JOLIETTE, Quebec, has inaugurated a movement to establish a sanatorium for tuberculosis.

DR. BLACKWELL, London, has been appointed house surgeon at the Sarnia Hospital.

THE Muskoka Free Hospital for Consumptives admitted 186 patients during its last hospital year.

DR. H. R. BRIGHT, of Drayton, has been appointed associate coroner for the county of Wellington.

DR. J. W. DANIEL, St. John, N.B., recently read a paper before the St. John Medical Society on that city's milk supply and its control.

DR. JOHN CHISHOLM, son of Dr. Chisholm, M.P., of Wingham, has located at Prince Albert, Sask.

DR. J. P. PENNYFATHER, Holland, Man., will establish a Sanatorium for consumptives at Spruce Hills, Man.

DR. EDMUND E. KING has been unanimously elected to represent Toronto East in the Ontario Medical Council.

DR. J. S. HART, Toronto, has been elected to the Ontario Medical Council to represent West Toronto District.

DR. E. JESSOP's many friends will be pleased to learn of his success at Roland, Man., since opening an office there.

THE National Sanitarium Association has commenced the publication of a magazine called *Canadian Outdoor Life*.

DRS. C. J. FAGAN and J. E. Davie, Victoria, recently addressed the Board of Trade of Victoria on tuberculosis.

THE Medical Council of British Columbia at its recent session in Victoria refused to reinstate Dr. R. E. Telford, Vancouver.

AT the recent British Columbia medical examinations at Victoria there were twenty-four more candidates than in any previous year.

DR. McLAUGHLIN, of Dashwood, intends leaving in a short time for Europe, where he will take up some special study of his profession.

ADVANCED consumptives to the number of 149 were admitted to the Toronto Free Hospital for Consumptives during the past hospital year.

IT took \$15,267.00 to run the Montreal Maternity last official year. The births numbered 403. The city will be asked to aid the institution.

DR. WILLIAM WARWICK has been appointed assistant pathologist and bacteriologist to the St. John, N.B., hospital, assisting Dr. G. A. B. Addy.

DR. WALTER B. KENDALL, Toronto, has successfully passed the Edinburgh examinations, and will do further post-graduate work in London and Dublin.

IN the outdoor departments of the Montreal General Hospital 932 patients were treated to a conclusion during the last quarter. There were 11,927 consultations in the outdoor departments.

DR. THOMAS R. HENRY, who has practiced for the past three years with his father, Dr. S. M. Henry, of Harriston, Ont., has located at Burgessville, Ont., having bought out Dr. Service of that village.

AT the initial meeting of the Chatham Medical Association, held in Harrison Hall, officers were elected for 1906 as follows: President, Dr. R. V. Bray; Vice-President, Dr. Musson; Recording-Secretary, Dr. Sullivan.

DR. F. E. WATTS, a young Toronto physician, has been appointed assistant to Dr. Bell on the Provincial Board of Health. He will spend the winter among the railway and lumber camps of Northern Ontario.

THE Royal Sanitary Institute of Great Britain, through its Dominion Board of Examiners, will hold examinations in the Provincial Board of Health's offices, Parliament Building, Toronto, on the 18th of December.

WE congratulate Dr. J. H. Cormack, St. Thomas, upon his splendid run for the Ontario Medical Council. Dr. Cormack is one of the leading young practitioners of Western Ontario, and will make a desirable acquisition to the Council.

REV. R. G. SCOTT, Dauphin, Man., who has been doing missionary work amongst Galicians in that province, has entered the Manitoba Medical College to qualify for the degree of M.D., so as to more successfully carry on his missionary work.

YOU are invited to join the Surgeon's Club, of Rochester, Minn. The object of the club is to provide a common place for meeting fellow visitors and for study and discussion of matters of surgical interest. The president and recorder are elected each Monday. The permanent secretary and treasurer is elected annually. Reporters are appointed each day to take notes at the hospital the following morning. Daily meetings are held at the club rooms at 4 p.m. The fee is \$1.00, good for one visit or for one month. Permanent membership \$5.00, limited to 100 members.