# Western Canada Medical Journal

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SURGERY AND ALLIED SCIENCES

TWO DOLLARS A YEAR

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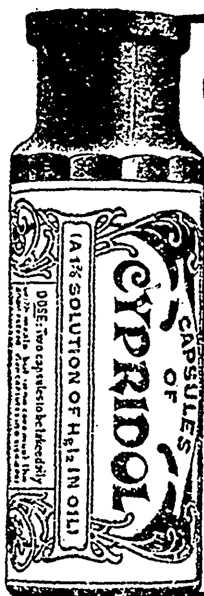


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# Western Canada Medical Journal

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REGINALD PHILLIPS, *Business Manager.*

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## INDEX TO CONTENTS


RICKETS ON THE PRAIRIE WITH SOME OBSERVATIONS ON PRACTICE ........ H. M. Speechly, M.D. 51

A PLEA FOR PURE MILK SUPPLY ........ A. L. Kendall, M.D.5 82

TALIPES VALGUS ........ R. C. Robertson, M.D. 69

EDITORIAL NOTES ........ 76

CORRESPONDENCE ........ 80

WINNIPEG CLINICAL SOCIETY ........ 8

MEDICAL NEWS ........ 9

BOOK REVIEW ........ 9


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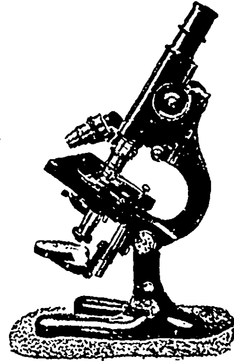

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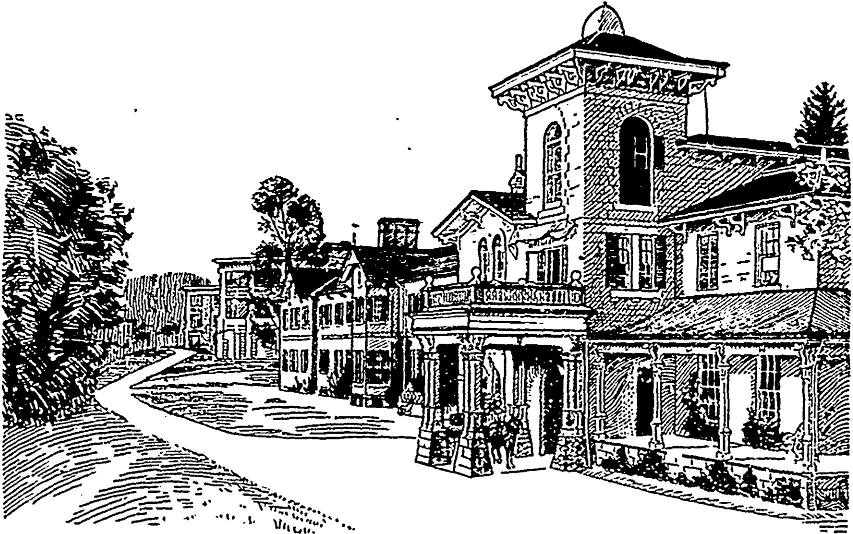

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# WESTERN CANADA MEDICAL JOURNAL

VOL. III. FEBRUARY, 1909. No. 2


## ORIGINAL COMMUNICATIONS.

## RICKETS ON THE PRAIRIE WITH SOME OTHER OBSERVATIONS ON PRACTICE


BY

H. M. SPEECHLY, M.R.C.S. (Eng.), L.R.C.P. London.

PILOT MOUND, MAN.


It might be expected that the disease known as Rickets or Rhachitis would be of rare occurrence in the rural parts of this Province. On this prairie that is actually the fact. I well remember in my first few weeks of practice here meeting a rough gruff farmer, who has since become one of my most faithful patients, saying, "Well, I guess you have quite a lot to learn about the special diseases of this country." My reply was, "Perhaps so, but in any case I am willing to learn." The sequel has proved my friend to be quite wrong. Why should he be right? The dwellers on this prairie are all of western European origin on whom come the complaints common to their race. In fact the boot is on the other leg. The medical man who has been trained thoroughly in one of the old seats of medical learning is familiar with the syphilitic and rheumatic states and with the rhachitic phenomena, of which younger men have seen but few cases, relatively. With the exception of certain phases of the entity called "prairie itch," which covers a multitude of diagnoses from eczema to syphilis,

there are no diseases peculiar to this prairie. Indeed diagnosis on the prairies is simpler by a good deal than in cities, real cities I mean with a population exceeding 100,000, mainly because syphilis and rhachitis are so uncommon.

I may be pardoned if I quote from the scholarly Hilton Fagge his account of the discovery of rickets as a diseased state. He says—"In the middle of the 17th century the famous anatomist and physician, Francis Glisson, drew attention to a disease affecting the bones of children which he supposed to have recently sprung up where it was first observed in the counties of Devon and Somerset. It was then known as "the rickets." On the ground that the dorsal spine is one of the first parts to be attacked and because the Greek word had some resemblance to the vernacular. Glisson styled the disease Rhachitis. Incidentally the word rickets is probably from the same root as the adjective "ricketty," as when one speaks of a ricketty chair, which is derived from the Anglo-Saxon "wrikken" to wrest or twist away.

Between the extreme acute rickets or infantile scurvy, which justifies Fagge's remark that "pathologically we may perhaps compare it best to scurvy," and through the well-marked cases to the other extreme of commencing rickets the symptoms are various and puzzling to anyone whose experience is from books only. If, however, a man has been in the thick of practical experience, such as the writer obtained in those "dear dead days beyond recall" in the ancient basement O. P. department of the good old London Hospital where ricketty children were thick as leaves in Vallombrosa, it would be discreditable indeed if he did not spot such cases however rare almost by instinct. The danger of rural practice is that a man inclines to become stereotyped and to lose that wary attitude of mind which refrains from too readily accepting even one's own diagnosis. Thus it is easy to find oneself forgetting possibilities and jumping at conclusions. Herewith I quote from memory a few facts about the half-dozen cases of ricketty children which I have encountered and which puzzled the local women of wisdom and authority, supposed or assumed, in infantile complaints.

First then, I will take the only case of acute rickets which

I have observed. It was the child of C., seven months old, which had been fed on the whole gamut of artificial foods. This was a tiny cranky marasmic mortal whose poor bones were so sore to the touch, nay his whole frame, that the poor child would make night and day hideous with his wailings. Sometimes his temperature was raised a degree or two. His digestive system was all awry from tongue to anus. Now his parents wanted to know why a swelling had appeared on, I think, the left thigh. Was it periostitis or an abscess or what? No, this was a haemorrhagic swelling of the skin and muscles, not unlike that which happens in real scurvy. In addition to the above symptoms the pallid, old facies, the sweaty head at night, and a tendency to the rib rosary indicated rickets, but there was no marked epiphyseal enlargement of the long bones. The cure? Patent foods were abolished and the child fed on orange juice, meat juices, and strained gruel. It had been noticed that the child yearned after the porridge on the table, significant sign. Ricketty children grow wild at the smell of good porridge or bread and milk. They are not so keen to take orange juice always, so that it is necessary to administer as much as they will take. Then there were the twin B. boys, square-headed, old-looking little chaps about a year old with fontanelles still unclosed, arched backs, delayed dentition, and sweaty heads at night and given to passing green, fetid stools. Even after appropriate treatment they declined to walk for months, because their bones were too weak to support them. Evidently they were affected by chronic rickets due to faulty dietary, owing to their mother's state of ill-health and inability to nurse them. Fruit Juice, bread and milk, gruel and grey powder put the bigger one to rights, but the smaller one was slower to respond and ere he got out of his ricketty state he was overtaken by a low form of congestion of one lung which carried him off despite all stimulation. Ricketty children are bad subjects for acute complaints. Due also to persistence in artificial food feeding was the S. child whose ricketty condition was also marked by broncho-pneumonia. With a good pulse, however, it was evident that the lung trouble was a side issue. To have treated the broncho-pneumonia only would have

been a mistake. Careful dieting, therefore, eventually transformed a puking, pallid, unhappy, constipated child into a normal little being. Two children were brought to me at different times from a distance with very similar symptoms to the above mentioned chronic cases, but their cases were complicated by obstinate vomiting induced by dietetic atrocities of the usual kind. The one recovered with difficulty but of the other I have heard nothing. All these children were Canadian born, but recently the child B., daughter of an English couple, was brought to me. This infant was between five and six months old and was a good sample of commencing rickets with slight enlargement of the epiphyses at the wrist, pallid and pasty in complexion and rather wizened. She had been fed artificially but yearned after the older child's porridge. Accordingly she was put on orange juice and strained gruel with immediate improvement. Unluckily during the hot spell in September last the parents over-fed the child and induced acute diarrhoea which was with immense difficulty quelled. There is no special drug treatment for rickets. After recognizing the condition I usually place the child on strained gruel, barley water, albumen water, raw meat juice or finely divided bread and milk. Small doses of grey powder or calomel with whatever magnesia or rhubarbs and magnesia mixture is favoured will usually settle the gastro-intestinal disorders. I world advise laying down the law on paper as to dietary details, because parents usually know nothing about diet and dieting. Regular daily baths and the gentle rubbing of body and limbs with camphorated oil are very useful and comforting additions to the treatment; and, while it is hardly necessary to urge the importance of good ventilation to the readers of this journal, it is important in furnace and stove-heated houses to remind the parents of the necessity for providing plenty of fresh air.

So much for rickets—by permission of the Editor and the readers of this journal I will ramble on a little further and allude to a few other experiences in more or less out-of-the-way complaints met with during the seven years of my prairie practice. Wherever I go I meet with the curious phenomenon known as Erythaema nodosum, so easy to spot

when once seen, so difficult to realize from book lore alone. Of the three cases I have seen in this neighborhood two were young women and one was a fine well-built farmer of about 40 years of age, whose system had previously become saturated with uric acid and other products of whatever we mean by auto-intoxication. This man had used through the winter large quantities of raw apples, porridge, and maple syrup, perhaps the three greatest sources of auto-toxaemia in the Province. One of the young women was in the same condition when the erythaema nodosum supervened, and I suspect the other was in a similar state, though I had no opportunity of investigating her case. Is not erythaema nodosum simply one of the manifestations of hydra-headed auto-toxaemia? None of these cases, as far as I am aware, showed any sign of cardiac disease, and it is worth noticing 'en passant' the fact that one of the cases was a man, because females are more liable to show this erythaema in the proportion of at least three to one, Stephen Mackenzie says five to one. To relieve the painful swellings on the anterior surface of the leg—the most usual site—nothing is better than rest in bed and a generous application of the medicated clay whether you call it Thermofuge or Anti-phlogistine.

Syphilis in all its stages is not very common on the prairies. In particular I can recall two roaring cases of tertiary phenomena, one of rupia of recent origin and another of multiple gummata of very ancient origin; also two cases of women innocent victims both, one married, the other unmarried, one had secondary manifestations moderately well-marked, and the other had a single gumma, details of which are for obvious local reasons suppressed. It is sufficient to state that the usual anti-syphilitic remedies were effective. I know of a fine case of Jacksonian epilepsy which which might have been amenable to operation, but the owner of the symptoms could not be persuaded to approach a hospital, partly because his condition justified his remaining the parasite on friends and relatives he had already become. Popular opinion was uncertain whether to pronounce him a humbug, but I have no doubt that he was a genuine case, having witnessed his symptoms more than once. Without losing consciousness, and only

occasionally becoming unable to stand during the nerve explosion, he was seized gradually with tonic spasms of his thumb muscles, sometimes on one side, sometimes on both sides. This state of spasms would extend to the whole arm and occasionally to the whole of one side, when he would be unable to stand. No exact cause of the condition could be stated, though it was attributed to a blow on the head received many years previously. He denied syphilis, and iodide of potassium in 30 grain daily allowance had but little effect, unless it slightly lessened the tonic contractions.

With regard to midwifery, I consider chloroform and the judicious use of the A.M.C. tablet as better aids than instrumental interference while of course I do not deny the necessity for the use of forceps on occasion. It may astonish some of your readers to know that in seven years I have used forceps only three times and am not at all ashamed of my record as an obstetrician. Of course I have performed internal version also and once had to undertake Caesarian section for contracted pelvis, two other medical men assisting; but this last operation was "un dernier ressort" and the patient died. I am quite certain that I would never teach a student to use forceps very often, but that, where the patient's condition as shown by the state of the pulse justified it, and under certain special conditions requiring haste, the use of forceps would be the lesser of two evils and should therefore be chosen. Out of five eclamptics, two six-months primiparae, in one of which premature delivery was effected, died and the other three recovered. Of these three one was a primipara and the other two multiparae. I have used chloroform, pilocarpin, and eliminative treatment in all these cases, but have never yet bled an eclamptic or used veratrin. Regarding eclampsia as a general auto-toxaemia in which all the digestive and execretory organs are involved, I think it should be the general practitioner's ambition to so educate his patients in elimination and watchfulness that eclampsia should be of the rarest possible occurrence. After securing as perfect drainage of the body as possible the pregnant woman should be carefully instructed as to the principles of dieting. Every pregnant woman ought to have her urine frequently ex-

amined during the last half of pregnancy at least. She should be taught her individual responsibility for her future child and that the absurd use of pickles, apples, candies, vinegar, and such like tend to form a fermenting foecal accumulation in a passage already tortuous and now increasingly hampered in its function by the intrusion of the growing uterus.

In presenting these notes the present writer is very conscious that to older practitioners they will seem very commonplace and lacking in originality, but believing they may be suggestive to some who have been but a short time in the profession he ventures to add his quota to the pages of this Journal.

# A PLEA FOR A PURE MILK SUPPLY

BY

A. L. KENDALL, M.D.C.M., McGill

VANCOUVER, B C.

One excuse for the writing of this paper, if one is needed, is the fact that in British Columbia there is no law, compelling dealers in milk to conform to a standard in regard to the quality and cleanliness in milk. In fact insofar as British Columbia is concerned, there is not provincial law of any kind governing the sale of milk. The situation calls for the gravest consideration. Up to a few months ago it is true, that there was a law, an absolute meaningless and unworkable act in force, through which milkmen were able to deliver dirty milk, fearlessly knowing that they could not be punished. The fat percentage required by the act, was much lower than that required anywhere else, and no bacterial content as mentioned. Even this poor excuse for a law was knocked down and out by Justice Clement, and his judgment was sustained on appeal to the full court. The situation at present is this,—there is a Dominion law supposed to be in force, requiring a certain percentage of fat, solids, etc., in milk, and through the pure food laws the milkman can be gotten at for adding adulterants. But strange to say, there is no official here to whom the power of prosecution is delegated. The customs officers are supposed to have this power, but have never exercised their prerogative. According to Justice Clement's ruling, no Province or Municipality in Canada has the power to pass laws governing the sale of that most universal of foods—milk. In the Dominion Act there is no mention made of a bacteriological standard, which is the most essential factor in getting pure milk supplied.

To sum it then, in British Columbia we are absolutely at sea, no local laws of any kind on the milk question and no one to test milk and carry on prosecution under the Dominion Act, which is at least a sorely defective one. The question of

bettering our milk supply is, I consider, a matter of more importance than any at the present time confronting the Health Authorities of British Columbia or Canada. It is of more importance than the building of sanitariums for the treatment of tuberculosis, for one aims at an uncertain cure, the other is a preventive factor. I am not be-littling the importance of the building of sanotariums for tuberculosis, but I do want to emphasize the importance of a pure milk crusade. I find that until about 1880 there was comparatively but little done in America, and less in the United Kingdom towards the bettering of the Dairy conditions. Since, however, a closer study in the milk chemically and more especially bacteriologically, and into the results arising from the feeding of infected and dirty milk to infants, has resulted in a great quantity of literature being published, and in places where intelligent authorities have acted on the information so derived, there has been a sharp drop in the percentage of deaths from the summer diarrhoea, Infective Diarrhoea, the disease which accounts for more deaths, than all the combined other infectious diseases, including Tuberculosis, is a disease which Dr. Robertson, of Birmingham, designates "a dirt disease." The infection is always through the food, and almost always through the milk supply.

I remember as a student in Montreal, that one summer an exceptionally hot one, that over ninety per cent. of all children entering the various foundling homes of that city during the summer months, died from diarrhoea. One child in six born in Monteral pays the death penalty before the age of two years. A wonderful tribute to the wisdom and efficiency of their health law, and the machinery of carrying such laws in force.

Gaffiking of Warrington, England, states that for that section of the country, which is a fair index of all England, that epidemic Diarrhoea accounts for more deaths than Measles, Scarlet Fever, Diphtheria and Whooping Cough combined. And that its death roll under twelve months almost equals that of Phthisis, for all ages.

The British Journal for Childrens Diseases, September, 1906, states that the infantile death rate in the United King-

dom is practically the same as it was in 1850. In sharp contrast with this statement, is the report of a New York City Health Board, which is as follows:—

| Date | Deaths from Diarrhoea. | % of Total Deaths. |
|---|---|---|
| 1882 | 4,050 | 10.68 |
| 1883 | 3,398 | 9.99 |
| 1884 | 3,679 | 10.51 |
| 1885 | 3,426 | 9.60 |
| 1886 | 3,494 | 9.35 |
| 1887 | 3,762 | 9.66 |
| 1888 | 3,489 | 9.68 |
| 1889 | 3,648 | 9.18 |
| 1890 | 3,346 | 8.34 |
| 1891 | 3,587 | 8.22 |
| 1892 | 3,602 | 8.13 |
| 1893 | 3,310 | 7.44 |
| 1894 | 3,040 | 7.38 |
| 1895 | 3,237 | 7.39 |
| 1896 | —— | 6.90 |

To show the relationship of the hottest weather, to the infantile deaths in the three hottest weeks in the City of New York in 1872, 1892 and 1896, I will read the following statistics:—

| Year | Total Deaths | Under 12 mo. | Diarrhoea | Total % | % Under 12 mo. |
|---|---|---|---|---|---|
| 1872 | 1,569 | 733 | 496 | 46.7 | 67.5 |
| 1892 | 1,434 | 563 | 293 | 39.3 | 52.0 |
| 1896 | 1,810 | 391 | 128 | 21.6 | 32.7 |

For 1900 in New York City, the total deaths in males charged against Small-pox, Chicken-pox, Measles, Scarlet Fever, Dyphtheria, Mumps, Whooping Cough, Typhoid, Influenza and Cerebro-spinal-fever was 5.438, 1,690 of these being under 5 years of age. For the same time there were 3,851 deaths from diarrhoea, 1834 being under 5 years. In addition there were 1,348 deaths charged to Marasmus, (a really rare disease), and inanition. Many of these deaths were undoubtedly due to diarrhoea, but not put down to such cause, through faulty classification.

J. Wicliffe Peck, Chemist of Great Ormond Street Hospital for children, London, says that in England, that one in ten babies is sacrificed to the Moloch of rotten milk.

When the City of New York fed the babies in charge of the City on milk from carefully selected cows fed on the Island, the death rate was as follows:—

| Date | Treated. | Died. | Percent. |
|---|---|---|---|
| 1895 | 1,216 | 511 | 47.02 |
| 1896 | 1,212 | 478 | 39.11 |
| 1897 | 1,181 | 524 | 44.36 |
| | | Average | 43.99 |

A pasteurizing plant was installed early in 1898, no other change in food conditions being made and the death rate was as follows:—

| Date. | Treated. | Died. | Percent. |
|---|---|---|---|
| | | Average | 43.49% |
| 1898 | 1,284 | 255 | 19.20 |
| 1899 | 1,097 | 269 | 24.52 |
| 1900 | 1,084 | 300 | 27.50 |
| 1901 | 1,028 | 186 | 15.09 |
| 1902 | 870 | 101 | 22.07 |
| 1903 | 542 | 111 | 15.63 |
| 1904 | 345 | 57 | 18.52 |

It would be an easy matter to indefinitely pad my paper with statistics, but what I have just read will go to convince anyone that the question of pure milk is one of some importance. All pediatrists claim that an overwhelming percentage of deaths in infants due to Diarrhoea, is due to contaminated and infected milk. Dr. Osler was once approached by a woman, who with tears in her eyes told him that Providence had seen fit to take away her baby, he responded that it was unfair to blame providence, who had nothing to do with the matter, and said, "It was rotten milk that killed your baby."

By far the greatest number of all these deaths occur in the summer months, or at the time when bacteria develop with enormous rapidity, and decomposition takes place in a very few hours in milk not properly handled and cared for. It has been proven by Freudenrich, that milk that contained 9,300 bacteria, two and a half hours after milking had increased to 5,700,000 per C.C. when kept at 59 degrees F. And kept at 77 degrees F, there were 577,500,000 bacteria per C.C.

It is extremely rare that milk in Vancouver will contain anything like as low as 9,000 bacteria per C.C., two and a half hours after milking. But for argument sake let us presume that such is the case. The highest temperature in July 1908 was 87.2 degrees F. The lowest 43.0, and the mean temperature 63.56 degrees F, so at this rate we must presume that our milk contains six million bacteria per C.C., at the end of 24 hours under the best of circumstances. When we consider that much of the milk used here is 48 hours old before the next supply is delivered the bacterial count is beyond the computing power of man.

| Specimen. | No. of Exams. | No. of Bac. | Hrs. After Milking. |
|---|---|---|---|
| 1 | 8 | 250,000 | 4 |
| 2 | 1 | 5,000,000 plus. | 16 |
| 3 | 1 | 150,000 | 4 |
| 4 | 1 | 800,000 | 8 |
| 5 | 1 | 60,000,000 | As delivered |
| 6 | 1 | 5,000,000 | " |
| 7 | 1 | 11,000,000 | " |
| 8 | 1 | 12,000,000 | " |
| 9 | 7 | 10,000 minus | 4 hours after milking. |

It is interesting to note that samples 1 and 9 containing 250,000 and 10,000 respectively per C. C. contained no sediment on standing or in other words no dirt. The dairymen selling this milk were found to be rinsing their cans with boiling water, and were more than ordinary careful about their dairies. Further they had not expensive apparatus for the production of milk, and if these men can deliver milk as good as they are doing, there is no reason why others should not do the same. Another thing worth remembering about the bacterial count above mentioned, is the fact that it was taken from milk at the time of delivery, and was intended to last till delivery, 24 hours later.

The condition under which milk is produced and shipped into Vancouver, is a lasting disgrace. Having practiced four years in a country district, supplying a large quantity of milk to the Vancouver market, I am in a fair position to know these conditions. I must state at the outset, that there is a sincere desire among the farmers to deliver as good an article

of milk as possible, while some others are hopelessly incompetent to supply a milk pure enough, except for the raising of hogs. The climate conditions are such, and transportation facilities so limited that a clean milk is a most difficult problem.

To commence with there is no proper veterinary inspection of cattle. Tuberculosis is known to be very prevalent among cattle in the Fraser Valley, and although we know that beyond a doubt that Bovine Tuberculosis is communicable to man, yet the Dominion Government will not make inspection and segregation compulsory, simply because they will have to pay out a few thousand dollars to eliminate the disease. In Holland stringent precautions have been observed for some years in the isolation of tuberculosis cattle, with the result that tuberculosis has almost been stamped out of their herds. In British Columbia we are no worse off in this respect than the United Kingdom, where according to Hullett (Professor Bac., Kings College, London), there are 80,000 tuberculosis cows supplying milk to the market, these figures however do not excuse us from our responsibility in the matter.

Another evil in the Fraser Valley is the attendant evils following so much rain. The annual rainfall being between 60 to 70 inches. It means that the roads leading away from stables for six months in the year are mires of manure, through which cows drag their bags and bellies. Currying and brushing cows thoroughly is almost unknown among our farmers. The hair on the underside of the belly is seldom clipped and if the bags are washed it is done in such a fashion as to make the manure present on the bag nice and liquid, so that when milking is begun, it flows with the milky stream into the pails and is shipped into town to be fed to our babies. Renk estimates that ordinary milk contains 6 ounces of dirt and manure per 100 gallons. Under present conditions it is unsafe to estimate the amount of manure coming into Vancouver in the milk supply. It is safe, however, to say, that it will be the most of that that is on the bags of the cows at the time of milking.

Our farmers further do not know what the sterilization

of milking utensils and delivery cans means. For if these utensils are scalded it means that a dipper of hot water is thrown in a ten gallon can and gently agitated for a few seconds. Mind you I think that the average farmer here does pretty nearly as well as he knows how or has made more or less attempt at it. One thing, he however cannot watch over, is the cleanliness in the hands, person and methods of Asiatics of all kinds, including a large percentage of greasy Hindus who do much of the milking.

Transportation facilities into Vancouver are such, that much of the milk is 48 hours old before the next supply comes in, as there is no ice being used to cool the milk or packed with the cans in transportation, the condition of this milk cannot be very well imagined. Certainly the bacteria in it cannot be counted.

The infant mortality in Vancouver, although high, cannot be all blamed on the milk, as owing to a certain amount of public agitation of the subject of pure milk, has led to the great majority of mothers and nurses giving their babies other foods than cow's milk, The deaths in Vancouver last year among infants under twelve months were 148, of which were due to Diarrhoea disease of intestinal disorders.

Now how are we to remedy a condition which effects not only Vancouver, but British Columbia and all Canada, for this important matter has as yet received scant attention anywhere in Canada. The greatest advance for a pure milk supply has undoubtedly been made in certain sections of the United States, in these sections, as statistics show, they have cut the death rate in half and each year thousands of infants are being saved, where under methods in vogue ten or fifteen years ago they would have been sacrificed. A glance at the methods they have adopted will enlighten us to some extent. The main advance has been made through the medium of the milk commissions, and certain scientific dairies.

To Dr. Henry Y. Coit, of New York, N. J., alone belongs the credit of having started the idea of a medical milk commission. Driven to exasperation in attempting to feed his own child by artificial means and hoping to gain nothing through indifferent and negligent legislatures he evolved his

idea of a medical commission and with characteristic energy fought this scheme through to success, and after several years got it on a working basis. The first milk commission was formed in Essex County, N. J., April 13, 1893, and since the idea has spread rapidly until most of the large cities have come into the possession of medical commissions, and a pure milk supply at least for infants and the sick. Briefly the scheme is as follows:—The medical societies of the various places appoint a commission of from three to five medical men who give their services free. This commission then meets and forms a standard to work from, and demand that the dairymen whose milk is certified shall voluntarily place the management of his dairy in regard to cleanliness, health of the cows, and delivery of milk in the hands of the commission. His cows, stables, and utensils shall be inspected at stated intervals by one of the commission or by a competent veterinary surgeon, and the cows are tested periodically for tuberculosis or other disease. The stables, milk houses, and utensils must be above reproach, wash basins, hand brushes, soap and plenty of clean water are kept apart for the milkers, who must use them conscientiously on their hands, white canvas suits are usually worn at milking time. The hair on the bags and bellies of the cows is kept clipped as short as possible. The cows are curried and cleaned daily as would be a thoroughbred horse. And in fact the little details which are compulsory in the production of clean milk must be observed and are subject at any time to inspection by the commission or its deputies.

There are two brands of milk delivered under the commission—certified milk and inspected milk.

Certified milk must contain 4% butter fat, solids 13%, bacterial count 10,000 max.

Inspected milk fat 3 to 4%, solids 13%, bacteria 100,000 max. in summer and 60,000 max. in winter. Certified milk is put up in glass bottles, and sealed while inspected milk may be delivered in cans properly inspected. The temperature of inspected milk must not be more than 50 degrees F. While certified milk must be kept 45 degrees max. temp.

The different milk commissions have different standards,

but on the whole it adheres to the above. Each commission has its own bacteriologist, using the City Official or when the business is large enough to demand it they have one especially for their own work.

The money for carrying out the work of the commission is raised by selling caps for bottles. These caps are made in two colors for certified and inspected milk respectively. They cost about $200 per million and are sold for $4.74 per thousand.

The advantage to the dairyman is that he is enabled to sell his milk at a considerable higher figure than his neighbor, who is not, or cannot qualify to place himself under the commission. The advantage to the public cannot be estimated.

Milk of this class naturally must be sold at a considerable advance over ordinary milk, and the public must be educated through the family physician. and by the medium of the press. Professor Harrington makes the statement that the average public would rather pay 8 cents a quart for milk plus manure than to pay 9 cents a quart for milk not so flavored. In Boston, Mass., the charitable societies have a fund whereby high-class milk may be supplied to poor people at ordinary rates.

The City of Rochester, N. J., were so impressed with the work of the commission that they decided to go into the dairy business on their own account. The idea being to supply a pure and hygienic milk and eliminate the question of profit. The result was to put certified milk within the reach of even the poorest, and in the first year of experiment in Rochester, the infantile death dropped 50%, and as the improvement still remains from year to year, it proves beyond a doubt that bad milk was a huge factor in Rochester in the infantile death rate.

There is no reason why other cities should not follow in the footsteps of Rochester, as an absolutely pure and clean milk can be produced for five to six cents per quart, and still be made to pay interest on the investment of the money.

Giving a case where mother's milk cannot be obtained for a baby there is no food known which is so efficacious as pure milk from cows. On the proprietary foods some infants will prosper, but they are very prone to Rickets,, Scurvy and intestinal disorders. Pasteurized milk, as shown by the New

York authorities, is infinitely better than cow's milk ordinarily produced and cared for, but on the other hand the pasteurization of milk is unnecessary, unless the milk is dirty and infected with too many micro-organisms to start with. Further pasteurized milk cannot be fed to infants indefinitely without the same danger attending the feeding of proprietary foods.

Much has been done in an educative way by the scientific dairies supplying certain cities in America and including Montreal in Canada. The lion's share of credit is due to the Walker-Gordon dairies. The original Walker-Gordon dairy was started as a fad, it was found to pay and at present almost all large cities in the United States have one of this company's dairies. And they have extended their business to Montreal and to several cities in England. They make a specialty of supplying milk for infant feeding, and the physicians instead of having the laborious plan to follow of explaining to mothers, many of them very ignorant, how to prepare modified milk, simply write a prescription calling for the 24 hours quantity of milk needed, containing whatever percentages of fat, prote, alkalinity and sugar deemed necessary for the case. This prescription milk is delivered on ice at a temperature not higher than 45 degrees F., and the mother or nurse fills the number of bottles required for the 24 hours' feeding; absorbent plugs are placed in the necks of the bottles, which are then placed on ice or in a cool place till feeding time. Such a dairy has been organized on a large scale in Vancouver, and will fill, when properly running, much of the demand as far as infant feeding and the feeding of the sick is concerned. The matter of legislation on milk is one which our provincial parliament will approach with extreme caution, owing to the number of rural representatives in the house. The Vancouver Medical Society last spring petitioned the Hon. Provincial Secrtary for a meeting, between himself, Dr. Fagan, Secretary of the Provincial Board of Health, a delegation from the Vancouver Board of Health and the Vancouver Medical Society Milk Committee, consisting or Dr. Gillies, Riggs and myself. The result was "no meeting" and no hope was held out by the Provincial Secretary that in the

future such a conference might be obtained. The desirability of such a body meeting the Provincial Secretary and discussing the most important question cannot be denied and I only hope that the Hon. Provincial Secretary will sometime in the near future grant us a hearing.

Some action will evidently have to be taken by the Dominion Parliament in giving to the various Provinces the right to construct and carry into force laws governing the sale of milk.

The question of pure milk is a very large one and fragmentary and disjointed as this paper may be I hope it will produce a vigorous discussion from the society that will lead to the bettering of the condition.

# TALIPES VALGUS

BY

A. C. ROBERTSON, M.D.

EDMONTON, ALTA.

Talipes Valgus, or Flat Foot is a deformity characterized by a marked pronation of the foot with obliteration of the arch, and with abduction of the front part of the foot. May be either congenital or acquired.

The congenital type is very common, I have noticed many children in this city, particularly among the foreign element who are suffering from this affection, these presented marked congenital flat foot, that is to say, the sole of the foot was convex or nearly so, and the whole foot pronated or rolled out. Very frequently you have associated a congenital calcaneo or equino valgus, more commonly the former condition.

The characteristics of the deformity in congenital valgus are a strongly pronated and abducted position of the foot relatively to the axis of the leg, with commonly two projections on the inner side of the foot corresponding to the head of the Astragalus and the side of the Scaphoid bone.

Acquired Valgus.—This type is much more common than the congenital, about 17% being shown in statistics, and is of several varieties, viz., Rachitic, Static, Paralytic, Spastic and Traumatic or Inflamatory.

Rachitic Valgus.—This variety is chiefly seen in connection with other evidences of Rickets, mainly with knock knee and to the extent that it is considered as one of the chief causes of knock knee, but it may also be seen before osseous deformity is marked and usually before the seventh year.

Static Valgus.—or typical flat foot is the most common of the different varieties and seen mostly in young adolescents approaching puberty, but may be seen in younger children, in some cases associated with so mild a degree of rickets

as to be difficult of classification as regards the Rachitic or Static variety. It appears in weak patients of imperfect muscular development and at any stage of life or age, is favored by ill-health and by anything which tends to depress the general condition, rapid growth is a very important factor, for the reason that the newly formed tissues are not able to bear the strain of the increased work.

This form of Valgus coexists to a large degree with lateral Spinal Curvature, even to the extent of two in every three cases, 65% of all cases of flat foot occur between the ages of 15 and 20 years, and are mainly found in adults who are obliged to stand continuously, as waiters, barbers, nurses, bakers, etc.., and the cause most commonly ascribed is, the superincumbent weight falling upon an ankle and foot unable to sustain it, or the disproportion between the body weight and the apparatus intended to sustain it.

Some authorities are of the opinion that the deformity is an anomaly of growth, that is to say, a persistence of the physiological pronation in the medio tarsal articulation (calcaneo—Cuboid and Astragalo—Scaphoid) which is normal when the child is at an age for sustaining weight, and that in Static flat foot an excess in the growth of certain portions of the Tarsal bones takes place and deformity results.

The sole of the foot of an infant is flatter than that of an older child, is slightly turned in and the absence of an arch may be seen by taking a tracing on smoked glass from a child say ten months old. The arch begins to form at about the age of one year.

Many writers have regarded the deformity as chiefly due to a contraction of the extensor and pronator (peroneal) group of muscles. Lorenz concludes that the deformity is due to an alteration in the positions of the Astragalus, Os Calsis and Scaphoid, which is simply an excessive pronation of the front of the foot at the medio-tarsal joint, and is the effect of weight falling upon a foot unable to sustain it.

Traumatic or Inflamatory Flat Foot.—The most common cause of traumatic flat foot is Pott's Fracture, where a valgus is the result of inefficient treatment or of a very severe and intractible fracture.

In severe ankle joint disease with destruction of tissue one sometimes sees very marked flat foot, which does not tend to grow worse because of the generally firm ankylosis of the joint, but the deformity may be severe.

Injury to, or functional impotence of the long peroneal muscle ,favors development of the condition.

Pathological Anatomy.—The anatomical changes are much the same in congenital and acquired flat foot. The bones in congenital flat foot even in severe cases show but little alteration in shape, the Astragalus is turned obliquely to one side and downward and the angle of the articulation faces more to the side than normal. The end of the Os Calcis may be slightly raised. The Scaphoid is turned to the outer side and is rotated somewhat on its central axis, so that the outer side is raised and the inner side lowered, the arch of the foot is obliterated and the inner side is more convex rather than concave.

In acquired flat foot the anatomical changes show very few alterations in the shape of the bones in light cases, the Astragalus is turned obliquely forward and downward and its head altered in position, so that its facet is on the outer side, the Scaphoid is rotated and its outer side raised. In severe cases there is almost complete dislocation of the Scaphoid outwards and sometimes there is a formation of osseous deposit which prevents the normal amount of play between the Scaphoid and the Astragalus.

Of the ligaments, the most important are the Inferior Calcaneo-Scaphoid and the Calcaneo-Astragaloid, the latter being the most important in its function of holding the Keystone of the arch in place, than does any arrangement of its components, all other ligaments connected with the concavity of the foot contributing to a lesser degree.

In all these cases we have a limitation of the ankle motion to the extent of even 35 degrees, the normal motion being from 76 to 80 degrees.

A slight amount of pronation when the foot is on the floor due to the superimposed weight, is normal, the excess being prevented by the muscles and ligaments.

The muscles which by their tonicity assist the ligaments

are those which pass around the inner malleolus to be inserted into the anterior part of the sole, the chief one being the Tibialis Posticus, which muscle is to some degree assisted by the Tibialis anticus and proneus longus. Long continued standing tends to weaken the muscles, thus throwing the strain on the ligaments, and being often repeated tends to weaken the ligaments while the weaker the muscular development, the sooner they become fatigued and the less resistance the ligamentous bands will possess. Any yielding of these ligaments will soon be manifested by the lessening of the concavity of the inner side of the foot.

The so-called "attitude of rest" is a strong contributing factor, the active position of the foot is one of adduction; abduction requires the least muscular exertion and consequently the greatest amount of ligamentous support.

Ill fitting shoes, especially those with pointed toes, favor a gait with the feet abducted, which in itself favors the development of the condition of flat foot.

Symptoms.—The foot has the appearance of being broad, abnormally long, is more or less everted and in severe cases the head of the Astragalus and Scaphoid tubercle form a marked bony prominence at the middle of the inner border of the foot.

The variation of the arch is best determined by a tracing made by wetting the sole of the foot and placing it upon a smooth sheet of ordinary brown paper, then enclosing the wetted outline with a lead pencil tracing.

The inner ankle is overly prominent and the whole foot is in an altered relation to the axis of the leg and has the appearance of being displaced outwards.

In severe cases the inner border of the foot presents a convex outline, the outer border is raised by contraction of the Peronei, causing the weight to be even more improperly transmitted.

Pain and tenderness are almost constantly present, being most marked over the Astragalo-Scaphoid articulation, in front of the internal malleolus and at the base of the first and fifth metatarsal bones, occasionally pain may be felt in front of the external malleolus. Coldness and numbness, conges-

tion and increased perspiration, caused by the impaired circulation and weakness, are common symptoms in this class of cases. Actual pain is felt only when the foot is in use; it ceases under temporary rest or relief from disproportionate work, and it is this remittance of symptoms, together with the fact that the discomfort is more marked in damp weather, that leads so often to the mistaken diagnosis of rheumatism.

The weak and dislocated foot is subjected to constant injury, to what may be considered or likened to a succession of light sprains, so that local congestion, tenderness, and swelling may appear together with muscular spasm, rigidity and pain on excessive motion.

Another symptom, the discomfort in changing from a position of rest to one of activity, which is usually present in slight degree at every stage, now becomes more prominent. The patient, after sitting, or on rising in the morning, is unable to walk, but staggers or limps for several minutes, which is explained by the fact that when the patient is at rest there is a partial reposition of the displaced bones, which become again forced into the position of deformity.

The pain and discomfort are more general in character, and are often referred to the Dorsum of the foot, representing muscular rigidity and tension, and to the ankle where the external malleolus is grinding out a facet on the projecting Os Calcis.

In acute cases there may be swelling, localized heat and redness, as for instance at the base of the first metatarsal bone. It does not follow that the degree of flat foot influences the amount of pain experienced, pain being often most severe in the least marked cases, while in cases where the structural change is very advanced, it may be insignificant. Pain is induced by walking or long standing, shooting up the legs, even into the thighs, and persists often for hours after the patient lies down, being sufficiently severe to prevent sleep.

Children as a rule do not suffer pain as does the adult, but towards night will complain of the feet aching.

The gait is characteristic, the feet are everted, the natural elasticity is wanting, and the patient complains of his feet being stiff and clumsy, while in standing the patient deliber-

ately throws the foot over so that the weight is borne more upon the inner border than is normal.

Diagnosis.—Breaking down of the arch with pronation of the foot, prominence of the inner malleolus.

Pain in foot and leg, coming on after standing, worse at night than in morning, with tenderness in the characteristic points.

Flat foot is most frequently confounded with Rheumatism but an examination of the arch with the characteristic points of tenderness, taken with the history of the case will usually be sufficient.

Any variation from the proper distribution of weight and strain upon the foot may be determined by drawing a line through the crest of the tibia from the center of the patella, continued over the foot should meet the interval between the second and third toes, if it falls over or inside the great toe, it shows that the foot is working to a disadvantage.

Prognosis.—The results of treatment are immediate and satisfactory. In cases of average severity relief can generally be given by very simple measures, a spontaneous cure is not to be expected.

Treatment.—Treatment will depend upon the nature of the deformity, its severity and duration. In children the general condition must be given attention. In Rachitic subjects this part of the treatment must be carefully attended to.

In older children with milder deformity it is best to correct the deformity by increasing the tonicity of the muscles than by the use of apparatus, giving proper systematic exercises, for example, rising on tip toe and walking on tip toe, regularly for some time each day.

Only the mildest cases can be treated by gymnastics alone, in most cases the standing position is characterized by so bad a position of the feet that some support to the arch is required to sustain it in an approximately correct position, this is best done by a thin metal support, shaped to fit the arch of the normal sole and worn inside the shoe.

In the most severe cases, before beginning other treatment it may be necessary to anaesthetize the patient and forcibly correct the deformity, the reduction being accom-

panied by the audible snapping of bands of adhesions, force the foot into a condition of over-correction and hold in that position by thick application of plaster Paris upon which the patient is encouraged to walk, the foot being so held for a period of time ranging up to four weeks. The necessity for longer retention in this way will be determined by the condition in which the foot is found upon removal of the plaster Paris.

In certain instances it will be necessary to divide the Tendo Achillis, when, for example, the range of dorsal flection is limited by resistant accommodative shortening of the calf muscles or when there has been very great pain or tenderness at the medio tarsal joint, and it is desired to remove the strain of leverage completely. Traumatic cases come especially under this head.

When complete correction is accomplished by this method the foot may be supported by one of the many plates devised for that purpose.

## EDITORIAL

So far the comments on Dr. Kennedy's letter, which appeared in last month's issue, are favorable to his proposal and it is thought time we took united action so that when the Dominion Conference meets at Winnipeg in August the men of the West will have come to an agreement as to the best policy to adopt. The proposal is clearly for the good of the profession as a whole—not just to benefit any special school or province and any individual who expects every school, individual and province to benefit at once by the proposed reform, exposes his provincial outlook. It is a law of life without exception that in order to obtain certain advantages we must forego certain others. Dr. Kennedy pointed out the absolute necessity for the sinking of self-interest. The members in truth who are blocking this measure are those who are more intent on the loaves and fishes of office than on their profession's welfare. One would imagine that, as we know we must progress or decay in life, they would realize that such a purely material object would inevitably lead to deterioration. Then there are those others who always stand by and watch saying they "have no objection and will not interfere." To these we may say "He that is not with us, is against us." Some of these are unfortunately on our Councils. When we appoint men on our Councils, it is to represent us, not to merely attend meetings. They should be heard giving forth definite opinions, and those who, while holding official positions, simply adopt a let-alone attitude, can hardly wonder if those who elected them say they are not representing, but misrepresenting, and the sooner the time comes for them to return to private life, the better. It is a good sign, however, that two men of the standing of Dr. Kennedy and Dr. Paterson should lead off by giving definite views on the subject. No one can possible accuse either of gaining anything by taking up the cudgels in defence of a Western Union and Reciprocity. They are not new or young men in the West, but pioneers—men holding important positions. We do not

object to opposition but to apathy or that meanest of attitudes "sitting on the fence." By opposition we hear of the weak points in our proposed reform. Therefore, criticism is welcome, for only so can we get strong and progress. It cannot be denied that the time has come when Reciprocity is an issue of greater importance to the profession than any other. Therefore it should be the pride of every man who has faith in this principle tq give it his moral and personal support and thus inthus increase the strength of the cause. We are told in a paper read at the American Editor's Association that the future holds two prospects—(1) Decline of medical prestige and era of quackery, or (2) a general readjustment of the medical situation. If this is needed in the States, it is certainly needed in Western Canada. Fortunately there already exists a strong desire for unity and it is for us to foster or hinder it. The principal hindrances are the members who maintain an unsympathetic attitude and the interests of vested rights. However, these difficulties might be amicably overcome if we could arouse that unselfish desire for our profession's good that Dr. Kennedy says is needed. What a chance we in the West have—untrammelled by the past, with the great experience of the outside medical world from which to learn! Surely, we will see to it that number one prospect will not be our fate!

As Dr. Paterson says, if registration is to be limited to Provinces, why not to Municipalities, and why should qualified men on the border line be liable to prosecution as quacks. It would be well also for our Councils to note that great changes in facilities for medical education are taking place in the West which may tend to limit the powers of the various colleges of physicians and surgeons. It certainly would seem wise for these colleges to exercise a little foresight and go seriously into the matter—discuss Dr. Kennedy's proposal and consider that of Dr. Paterson in which he thinks it advisable for the Colleges to pay the expenses of a delegate to visit each Western Province. One can at once see the great assistance a delegate would be in getting at the real desire of the men, and we might also get the voice of the profession by a plebiscite. In the treasuries of the four Western Provinces should

be ample funds with which at present nothing is being done and from which the profession is receiving no benefit. This would be one way for them to benefit. That the status of the profession would be raised by one examination conducted by the most capable men from each province can not for a moment be doubted. It is said B. C. will not consider Reciprocity, but clearly it is not the general profession of B. C., but the selfish attitude of several members of the Council and we hear the men do not consider they are represented on this matter by the attitude of their council. The great distances in B. C. make attendance at meetings to vote difficult for those away in outlying, isolated districts and so it is easier there than anywhere else for medical affairs to get into the hands of a few. That no member has troubled to take notice of Dr. Smith's letter is surprising, as that letter practically accused the B. C. Council of arrogance or weakness. It is all very well to leave things alone, but those who take office have a duty to their electors. Possibly they may have good reasons, but why not come out frankly and give them and so prove they are doing their best for their profession. In Dr. Speechly's paper the fallacy of the objection often raised that one needs special medical knowledge for each province is clearly shown. Let each supporter then endeavor to rouse interest in this important professional matter so that we may proceed to organize and agitate along legitimate lines. The time has come when a definite plan must be adopted. So far there has been too much drifting. Of the two hindrances, apathy and opposition—it is the apathy which is the greatest block to progress. Active opponents, no doubt, have their reasons, but we wish they would give them forth. All we want is for each man to vote for the principle in which he truly believes. If he does not do this, then we become the victims of opportunism and wire-pulling, and progress is hopeless. Our future professional welfare is at stake as well as the welfare of the public and it certainly is the duty of all those who have knowledge and experience to come forward and help us map out the best policy to be adopted.

The Manitoba Meeting to be held at Brandon on June 22nd and 23rd would be a very opportune time for final dis-

cussions so that the West may bring a united opinion to the Dominion Conference in August. Let each member who believes in Reciprocity and a Western Association proceed at once to do his part towards a successful and harmonious gathering at Brandon, and let the profession of each province see that their Councils proceed to elect delegates as their representatives to confer on these important matters.

Answer to Subscriber, Sask.—The reason the Report of the Annual Meeting of the Saskatchewan Medical Society in July last, and the papers read at that meeting have never appeared in the W. C. M. Journal is that the Secretary never forwarded to us either the Report or copies of the papers. Certainly we should have been willing to publish the same as we have done for other Societies had we received them. Dr. Todd's paper will shortly appear, he having kindly forwarded a copy himself last month.—Editor.

## CORRESPONDENCE

*To the Editor of the Western Canada Medical Journal.*

Dear Sir:—

I was very much pleased with the letter by Dr. G. A. Kennedy re a common examining board and registration for the four western provinces in the last issue of your Journal.

The people living in these provinces are of the same class: the diseases affecting them are similar and the medical men in each of these are of equal standard.

A line is defined as "length without breadth" and yet a medical man, even the most highly qualified, entitled to practice in one province, living close to the line dividing it from the next one, is not at liberty to attend his immediate neighbor in distress, on the other side of this line, without the risk of a heavy fine, just as the greatest quack would be. Why? Simply selfishness; each trying to maintain his own preserve.

If we of the profession cannot take a more liberal view of the situation and devise some common sense reciprocal scheme, then it is high time our Provincial Legislatures stepped in and did it for us. The advocates of the present condition might just as well insist upon the practice of a medical man being limited to the municipality in which he resides. Why should not municipal limits bound our practices just as provincial limits do in Canada?

I am strongly in favor of some such scheme as Dr. Kennedy sets forth to secure partial or full reciprocity between these four western provinces.

Quebec, aided to a certain extent by Ontario, killed Dr. Roddick's bill. The conditions in the east are different from those in the west, and nature has separated the eastern provinces from the western ones so effectively, that there is nothing to prevent the medical men in the latter from coalescing in a reasonable scheme for their own good and the public benefit without any chance of it being said that it was in antagonism, or to injure, the east.

In the three western provinces the various legislatures are establishing one provincial university in each. In Manitoba a commission is revising the constitution of ours. It is hard to tell what privileges, what powers, these legislatures may take away from the various Colleges of Physicians and Surgeons and hand over to the various universities. I believe in the principle of centering, as much as possible, the control of all educational qualifications in the one Provincial University. Under the circumstances I think it behooves us to put our medical legal regulations in a reasonable shape, and thus perhaps forestall unwise and unnecessary interference. To accomplish this I think the very best step would be the formation of a Western Canada Medical Association at the meetings of which the whole question could be freely discussed, carefully considered and a decision arrived at by all the members of the profession.

I do not agree with Dr. Kennedy's suggestion to have deputations from the four provinces meet in Winnipeg in August at the time of the Canadian Medical Meeting. The British Scientific meets the day following and lasts for some days. The medical men here will be so occupied with social and other duties that it would be impossible for

them to find the time necessary for a proper consideration of such an important matter. These deputations from British Columbia, Alberta and Saskatchewan should attend, if interested sufficiently, the annual meeting of the Manitoba Medical Association at Brandon, in June. Then and there it would be a subject of the most vital importance.

I agree with you Sir, that what is needed is a leader who would assume a similar position to that which Dr. Roddick did, and devote some time and energy to securing a Western Medical Association and through it partial or full reciprocity in the West.

I know of no better man to do this than Dr. Kennedy. He would require to visit every portion of the territory and present the proposition before every local medical society. His expenses might be met by the various Colleges of Physicians and Surgeons.

Dr. Kennedy's letter should be carefully considered by every medical man in the West.

Yours truly,

James Patterson.

Winnipeg.

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*To the Editor of the Western Canada Medical Journal.*

Dear Sir:—

With regard to the proposed Western Canadian Medical Association, I for one would like to see the medical profession in the West rise to its proper level and by a wise, fore-seeing, and liberal policy prove that it is not only a learned, but also a practical patriotic body. Petty parochialism, pottering provincialism, and priggish pride of place in medical politics must be swept away, if only as a united profession we western medical men will adopt a statesmanlike attitude in this important matter. The general public are watching us just now. At present the general public are in doubt as to whether as a whole we are an enlightened profession. They detect too much individual selfishness both in the units and in the sectional provincial bodies. They cannot understand the absurd anomaly that a Canadian citizen competent to practice as a medical man in Winnipeg should be debarred from practising in Moosomin or Calgary or Vancouver until for each place he passes another provincial examination. "Why," they argue, "do not you medical men have one standard of examination for the whole Dominion, which once passed qualifies our doctors to practice anywhere in Canada?" Why not indeed? Let us medical men of the West make a move in the right direction. The next Dominion meeting which is to be held in Winnipeg is a golden opportunity. Let us get together representatives of the four Western Provinces with the object of uniting Western medical men into one strong Western Medical Association whose watchwords will be Patriotism and Reciprocity.

Yours truly,

H. M. Speechly, M.R.C.S., Eng., L.R.C.P., Lond.

Pilot Mound, Man.

## PROCEEDINGS OF THE WINNIPEG CLINICAL SOCIETY

The Winnipeg Clinical Society met January 12th, with the President, Dr. Hunter, in the Chair. The secretary read the minutes of the previous meeting.

Dr. Montgomery presented a patient suffering from hiccoughs. With every breath, the patient hiccoughed. This condition has lasted for six years. Lost 25 to 30 lbs. weight; complains of bad stomach; used catheter four years. Walk is staggering: no pains in extremities; Romberg's sign; loss of reflexes; no eye symptoms; no insufficiency of muscles of eye; pupils act to light; accommodation almost perfect considering patient is about 45 years of age; no atrophy of optic nerve. Nothing found to relieve hiccoughs. Examination of urine gives specific gravity 10-21 acid, no albumen, no sugar, no casts. Patient has had history of specific disease, and used alcohol up to three years ago. Loss of appetite and symptoms of gastritis. Stomach Tube used with good results. Strychnine and other remedies given for stomach. Only remedy used for hiccough was tincture of aconite rubbed on belly.

Dr. Lehmann spoke concerning the use of tincture of aconite in this manner and said he had got good results; it acted apparently in a psychic manner. Dr. Lambert had also found good results with the same treatment.

Patient can stop hiccoughs when lying down ready to retire by inducing vomiting with the finger in his throat, and then lying perfectly still, on right side. If he changes to left side or back, hiccoughing immediately begins, and vomiting has to be again induced.

Dr. Hutchinson thought it might be tabes.

Dr. Brown—If we have belt-like areas of anaesthesia we have sufficient to diagnose tabes.

Dr. Hunter—No anaesthesia of any sort; no tactile anaesthesia in mammary region or pain in lower extremities. I cannot find any history of hiccough as a symptom of tabes. I should think it suggests a gastritic. I saw a case some time ago that was stopped by two or three doses of nitro glycerine, and another by a quarter grain of morphia. In this case there are no laryngeal symptoms.

Dr. Hunter raised the point whether it was the liver condition or the kidney condition in this case. He thought it likely this was a case of liver affection.

Dr. Dorman submitted a case of a little boy, aged 7, which he had diagnosed as bronchiectasis. Owing to an attack of acute bronchitis it was impossible to observe all the symptoms. He had always been a weak child; had ptosis of the right eye from time of birth; had to have circumcision for difficulty in passing water. Two years ago had contracted a cough and this has been present ever since. Three months ago the breath became fetid, and boy spat up large quantities of sputum of a foul odor, and a liquid consistency. This spitting occurs once every two or three weeks, or a month, and amounts to about a cupful at times. Examination of sputum shows no tubercle, nor broken down tissues. Clubbing of finger nails; had a rupture and had an operation for that six months ago; has a rupture on the other side, associated with an undescended testicle. Had measles four years ago. Sometimes vomits with the cough. There is quite a quantity of pus in sputum, with occasional specks of blood.

Gurgles heard at times. Attack of coughing generally occur when he wakes in the morning. Dull areas in portions of the lungs.

Dr. Rorke—There is a dilatation or saculation of the bronchi.

Dr. Dorman—The breath sounds seem to be suppressed. They can be heard over the area but they sound far away.

Dr. Brown—It might be a localized empyema discharging into the lung. It seems to be pretty close to the surface and the fact it is never otherwise but dull might suggest that condition.

The question of X-ray picture being taken was raised, and Dr. Bond said about two years ago he had a patient with a similar condition, history of expulsion of badly smelling sputum and pus from time to time, and accompanied with a great deal of coughing at various intervals and quite copious hemorrhages. A radiograph was taken and the site of abscess located. It was fairly distinctly marked and less in size than a dollar. High frequency treatment was adopted and the treatment extended over nine or ten months. A cure was the result. These cases lend themselves much more readily to X-ray treatment than do abdominal cases, owing to the large proportion of air space in the thorax. The X-ray causes contraction of the blood vessels and keeps germs from coming in.

Dr. Hunter suggested the administration of eucalyptol by means of a special syringe. Tell the patient to protrude the tonge, holding it with a towel, and instruct the patient not to swallow. This closing the oesophageal opening prevents the medicine going into any other than the right channel. This causes deep breathing, and coughing, and in that way tends to get rid of fluid and tends to expansion of the lung.

Dr. Williams showed a nose case, in which there was an ulcer on the left lachrymal region, and a considerable discharge from the nose. In 1907 the patient was out stacking in harvest, and a sheaf hit him in the face. He noticed a swelling about a week after, with a white centre. He poulticed it for three or four nights and it broke each night. In three or four weeks it got perfectly well. It broke out in December, and he had an ulcer half an inch deep with overhanging edges, and also another on the left.

History—Twelve years ago of contracting gonorrhoea and sore on penis. No rash nor any symptoms of syphilis. Sample of discharge from ulcer examination, but proved negative, neither as to tubercle or syphilis. It was thought this was of specific origin.

Dr. Williams showed a second case, a patient with disclocated lens. Dr. Brown recommended wide iridectomy in the upper half. as the trouble seemed to be all in the lower quadrant.

Dr. Montgomery showed a patient, male, aged 40, who had been treated for sciatica. Dr. Galloway made an examination, but could not place the diagnosis definitely; he thought it lay between a T. B. hip and rheumatoid arthritis.

Dr. Lehmann thought Dr. Galloway's remarks had fully covered the case but until absolute diagnosis were made, he thought nothing should be done.

Dr. Halpenny showed a case of a negro, structural steel worker, who was struck on the forehead by a falling piece of iron, resulting in a wound in the skull, dura ruptured, and one piece of bone driven into the brain three-quarters of an inch. He was in hospital 18 days; the bone removed within an hour and a half after accident, and he was put to bed for two days. He left hospital on eighteenth day with wound healed. The question arises whether a plate should be used. I think in this case, putting in a plate is rather bad surgery. At the time he was in the hospital I took the liberty of writing Dr. Cushing of Baltimore, who is probably the leading brain surgeon in America

at the present time, and his advice was, under no circumstances to put in a plate; if something had to be done, resort to some kind of bone and flap. The difficulty with plates was, they could not be got to stay in place, but Dr. Halpenny said he only had the statements of others more experienced and they said it was unsatisfactory. Bone transmission was discussed and it was thought that, for appearance's sake, this would prove satisfactory, as the bone makes a continuous joint, but Dr. Halpenny said he didn't feel justified in doing a further operation for the sake of appearances only. The hair would cover this if let grow.

Dr. Halpenny also showed a case of general, free, supurative peritonitis; the patient took sick on the 8th of November, and on the 10th of November at one o'clock the physician, who saw him that morning for the first time, asked me to see him, and we operated at three o'clock in the afternoon. He had appendicitis, in which appendix had already ruptured. There were large quantities of pus through the lower half of the abdomen. The operation consisted in what Murphy advises: "Get in quickly and get out quicker." We merely made an incision; the appendix was very easily found; no adhesions, and the appendix popped right into the incision; tied off with silk ligature; then rubber tube about three-quarters of an inch diameter inserted into the pelvis. Although only a little pus leaked through the wound, when the tube went to the bottom of the pelvis the pus spurted out about two inches above the tube, showing very much more tension in the pelvis than in the upper part of the abdomen. The wound was sutured in layers with buried catgut, and silkworm superficial. The head of the bed was raised about two feet. Normal salt solution given continuously by the bowel for two days, and for the next succeeding three days gave it about half time, and the next four days two hours on and four hours off. The wound was healing and patient sat up ten days after that, and about the fifth week he was out. No abdominal pain or cramps, very little indigestion. No signs of adhesion over the abdomen. No discomfort in any way. No sign of hernia. Patient is not now wearing anything other than a small pad for comfort.

Dr. Halpenny then gave a paper on the method of performing this operation for free suppurative general peritonitis. "Time is the essence of the operation. When all preparations have been made and all who are to take part in the operation are scrubbed up, gowned, etc., the patient is placed on the table, shaved and scrubbed up, is given the anaesthetic and the operation begun at once. There should be two assistants to the surgeon, the second of whom hands instruments as required. There should in these cases be two nurses assisting, one whose duty it is to handle gauze, and the other should handle the sutures. There should also be one house physician and two nurses to render such other assistance as may be required. The patient should be moved to and from the operating room in a sitting posture.

Free suppurative general peritonitis is an inflammation of the peritoneum with more or less pus unconfined by adhesions; it is usually caused by some break in the continuity of the digestive tract, more commonly a rupture of the appendix than of any other part. One of the first points established in what is now thought by many to be the best treatment, was that the peritoneum does not absorb equally in all the parts (Muscatello). The region of the diaphragm absorbs most rapidly, and the pelvis the most slowly. The tremendous absorptive power of the peritoneum has been demonstrated by injecting fluid into the abdomen of an animal, when it has been found that 1.3 per cent. of the body weight has been absorbed in an hour.

ollowing on this, Clark concluded that it would be well to take advantage of this law of nature and have the patient absorb the fluid from the abdomen rapidly, that the trouble be terminated quickly, and to accomplish this elevated the foot of the bed, with the result that almost all the patients died. Then Fowler, arguing that a toxine absorbed slowly will not do as much harm as if absorbed rapidly, elevated the head of the bed. This was a distinct advance, and results were much better. Moreover, well diluted poisons are not as toxic as the more concentrated ones, and on this fact probably depends the success of Murphy's treatment. Cannon of Boston, by feeding animals per rectum bismuth mixed with food, and watching with the fluoroscope, has shown that reversed peristalis is the normal habit of the large bowel, so that contents passing from the small bowel to the large one again and again sent back to the ileo-coecal valve, and food injected into the rectum is carried right up to the valve. Therefore, fluids passed slowly into the lower bowel will be carried up full length of the large bowel so that absorption will take place from a considerable area. Furthermore, moderate distension is the normal condition of the large bowel, so that the fluid does not need to be absorbed immediately. It is only when hyperdistension occurs that the patient voluntarily expells the contents. Attention to this point has much to do with failure or success of the method. The treatment employed in this case was, as nearly as we could carry it out, that first used by J. B. Murphy. This consists merely in maintaining the Fowler position, and in giving the patient normal salt solution continuously by the bowel until toxic symptoms have disappeared, usually three or four days. To secure the Fowler position the patient may sit up in bed, or the head of the bed may be elevated. I prefer the latter, and to keep the patient from sliding down in bed I prefer to place a bolster across the bed, which is slung to the top of the bed with a sheet in such a way that the patient rests comfortably against it. To put a board across the foot of the bed and expect the patient to hold himself up by the strength of his legs is, to my mind, a poor way, although recommended by some. Use a good sized jar, protected by hot water bottles to keep the fluid at the proper temperature, attach a 3/8-inch rubber tube; have the level of the top of the fluid 6 to 10 inches above the point of intake. If the patient is sitting up in bed use a glass douche tip to insert into the rectum, having it bent almost at right angles three or four inches from the tip. If the patient is lying with the head of the bed elevated, use the rectal tube, and fasten by adhesive plaster. In either case there must be sufficient holes of such a size that the flow of water in and out of the tube may take place quickly. 'The flow must be controlled by gravity alone, and never by forceps or other contsriction of the tube, so that when the patient endeavors to void flatus, the fluid can flow quickly back into the jar; otherwise it will be discharged into the bed." Keep the fluid at 100 degrees and give continuously for three or four days, then intermittently for four or more days. The patient will absorb large quantities. This patient absorbed almost 40 pints the first 24 hours. Murphy cites the case of a child 11 years old who took up 30 pints in 24 hours. Large quantities of urine are voided, the patient presented to-night having voided 120 ounces the first 24 hours, and averaged 75 ounces for five days. I am trying to find the average amount of urine voided during each 24 hours after an ordinary laparotomy and will report at a later date. LeCoute thinks 15 ounces is the average for the first 24 hours, but it seems to me it would be over 20. I want to work out the average amount voided by these patients of general peritonitis and by other cases.

As to why so much benefit is derived from this treatment, the

chief point is that the current of lymph is reversed so that in place of the peritoneum absorbing toxines it is itself bathed in fluid. There is not a large quantity discharged from the drainage tube as a rule. The skin of the patient is usually moist, but sweating would not account for much of the fluid. The kidneys are active, but that would not dispose of such large quantities. The patient just seems to get completely saturated for in about two days it will be found that much smaller quantities are absorbed, and the patient is so filled with fluid that he cannot absorb anything from the peritoneal cavity. The simplicity of the operation is also important. No violence is done to the peritoneum, the lymph is not wiped off, the bowel is not handled, the cavity is not flushed out; any attempt at removing the lymph and pus by wiping will leave a surface more or less raw, which will absorb more quickly than the surface already protected by nature. Any attempt at flushing out the cavity will spread the infection to parts not yet involved. Absorption depends not so much on quantity as it does on the degree of tension, and drainage is all that is required to relieve that."

Dr. Hunter—I think we ought to thank Dr. Halpenny for the way in which he has brought forward this subject. We read on every hand that those who adopt that method get the results, and I think Dr. Halpenny is about the first to take up this method in this part of the country, and it is only right he should get the credit.

Dr. Hutchinson pointed out that Dr. Murphy, ten years ago, laid it down that practically every case of diffuse suppurative peritonitis died, but since adopting his present method he has been getting 98% recoveries. He strongly emphasizes the principle that the less interference there is, the more recoveries result. He quotes statistics showing that in 200 cases of laparotomies for peritonitis of this nature, in 90% they had simply opened the abdomen and wiped out the pus, with a mortality of 40%. Another list of cases, opened the abdomen, flushed it and wiped it out thoroughly, with a death rate of 60%,—20% higher. In another series of cases they washed it out and drained it and the mortality was higher, showing that every step they went further into the operation, the results were poorer. The better way is to open up the abdomen, repair the tear or remove the appendix, as the case may be, put in a drain, close the wound, and get the patient back to bed. Operate as quickly as you can, and get through it just as rapidly as you can, and get the patient back to bed.

In connection with the preparing of patients for operations in our local hospitals, Dr. Hutchinson commented upon the loss of time in getting the patient ready. He said that the patients should be brought into the operating room and while being anaesthetized they could also be scrubbing up and preparing the patient. He had seen this method pursued in an Eastern hospital with good results. It was granted that in the case of some nervous patients it was better to administer the anaesthetic outside the operating room.

Dr. Munroe asked Dr. Halpenny if he always removed the appendix, and he replied that he did, in all case of free supperative general peritonitis, due to appendicitis.

Dr. Hughes asked Dr. Webster what anaesthitic he uses in such cases, and Dr. Webster replied that as a rule he gave ethyl-chloride, and then ether, which left no special after-effects, as a rule.

Dr. Webster also commented on the delay in hospitals in preparing for operations, and said that the delay ranged from eight to thirty minutes.

Dr. Montgomery asked Dr. Halpenny if he would remove the appendix in suppurative peritonitis with adhesions.

Dr. Halpenny—In free suppurative general peritonitis due to the appendix, remove the appendix first. If it is a perforated typhoid ul er, sew that up; if it is a perforated duodenal ulcer, sew that up. If you have pus circumscribed by adhesions you have not got free suppurative general peritonitis. If you have such a circumscribed collection of pus do not remove the appendix unless it is visible, without any disturbance of the adhesions. If in freeing an appendix from an abscess you break through the wall flood the peritoneum suddenly, the chances for that patient are less than in a case where no adhesions had ever been formed and the appendix had burst, for in the former the sudden large dose is much worse than is the sudden smaller dose in the latter case.

Dr. Lehmann stated that the method of rectal injection outlined was not favored extensively on the continent. Their mode is to make a small incision, or sew up a large one if it is made, and only leave room for drainage tube. They insist on keeping tension down. In some cases they put the patients in upright position, and some they do not.

Dr. Brown suggested a glass drainage tube the first 24 hours, with aspirations.

Dr. Halpenny said the chief objection to a glass drainage tube is that it is so unresisting it is found there are more cases of obstruction of the bowel complete or partial, than when a rubber tube is used. As to sucking out the tube every fifteen minutes, half hour, or hour, the concensus of opinion is that if you leave a hole, tension is relieved sufficiently that the patient doesn't absorb much toxic substances.

Dr. Lehmann went on to explain that on the Continent they use a U-tube which has a spool of gauze at the one end and this is drawn through to draw out the secretion of pus which may be in the bottom of the U, but they don't endeavor always to get out the last drop.

Dr. Milroy—I would like to ask Dr. Halpenny about results from this method of treatment.

Dr. Halpenny said he had been fortunate in seeing Dr. Murphy's fifty-first case, (being his fifth case of typhoid perforation) and this was his forty-eighth case to recover. Moynihan of Leeds, England, reported nineteen consecutive cases with two deaths; Sonnenberg of Berlin reports eight recoveries out of twelve successive cases. "With my friends out of ten consecutive cases, including three typhoid perforations, I have had eight recoveries, the deaths both occurring in typhoid perforations."

Dr. Hutchinson suggested this mod. of application of the saline solution in eclampsia, and haemorrhage where you want to fill up the blood vessels.

Dr. D. S. Mackay said he had watched Sir James Barr of Liperpool carry out the method in uremia, of giving the continuous saline with good results. He always bleeds through the media basilic and administers the saline either by the rectum or by subcutaneous method. He has used this method for eight years.

Dr. Hunter remarked that in uremia the kidneys do not excrete very freely .

Dr. Mothersill asked Dr. Halpenny how far the tube is inserted into the rectum, and Dr. Halpenny replied about four inches.

A case of eclampsia was cited as having been treated where three pints of normal saline solution was introduced every two or three hours during a twelve hour period. 90 ounces of urine secreted and markedly favorable results in the eclampsic condition within six hours of the saline administration. No blood withdrawn.

The Winnipeg Clinical Society met Tuesday, January 26th, with the President, Dr. Nichols, in the chair.

Dr. Moody presented a case of syphilis, showing an annular ulcerated sore on the head. When he came under my notice, the sore was covered with a large greenish yellow crust, matted into the hair. Fomentations and other means used since admission to hospital, to clean it up. Peculiar circinated appearance of ulceration and the bunched ulcers are rather peculiar, also the amount of scarred tissue around the forehead. History dates back five years, but up to last year there was nothing important. Since last spring the ulcer formed and has not healed over. Irritated considerably during threshing, and got cold, has been treated with iodine. Patient married five years ago, two years after primary sore. First child was miscarriage. Second one was full time, and died within two years. Next child was miscarriage and since that there are three children, all said to be healthy.

Dr. Hughes—It has appearance of specific. Dr. Moody's point about healthy children is important. One often sees that in fairly healthy people very often after the disease has lasted about three years a certain immunity is produced. In early childhood these children may not show signs of hereditary syphilis, i. e., snuffles—rash on buttocks, etc., but later certain certain nervous diseases develop.

Dr. Moody—He had first sore on penis—the chancre—seven years ago. He had not treatment and no symptoms developed until after three years. After marriage another sore appeared on penis which healed. A small sore appeared on the forehead and has given him more trouble, but healed over and broke out again. He didn't ascribe any particular importance to this sore on forehead until this spring. Had some treatment from doctor in country and it healed up right away. Broke out during threshing time, got cold in it, and dust in it, and it has remained in present state since. Has been given specific treatment.

Dr. Hughes—Point of reappearance of sore on penis is very interesting, and question of reinfection, and question of what is real cause of breaking down of injured part. The relation also of ulcer taking place in head, and about the crown being a position where there are so many smaller glands to those found around the corona makes one think whether those injuries or ulcers are not kind of a glandular cause. not a true syphilitic manifestation, but anyone having had a primary sore and not taken thorough treatment if they have an injury from any reason, the tissues break down. As to scarring, I think in any extensive ulceration one will find considerable scarring usually. Finding scars or ulceration in the mouth, or a primary sore, I would put him down as syphilitic. Seldom do ulcers around the mouth give way to treatment so quickly as syphilitic ulcers. I think the condition of mouth and hair the chief guide.

Dr. Lehmann also diagnosed it as syphilitic, basing his diagnosi on the appearance of the ulcer and scar formation, the healing and breaking down at the same time, and the condition of the mouth. He didn't pay much attention to history in venereal diseases, owing to so many patients lying about it, and he thought one must take appearances as one finds them.

Dr. Meindl cited a case of actinomycosis he had treated four years ago, very much similar to that shown to-night—considerable scarring, little more destruction of tissue, healing and breaking down, quite deep ulcer, and man had suffered five years from it, where it had healed and gone away.

Married man, no children, no syphilitic history. Microscopical examination showed actinomycosis. Healed very readily under pot. iodid and calomel.

Dr. Trick showed a case of carcinoma of the tongue. Had operation removing the left jaw bone last May. There was still a little discharge from the mouth. Glands were involved, and also removed. The growth first started in tongue, left side.

Dr. Lehmann suggested bringing the jaw over, to be able to masticate more properly, by means of having one of the teeth ground so as to produce a gliding surface and by closing the mouth this will bring the part of the jaw which remains, back into place. This in many cases has brought excellent results.

Dr. Montgomery presented a case of trachoma, upon which he operated at the meeting. A lengthy discussion on differential diagnosis was held upon trachomatous and follicular conjunctivitis. Trachomatous bodies are more numerous on upper lid than the lower. Patient shown had ulceration of the cornea which very seldom occurs with follicular conjunctivitis. Dr. Montgomery pointed out that Trachoma had done a great deal of damage to eyesight. To distinguish between Trachoma and Follicular Conjunctivitis, in trachoma the bodies are'nt so large, and are a greyish white color. He had found the expressive method of surgical treatment the best means of treating the trachomatous condition. Medicinal treatment is very slow. Dr. Montgomery's method was to roll the lids, squeeze out the granulations, and treat the eyes after with hot water until active inflammation is gone. and then start to rub in yellow oxide of mercury, 6 gr. to the ounce. Then you furnish them with medicine to use for a year, or as long as they will use it. If it is kept up it will save many eyes. I wouldn't advise use of other caustics. Trachoma is highly contagious, but the germ has not been discovered.

Dr. Watson also spoke on the prevalence of Trachoma in the United States and remarked how strict were the inspections of all entering the United States, and no one suffering from Trachoma is allowed to enter. He claimed that the disease is incurable It is found in children of four, and old people of seventy years of age. He thought the method of treating them with the Knapps roller forceps removes the granulation but it leaves the scarred tissues there. His method of diagnosis of chronic trachoma was by presence of cicatricial tissue. He remarked that Trachoma is common among the Turks, Greeks and Doukhobors. The Irish are more afflicted with it than any other English speaking nation.

Dr. Fletcher said he had seen a number of cases treated with X-ray and cures claimed. These were in the early stages.

Dr. Sharpe remarked on the prevalence of it in the Mennonite Reserve in Southern Manitoba. Often two or three of a family, and a servant or employee on a farm would have it.

Dr. Nichols showed a microscopic slide showing a condition of splenic leukemia.

Dr. Galloway showed two cases of club feet, one patient being a boy and the other a man of 26. Boy, age 10, had been treated in a St. Louis institution for six months where mechanical means were adopted for treatment; no permanent improvement. Photos were exhibited showing condition before operation. Operation had been performed, and the form and function of the foot were now good. Dorsal flexion was normal in degree, and boy was able to walk nicely. Dr. Galloway gave an interesting talk on method of treating these cases, and showed the instruments ,wrenches, etc., which he uses in bringing the feet back into position. He cited a case where Phelps' operation had been performed by a surgeon on a child at nine months

of age. He considered this quite unjustifiable. After a patient had reached adult life, it mattered little whether the age was 20 or 40, and good results could be obtained by practically the same methods as he used in children, although more subcutaneous cutting might be required than with children. In children he preferred not to begin the active surgical treatment of these cases until child is 12 to 14 months of age. At this age there is very little use of the knife except for cutting the Achilles tendon. He favored doing as much cutting subcutaneously as possible, as being the safer from infection. Over-correction of inversion and abduction of the foot must first be secured. Then the tendon Achilles is divided and the wrench can be used if necessary to overcome the equinus position of the foot. It takes from three to five dressings before perfect correction of the deformity can be completed. The gradual correction gives better results than the severe open operations which attempt correction at one sitting.

Dr. Lehmann thought almost any foot can be corrected without removing any section of the bone or interfering with the bone.

Dr. Galloway said that if there was ankylosis from infection following a previous operation a bone operation might be necessary, but in the average adult case perfect results can be obtained without resorting to bone operations and open incisions and the foot had better form and function.

Dr. G. W. Fletcher showed a patient on which an operation hed been performed for deviation of the septum. December 17th, 1908, patient had complained of deafness, nasal discharge and obstructed breathing. Had obstructed breathing for two years. Dullness of hearing. fullness in the ears. Could hear with right ear, moderately loud voice 12 inches; right, 14 inches.

This operation was originated by Killian of Freiburg for the relief of nasal obstruction caused by deviations of the nasal septum. The operation is designed to replace by an accurate and certain method, the crushing and uncertain methods formerly in vogue for the relief of this condition. The operation consists briefly in the elevating of the mucous membrane from both sides of the septum and the removal of the cartilage from between the same by cutting instruments after which the membranes are allowed to come again into apposition and heal together. The following steps are carried out in performing the operation: Anaesthesia of the mucous membrane by the rubbing into both sides of Crystals of Cocaine and adreualin chloride (1-1000) three times at intervals of 5 minutes. 2. The placing of a vertical cut anteriorly upon the convex side in front of the deviation of a length of about ¾ of an inch. 3. The elevation of the mucous membrane from its convex side of the cartilage. 4. The cutting through the cartilage at the same place as the first cut was made. 5. Similar elevation of mucous membrane from the concave side. 6. Removal of entire deviated portion of septum by means of knives, forceps and scissors. 7. Lastly, the two flaps are allowed to come together and packing inserted for 24 hours.

If properly carried out, the results are exceedingly good. This holds especially in narrow noses where the breathing space is actually increased by removal of the septum, and in all cases the breathing is equalized between the two nostrils, a very important consideration. The older operations going under the names of Gleason, Moure, and Asch, consisted in forcibly crushing or shoving the septum from the obstructed to the freer side. The results were very often disappointing and always uncertain. There is no doubt the described procedure marks a great advance in the treatment of this line of cases. The young man presented was operated upon about 5

days ago for this condition. He complained of greatly obstructed breathing through the nose, discharge, mouth-breathing, and dullness of hearing. Upon examination the right middle turbinate was greatly enlarged and the septum was strongly deflected to the left, so that breathing through the left side was nearly impossible. The right side was first corrected by amputation of the middle turbinal, and later by cauterization of the inferior bone. Then some time later the Killian operation was performed upon the septum with the result you can see. The breathing is free through each side and of equal amount. The hearing has greatly improved under the nasal and throat treatment and by the use of the Politzer's bag.

Dr. Sharpe showed a case of cerebral gumma. Possible infection two years ago, no definite history of sore. On 6th January patient was vomiting, and had pulse 64, temperature normal, respiration normal. Condition rather dull. Believed he was recovering from New Year's festivities, but on 7th he was in same condition, besides hiccoughing started and continued until 12th January. Hypnotism by Dr. McDermid was the only relief for that, after every other known method of stopping the hiccoughing had failed. He had headache, inability to stand or sit up, and tendency to fall to right. Reflexes on right side normal; on left, tendon reflexes were exaggerated. Said he had numbness on right side, but test for anaesthesic areas showed nothing. Dr. Fletcher examined the discs, and drew my attention to a ptosis on the right side and at the time the eye was examined there was a nystagmus, veins had swollen, and the left pupil enlarged. Diagnosis of gumma and patient put on increasing doses of pot. iodid and improvement noticed. Urinalysis was normal, specific gravity 1030, no albumen, temperature 98⅘, never more and generally below; pulse varied 56 to 80 and respiration from 16 to 20. He was allowed to smoke, and given strong coffee, with good results, apparently. Headache and other symptoms in almost every particular are improving. I would place the seat of gumma in the base. No muscular paralysis of the eye. It seems difficult for patient to express his thoughts. There are scars on the skin.

Dr. Hunter agreed with Dr. Sharpe, pointing out any other growth inside the brain, outside of sarcoma, will give considerable improvement with pot. iodid, for the first week or so. If syphilitic, one has to be cautious as interpreting all these conditions from a single lesion. In syphilis one is apt to get a multiplicity of lesions.

Dr. Sharpe—I started him out on five minim doses of pot. iodid, saturated solution, and increased that to 20, three times a day.

# GENERAL MEDICAL NEWS

## VITAL STATISTICS

Winnipeg, January, 1909.

| Disease. | Cases. | Deaths. |
|---|---|---|
| Typhoid Fever | 29 | 2 |
| Scarlet Fever | 9 | 0 |
| Diphtheria | 5 | 0 |
| Measles | 309 | 2 |
| Tuberculosis | 3 | 1 |
| Mumps | 2 | 0 |
| Scabbies | 2 | 0 |
| Whooping Cough | 5 | 0 |
| Chicken-pox | 5 | 0 |
| Small-pox | 4 | 0 |
| | 382 | 5 |

Births, 367; Marriages, 162; Deaths, 126.

Edmonton, January, 1909

| | City Cases. | Rural. | Total. |
|---|---|---|---|
| Measles | 9 | 1 | 10 |
| Typhoid Fever | 7 | 11 | 18 |
| Tuberculosis | 0 | 1 | 1 |
| Chicken-pox | 0 | 1 | 1 |
| | 16 | 14 | 30 |

New Westminster, 1908—Births, 321; Marriages, 136; Deaths, 317.

## MEDICAL NEWS

The New York Board of Education is presenting a course of health lectures at the different public schools. These lectures treat such subjects as care of the teeth and skin and give suggestions as to the prevention of tuberculosis.

Dr. McCormack, chairman of the American Medical Association, visited St. Paul's Society last month. For eight years, Dr. McCormack has devoted his entire time to travelling about the country carrying the propaganda of organization to the various medical societies and talking to the people

upon subjects of health, pure food and the bettering of sanitary conditions.

Dr. C. J. Fagan, Provincial Health Officer for B. C., who was sent last summer by the Provincial Secretary to study methods in vogue in the East in connection with the business of the milk supply to the public, has now issued the report of his research and observations, details of which we hope to give in a later number.

A Field Ambulance is being organized in Vancouver. About 90 officers, non-commissioned officers and men are required. Applications for enrolment may be made at the Drill Hall on Friday evenings at 8 p. m. The ambulance corps will be a separate organization from the local regiment, but is under direction of the Dominion Department of Militia.

The statistics for Nanaimo, B. C., give a low death rate and few cases of the "White Plague." The detailed report shows that Nanaimo has some right to consider its climate ideal in many respects.

Ninette, Manitoba, has been decided on as a site for the Sanatarium. Dr. D. A. Stewart, late of the Winnipeg General Hospital, has been appointed to carry out organization work in connection with the Sanatarium.

Dr. Young, Provincial Secratary of B. C., is to introduce a bill at next session on the subject of Medical Inspection of the Schools of B. C., Vancouver being the only city at present which has regular official inspection.

An agitation has been started in England which has for its object the safeguarding of patients by the restriction of the functions of an anaesthetist to specially trained and experienced men.

An instrument for graphically recording the variations in the heart beat and character of the pulse in health and disease was exhibited for the first time at a recent meeting of the Royal Society of Medicine. It is the invention of Dr. James MacKenzie, and consists in the main of an appliance by which the heart, the pulse beat and the movements of the

chest in respiration are simultaneously recorded in ink upon an appropriate chart.

The King is interested in the formation of a Royal British Radium Institute, in connection with which there will be a Medical Department.

A delegation representing the public hospital of Alberta interviewed Premier Rutherford and presented a petition for an increased grant in aid of the hospitals. It was pointed out that the government grant is now 50 cents per non-paying patient and 25 cents per paying patient. The hospital asks for a rate of 50 cents per head for all patients. They claimed the hospitals were supplying more than they were compensated for because their patients are drawn from all the outlying portions of the province. The matter will be brought to the attention of the House.

The recommendations of the Winnipeg Hospital Commission are briefly as follows:—

1. That the cost of the extension of the hospital be borne by the City; the Province; Subscriptions and the Dominion Government.

2. That all patients treated at the hospital be charged for and Municipalities and Provinces pay for their patients at the rate of $1.00 a day.

3. Legislation be secured to give the hospital the power to collect the amounts from the Municipalities and provinces.

4. Semi-private and private patients be retained, but on separate floors if possible.

5. Winnipeg pay 75 cents a day for poor patients.

6. The Medical Superintendent be supreme and be a permanent official.

7. The representation of the City Council on the hospital be reduced from eight to five.

8. The Commission estimate that a modern up-to-date hospital should cost $1,000 to $1,500 per bed.

9. That large hospitals can be more economically administered than a small one.

10. The Commission consider that a civic controlled hos-

pital should be under the control of an independent Commission as nothing is so detrimental to the efficiency of a hospital as the introduction of ward politics which are thought by the commissioners to be inevitable with control by the City Council.

11. As to the question of having paying patients the Commissioners state that private and semi-private patients are necessary. They say experience shows that hospitals attract a better class of men to their staff and have more efficient management where paying patients are admitted than where only charity patients are received, and they also deem it better to have the two different classes of patients provided for on different floors.

The following sources of revenue are suggested:—(1) Paying patients; (2) patients paid for by the Municipalities; (3) a per diem allowance by the Dominion Government for recently arrived patients; (4) a per diem allowance by the Provincial Government; (5) voluntary contributions; (6) income from endowment.

It is also recommended that there be an isolation hospital administered by the Health Officer—and the the cost per diem per patient should not exceed 90 cents.

Thanks to the untiring efforts of Mrs. J. H. R. Bond, Winnipeg has now a Children's Hospital—the first of its kind in the West—which was formally opened on Saturday, Feb. 5th, by the Mayor. The Board of the hospital is composed of women, Mrs. Bond, the promoter, being President, and Mrs. W. S. Grant, Secretary. The Board is assisted by an advisory Board consisting of Messrs. T. Mayne Daly, R. Max Dennistown, R. Campbell, C. H. Enderton and Dr. Milroy. The following is the Medical Staff:—

Physicians: Drs. Rorke, Field, Dorman, Richardson.

Surgeons:—Drs. D. S. Mackay, Kenny, McLean, Hiebert.

Consultants (Medicine):— Drs. J. R. Jones, Moody, Bjornson.

Surgery:—Drs. Nichols, Todd, McKenty.

Specialists:—Drs. Victor Williams and Raymond Brown (Eye, Ear, Nose and Throat); Dr. Lehmann (Orthopoedic

Surgeon); Dr. Bond (Electro-therapeutics); Dr. Hughes (Dermatology).

Matron:—Miss Elsie G. Fraser.

## PERSONALS

Dr. Dolby, Vancouver, has returned from his visit to England and is staying a short time in Victoria before taking up his practice.

Dr. and Mrs. Morrison of Calgary Sanatarium are taking a week's holiday at the coast.

Dr. A. Paling, F.R.C.S., of Burton, England, is visiting the West.

Dr. Whyte, Winnipeg, has gone for a post-graduate course to Chicago, New York and Baltimore.

Dr. D. A. Taylor of New Castle intends settling at Lethbridge, Alta.

Dr. J. Westwood of Coleman is taking a three weeks' holiday at the coast. Dr. O'Hagan of Blairmore is taking charge of his practice in his absence.

Dr. and Mrs. Hall are visiting California where Dr. Hall will give a series of lectures.

Drs. Walker of New Westminster, Proctor of Kamloops, and R. E. McKechnie were at Victoria lately attending the Council meeting.

Dr. Claye Shaw's successor as lecturer on Mental Diseases at St. Bartholomew's Hospital is Dr. Robert Jones, M.D., F.R.C.P., the well-known Medical Superintendent of Claybury Asylum. The students in future will gain their experience in the extensive wards of Claybury, where over 2,000 patients are cared for.

Dr. Pirie, Calgary, has returned from his visit to the East.

Dr. Raymond Brown has returned from Chicago.

Dr. Archibald of Strathcona has gone for a visit to New York.

Dr. O'Brien, Dominion City, President of the College of Physicians and Surgeons, paid a short visit to Winnipeg.

## MARRIED

SEBOLT—LAMONT, 21st January, by the Rev'd D. Mackae, Miss Nellie Jane Lamont, B.A., daughter of Mr. and Mrs. R. Lamont, Victoria West, to Frank Raymond Sebolt, B.A., M.D., of Regina, Sask.

# BOOK REVIEWS

"Diseases of the Digestive Canal," by Dr. Paul Cohnheim, Specialist in Diseases of the Stomach and Intestines in Berlin. From the Second German Edition, Edited and translated by Dudley Fulton, M.D.—Lippincott Co., 1909, Montreal.

This work can be cordially recommended for giving an up-to-date and purely practical account of the diagnosis and treatment of gastro-intestinal disease.

Cohnheim insists on the great importance of a careful history and shows how, from this alone combined with ordinary physical examination, a diagnosis may be made in the majority of cases met with by the general practitioner. It is surprising how convincingly he proves his point.

The distinction between organic and nervous disease is specially well dealt with and enforced by a wealth of illustrative cases. In view of the large number of nervous dyspeptics in Western Canada, Cohnheim's book is very opportune.

The modern methods of the examination of the gastric contents and of the faeces are well described and their uses and limitations duly set forth; the descriptions constantly bear in mind the needs of the general practitioner.

The chapter on Constipation is worth a study: the distinction too often forgotten, between the atonic and the spastic variety is clearly drawn and the value in the latter of oil enemata, belladonna and other anti-spasmodics combined with bland diet insisted on.

One would forget the work was a translation, were it not for some notes added here and there—among them, duodenal ulcer is more fully dealt with. The knowledge gained by Anglo-American surgeons about this condition would seem to diffuse slowly in Germany.

The book is well got up and the illustrations are good.

Chas.Hunter.

Rotunda Practical Widwifery. By E. Hastings Tweedy, F.R.C.P.I., and G. T. Wrench, M.D. From the University Press, Oxford. McAinsh & Co., Toronto.

This work, coming as it does from the Master and late Assistant Master of one of the world's greatest Maternity Hospitals, naturally must come up to a very high standard.

As indicated by its title it is a practical work on Midwifery, embodying the present teachings and also the experiences of its former masters.

The methods at present in use which have been evolved from years of experience and close observation are given in detail.

One very pleasing feature in this work is the amount of space given not only to the diagnosis of normal and abnormal cases but to treatment. This subject is given in detail and any practitioner may carry out the methods as in use at the Rotunda.

Two points in treatment we consider are worthy of special mention, viz.: Accidental haemorrhage and Eclampsia.

The various emergency operations which a practitioner may be called upon to perform at a moment's notice are clearly and carefully described.

The anatomy of the pelvis and the subject of embryology are left out and there is very little given on the mechanism of labor, but the management of normal labor is given in detail and should

be of great value to the practitioner in aiding him to prevent the normal from becoming abnormal or to the early diagnosis of an abnormality.

The very important subject of puerperal sepsis in all its forms is dealt with in detail and from the very clear way in which it is presented it cannot fail to help the practitioner in his efforts to deal with this very grave condition.

The subject of the care of the healthy infant and artificial feeding is gone into in detail. The book is well written, is interesting and free from a rehash of other works. The subjects are well classified and indexed, the volume is of convenient size and well worthy a place in a practitioner's or student's library.

D. S. Mackay.

Owing to many demands from the profession, Dr. Charles A. Hodgetts, the Chief Health Officer of Ontario, has issued a second edition of his convincing pamphlet on Vaccination. Thousands of parents object simply because of ignorance. The distribution of this pamphlet among the general public should do much in educating them as to the disastrous results which may follow the present encouragement of indifference. Masterly arguments are taken from the works of Drs. Immerman, Welch and Schamberg and Metchnikoff.

## NOTICES

The papers and discussions of the American Editors' Association at the Chigaco meeting are of great interest not only to those journalistically engaged but to the profession at large. The transactions are now in book form and will be sent postpaid for 50 cents. Many important subjects are dealt with such as:—"Medical Book Reviews," "The Function of the State Association Journal." "The Future of the Independent Medical Press," "The Spirit of 1908," etc.

Do not forget that the Manitoba Medical Association meets at Brandon June 22nd. Also any willing to contribute papers should communicate at once with the secretary—Dr. Halpenny.

Battle & Co., St. Louis, inform us they have charts of fractures which will be sent free to any medical man on application.

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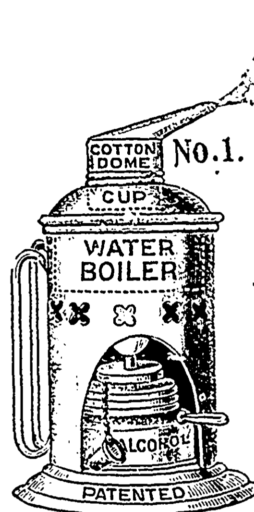


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| Ammonium chloride | $NH_4Cl$ | .8560 |
| Sodium bromide | $NaBr$ | 1.3866 |
| Sodium iodide | $NaI$ | 1051 |
| Sodium carbonate | $Na_2CO_3$ | 13.5582 |
| Calcium carbonate | $CaCO_3$ | 9.5000 |
| Magnesium carbonate | $MgCO_3$ | 31.3460 |
| Alumina | $Al_2O_3$ | .1190 |
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# NOTICE

## ODD-NUMBERED SECTIONS

As already publicly announced, odd numbered sections remaining vacant and undisposed of will become available for homestead entry on the coming into force of the Dominion Lands Act on Sept. 1, next.

As the records of only the even numbered sections have hitherto been kept in the books of the various land agencies in the western provinces and the time having been very limited since the passing of the act within which to transfer the records of all odd numbered sections from the head office at Ottawa to the local offices, it is possible that the transfer of records in some cases may not have been absolutely completed by the 1st September. In any case where the record of any quarter section has not been transferred, application will be accepted but will have to be forwarded to head office to be dealt with.

As it has been found impossible as yet to furnish sub-agencies with copies of the records of the odd numbered sections and in view of the large probable demand for entries, all applicants for entry upon odd numbered sections are strongly advised to make their applications in person at the office of the Dominion Lands Agent and not through a Sub Land Agent. Applications for even numbered sections may be dealt with through the Sub-Land Agent as before if desired.

J. W. GREENWAY,

Commissioner of Dominion Lands,
Winnipeg, August 22, 1908.

## Synopsis of Canadian North-West Homestead Regulations

Any even numbered section of Dominion lands in Manitoba, Saskatchewan and Alberta, excepting 8 and 26, not reserved, may be homesteaded by any person who is the sole head of a family, or any male over 18 years of age, to the extent of one-quarter section of 160 acres more or less.

Application for entry must be made in person by the applicant at a Dominion Lands Agency or Sub-Agency for the district in which the land is situate. Entry by proxy, may, however, be made at an Agency on certain conditions by the father, mother, son, daughter, brother or sister of an intending homesteader.

DUTIES:

(1) At least six months' residence upon and cultivation of the land in each year for three years.

(2) A homesteader may, if he so desires, perform the required residence duties by living on farming land owned solely by him, not less than eighty (80) acres in extent, in the vicinity of his homestead. Joint ownership in land will not meet this requirement.

(i) A homesteader intending to perform his residence duties in accordance with the above while living with parents or on farming land owned by himself must notify the Agent for the district of such intention.

Six months' notice in writing must be given to the Commissioner of Dominion Lands at Ottawa, of intention to apply for patent.

W. W. CORY,

Deputy of the Minister of the Interior.

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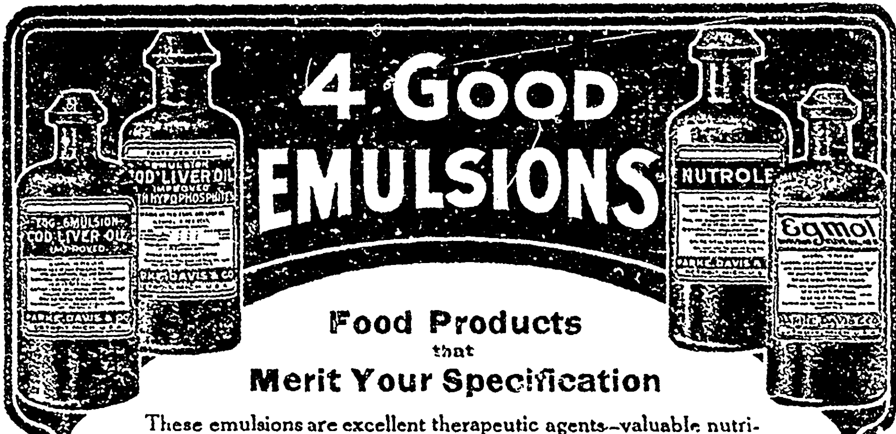


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BRANCHES: NEW YORK, CHICAGO, ST. LOUIS, BOSTON, BALTIMORE, NEW ORLEANS, KANSAS CITY, MINNEAPOLIS; LONDON, ENG.; MONTREAL, QUE.; SYDNEY, N.S.W.; ST. PETERSBURG, RUSSIA; BOMBAY, INDIA; TOKIO, JAPAN; BUENOS AIRES, ARGENTINA.