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# The Canadian Practitioner and Review.

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## Original Communications.

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### SOME EXPERIENCES IN THE WAR IN SOUTH AFRICA.

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A great war necessarily presents many phases and points of view, and as the time allowed for the reading of papers by associations, such as I have the honor to address, is limited, I shall only deal briefly with one or two phases which I hope may prove of interest.

The war in South Africa is interesting surgically because of the experience which has been gained of the effect of modern arms of precision, and of antiseptic methods on the field of battle and in the hospitals. It is too early yet to draw deductions from the statistics of the war, but it may be noted in passing that while 936 officers and 11,701 non-commissioned officers and men have been wounded—12,637 in all—only 732 have died of wounds received in action, an infinitesimal proportion, which may be fairly ascribed to the aseptic character of the bullet, to the prompt application of a first aid dressing and to the able and eminently efficient treatment which the wounded received at the hands of the medical officers in the hospitals. The Mauser bullet has justly been described as a merciful one. Its action upon human tissues depends, however, upon the range at which it is fired. It has been noticed that when it is fired at short ranges, within two hundred yards, it has an explosive character. The nickel case seems to expand and become de-

tached, causing a severe lacerated and contused wound, which heals but slowly. If it strike bone it crushes and destroys it. If fired at longer ranges it makes a clean drilled hole in bone, and if it strike soft parts only a very small wound is made, there being little difference between the wound of entrance and that of exit, which bleeds but little unless an important vessel is injured. In the case of the soft-nose or dum-dum bullet the wound is much more severe, for even where the soft parts only are injured the expansion of the lead causes great destruction of parts and a huge wound of exit, the wound of entrance being small. When it strikes bone it pulverizes and disintegrates it. If the range is very long, 2,000 yards or more, the soft-nose bullet "mushrooms" and causes an extensive flesh wound. It has been alleged that poisoned bullets were used. I have seen many of these so-called poisoned bullets. They are simply green with verdigris, which in all probability is burned off in the rifle while the bullet is in transit through the barrel. I have heard of no case where poisoning by a bullet could fairly be said to have occurred. It has been charged that explosive bullets have been used. I very much doubt the fact. The explosive character of Mausers at certain ranges has already been referred to. It is probably this which gave rise to the statement. When a Mauser bullet strikes a hard substance at a short range the impact is terrific and causes the bullet to fly into a thousand pieces. Besides Mauser rifles the Boers made use of many thousands of Martini-Henrys. As is well known, the bullet is a heavy one, and where wounds are inflicted they are in striking contrast to those inflicted by the Mauser. Great destruction of soft parts or bone follows, necessitating amputation in many cases. It is remarkable how few amputations have been performed during this war. Dr. Kendal Franks told the writer that in his experience not more than twenty amputations had been done in 3,000 cases, which must be attributed to the character of the wounds and to the conservative spirit of the surgery of the day. I had the opportunity of examining a good many Boer wounded and found that the bullet of the Lee-Metford rifle inflicted a wound very similar in character to that of the Mauser. It is not necessary, therefore, in this place to say anything more on that head. The effect of shell-fire was interesting, if not destructive. The Boers say it is no good and only makes one keep one's head down. The lydite shells are not nearly so destructive as was supposed. When they strike soft ground they do not explode. When they strike a rock they explode with great violence, but our friends the enemy were so cleverly entrenched that but few were injured by them. I remembered seeing one man stained a bright yellow from head to foot and apparently not much the worse for it. They said

the escaping gas made their heads ache and they found that a few drops of vinegar taken inwardly relieved it. Every Boer was provided with a small bottle of vinegar to ward off the ill effects of lydite. I have said that I had the opportunity of seeing a good many Boer wounded, and as their condition presented special features of interest, I will venture to detain you a few minutes by referring to some of the cases I saw. When I was at Kimberley we had 147 Boer wounded in the roller rink, which had been converted into a temporary hospital. They were of all ages, from fifteen to sixty-five, and bore their captivity and sufferings with dignity and patience. They had been wounded at Paardeberg chiefly, and in many cases the wounds had been undressed for sixteen and seventeen days. I remember one man who had been shot through the elbow joint. His only treatment had been the universal Boer remedy, tobacco juice. The arm was enormously swollen and almost erysipelatous in appearance. Mr. Roberts, civil surgeon, opened up the joint freely and removed considerable masses of bone, and found a large piece of shell so firmly imbedded in the humerus that it could not be removed. The wound was very offensive. It was freely drained and douched with bichloride, dressed antiseptically and supported by a rectangular splint. This man made an excellent recovery, with a movable joint. Another man was shot through the body by a round ball from a shrapnel-shell. The projectile entered four inches below and to the left of the heart and came out through the sixth intercostal space on the right side and posteriorly. He had been wounded sixteen days previously, and at the time that I saw him he had practically no symptoms. This is the more remarkable when the character of the missile is considered. I have seen a good many penetrating wounds of the abdomen which have produced little immediate disturbance. One was the case of a medical officer who was shot through the stomach. He had little to eat for twelve hours before his wound. When he was wounded he had the sense to abstain from drinking, notwithstanding the urgent thirst; and further, he lay still where he was for twelve hours. He made an excellent recovery, but I observed that some three months after his wound had healed that he complained of dragging and discomfort in the neighborhood of the wound, and was eventually invalided home. Two of his companions who had been shot through the abdomen at the same time were so unwise as to drink water and died in a few days from peritonitis. This may have been caused by the filthy water. It was generally understood in South Africa that abdominal section in wounds of the intestine was inadvisable, judged by the results; but I know of one case where an excellent result was obtained. It was surprising how great joints like the knee could be pierced

by Mauser bullets with impunity. I remember the case of an officer who was shot through the knee joint at the battle of Korn Spruit. In six weeks he was walking about without a crutch, and had returned to duty. Ten days later this officer, with his squadron, was ordered to take a kopje. His brother officers were killed beside him, and he was shot again in the same knee. The wound proved to have been caused by a spent bullet, and was unimportant, though the missile had lodged in the patella tendon. Wounds of the chest by Mauser bullets were comparatively innocuous, and healed readily. In some cases there was a considerable hemorrhage into the lungs, with marked difficulty of breathing. If the obstruction was not so great as to seriously interfere with respiration, these cases, recovered. Wounds of the head were necessarily more serious, but I observed several in which there was considerable destruction of brain tissue, which afterwards made good recoveries. One case was that of a boy who was shot in the left side of the skull, close to the coronal suture, the wound running antero-posteriorly, and who had right hemiplegia, from which, after removal of fragments and depressed bone, a good recovery was made. A young Boer was shot through the mastoid, the ball coming out just above the zygoma. He made an excellent recovery, with impaired hearing. I notice that many apparently minor cases of grooving of the outer table of the skull were accompanied by reflex symptoms. Wounds of the eye were of frequent occurrence, and in most cases were most destructive. I saw two cases in which both eyes were lost, the bullet passing through the orbit and cutting the optic nerves. Another man had the optic nerve cut on one side, and, strange to relate, on the nerves of motion, cut on the other. There was almost complete ophthalmoplegia and mydriasis, but the vision was otherwise unimpaired. Cases of injury from fragments of shell and sand, thrown into the eye by exploding projectiles, were very common. Altogether, wounds showed a surprising tendency to heal rapidly, even under the most trying circumstances, which was due to the character of the bullet, the early application of an antiseptic dressing, enforced temperance among the troops, their general good health, and the careful and painstaking work of the Royal Army Medical Corps.

Before closing I wish to make a very few brief remarks upon the hospital administration in South Africa—a subject which is occupying a large place in the public mind because of the attacks which have been made upon the administration under the guise of philanthropic interest in the welfare of our soldiers, but which is in reality a thinly disguised and discreditable political attack upon the Imperial Government. The position was this: The Orange Free State is a land which produces

little towards its own support in food for men and horses. Its main artery of communication is a narrow-gauge railway, of the length of 725 miles, between Capetown and Bloemfontein, where the alleged atrocities are said to have taken place. Suddenly a hundred thousand soldiers and twenty thousand camp-followers are thrown into this country, already bare and hardly able to feed itself. Add to this twenty-five thousand horses, mules and oxen, all of whom, men and animals, have to be fed by this narrow-gauge railway. In addition there are munitions of war—horses, mules, guns and soldiers to be carried, besides miscellaneous hospital and personal stores, passengers, as well as food and merchandise for the residents of the country. With a limited rolling stock I leave it to you to imagine how difficult was the problem which confronted our army; a problem which was rendered still more difficult by interruption of communication by the blowing up of bridges. Then, almost without warning, a great epidemic of enteric fever broke out. In one day upwards of a thousand men were admitted to the hospital.

Would it be surprising that beds and bedding were hard to find, or that orderlies and nurses were over-worked? Naturally, under the circumstances, the field hospitals had to be utilized as stationary hospitals, though they are neither equipped nor intended for such work. The officers and men of the Royal Army Medical Corps rose to the occasion, and did magnificent work, heroically sacrificing themselves on the altar of duty, as is proved by the death and disability returns. In short, everything was done to meet the requirements of the emergency that circumstances permitted of, and there did not exist the neglect and misery so graphically and glibly set forth by certain untrustworthy politicians. No one was more keenly interested and sympathetic than the Commander-in-Chief, Lord Roberts, and I always found him most willing to grant every reasonable facility in getting up stores and comforts, and in aiding our work in every way.

The history of this war redounds to the credit of the medical officers, civil and military, who worked so faithfully, so energetically, and so successfully to alleviate suffering and assuage pain. The medical organization of the army is by no means perfect, and will require readjustment when the war is over. The medical officers should be given entire control of their supplies of medicines and drugs. They are now supplied by an ordnance department. Could anything be more absurd? There should be less red tape and more latitude in the purchase of comforts for the sick. A sufficiency of transport should be always available for the sick and wounded. The orderlies should receive higher pay and be recruited more carefully. The

sanitary arrangements should be more directly under control of the medical department.

These are a few of the changes which will enable the medical department to more thoroughly and efficiently carry out its work of mercy and relief. The Royal Army Medical Corps contains some of the ablest and most capable men I have ever met. It is a credit to the army and an honor to the nation.

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## ERYTHEMA BULLOSUM.

BY DR. GRAHAM CHAMBERS, TORONTO.

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Erythema bullosum may be defined as that form of erythema multiforme which exhibits in the highest degree the pathological change which is present in the latter disease. Thus I look upon the hyperemic spot, papule, tubercle, edematous nodule, vesicle, and bulla as lesions representing different degrees of the same pathological process. All the forms of lesions are inflammatory in origin, but there is always present, in addition, more or less angio-neurotic edema.

From a pathological standpoint, therefore, erythema multiforme may be said to form a connecting link between angio-neuroses such as urticaria, and non-neurotic dermatitis such as impetigo. Pemphigus and dermatitis herpetiformis may be placed in the same category. No wonder then we find cases of erythema bullosum, such as discussed below, which approach in their clinical manifestations the diseases acute pemphigus and acute dermatitis herpetiformis.

As stated before, erythema bullosum is a variety of erythema multiforme. In adults the multiformity of the lesions is usually well marked, whereas in children it is not unusual to find vesicles and blebs the sole lesions present. These are the cases which closely resemble pemphigus. The bullæ may develop upon hyperemic spots, papules, etc., or arise from the apparently normal skin. The lesions may be discrete or arranged in groups, and show by their method of extension an herpetic quality. Thus, round a vesicle or bleb a ring of vesicles or blebs may form. This ring again may be surrounded by a second, and so on until we have three or four rings of vesicles or bullæ. When the lesions are arranged in this circinate manner, the disease is usually classed with that variety of erythema multiforme known as herpes iris. The contents of the lesions are at first clear but many of them soon become purulent. Hemorrhages may take place into the bullæ. The blisters do not readily rupture, but dry up to form flat scales.

The exudation rarely contains sufficient fibrin and leucocytes to form a crust. After healing has taken place pigmentation usually remains for a time. This in the iris form has somewhat the appearance of a target. The eruption is rarely universal or chronic, but runs a course of from two to six weeks. Relapses frequently occur, particularly in the autumn and spring. The lesions are generally situated on the hands, legs, face and neck, but may occur in any part of the body. Even the mucous membrane of the mouth is sometimes affected.

In the great majority of cases the diagnosis of erythema bullosum can readily be made out. The multiformity of the lesions, and in particular the presence of one of the iris forms, as well as the distribution of the eruption, forms a picture difficult to mistake for any other disease. However, when the lesions are either vesicles or blebs, considerable difficulty is experienced in differentiating the disease from other bullous affections such as pemphigus, dermatitis herpetiformis, bullous impetigo, bullous syphiloderm and urticaria bullōsa. Pemphigus, in particular, sometimes bears a very close resemblance to this disease. Thus, in both diseases, the blebs sometimes appear on apparently normal skin, and when developed are not surrounded by red areolæ. However, if the case is watched for a few days some other forms of lesion can usually be made out in cases of erythema bullosum. In addition, the following points of difference may be noted. Pemphigus is usually a chronic disease; erythema bullosum is acute, running its course in from two to six weeks. The eruption of erythema bullosum is more or less symmetrical, usually appearing on the arms, hands and lower limbs, whereas in pemphigus the lesions are scattered about irregularly and do not as a rule show any symmetry in their distribution. The lesions of erythema bullosum are frequently grouped and concentrically arranged. In pemphigus there is no tendency to such arrangement. These characters are usually sufficient to make a diagnosis. However, cases are occasionally met with which have part of the symptoms of both diseases, and then the diagnosis can only be made by watching the cases for some time.

The etiology of erythema multiforme is somewhat obscure. Toxines circulating in the blood are probably the cause of the majority of cases. Several cases have been recorded as the result of shock.

The bullous variety of erythema multiforme is considered by most writers a rare disease. This has not been borne out by my experience, as I have seen during the last two years seven cases. In five of these the diagnoses were readily made by the distribution and multiformity of the eruption. In the remaining two cases considerable difficulty was experienced in



classifying the diseases. The following are short notes on four of the patients:

CASE I.—December, 1898; female, aged thirty. Bullous eruption on lips and mucous membrane of mouth. The blebs readily ruptured, leaving irritable looking surfaces. Blebs, papules and circinate lesions on backs of hands. Slight fever for a few days. Examination of urine showed a marked increase in the quantity of indican. The patient recovered under treatment in three weeks. Five months after this attack the eruption appeared again, and was very similar in character to the first, but was not so severe. In both attacks



CASE III.

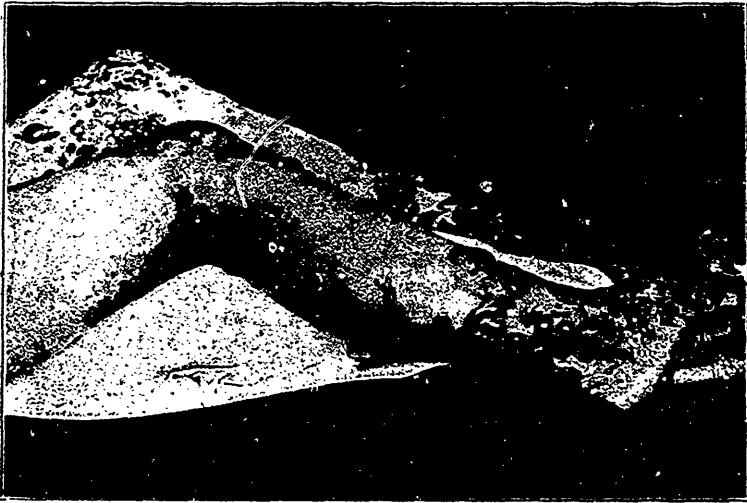
the patient was treated with a mixture containing arsenic, sodium salicylate and cascara sagrada.

The distribution of the rash and the presence of the iris form of lesion on backs of hands made the diagnosis of this case very easy.

CASE II.—Aged twenty-eight; a patient of Dr. William Oldright. I saw him in consultation in the spring of 1898. Patient was a heavy cigarette smoker. An analysis of his urine showed a marked increase in the quantity of indican. An examination of the eruption showed it to be a case of herpes iris, with hyperemic spots in the mouth and on the conjunctivæ. The patient was treated with intestinal antiseptics and tonics, and made a rapid recovery. During the following summer he had a slight attack while on a visit to British

Columbia. In the autumn of the same year the patient was attacked by the disease again, and the symptoms were similar to those of the first, but much more severe. Vesicles and blebs formed in the mouth, and the conjunctivæ of the eyes were highly inflamed. The patient recovered from this attack in about three weeks.

CASE III.—Female, aged ten; was admitted into St. Michael's Hospital on April 26th, 1899. The rash had appeared on the body about two weeks previous to this date. The child was vaccinated about a month previous to appearance of the eruption. At the time of admittance the lesions were not multi-



CASE III.

form, but either vesicles or blebs. The eruption was fairly symmetrical and widely distributed on the arms, hands, legs, buttocks and neck. The patient stated that a lesion was always preceded by a red spot. The contents of the majority of the lesions were clear, but some contained blood and others pus. There was more or less grouping of the lesions, but very little tendency to concentric arrangement. There was a slight elevation of temperature. Three days after admission some erythematous and circinate lesions appeared on palms of hands. It was about this date that the photographs were taken by Dr. Edmund E. King. After this the patient began to improve and in about a fortnight was nearly free from the lesions, when a recurrence of the eruption took place. The blebs were not so large as at the beginning of the disease, and in addition a few

papules and erythematous patches were plainly visible. Since that date the patient has gradually improved, and at the present time is apparently cured. The child complained of very few subjective symptoms. The affected parts were tender to the touch, but there was no complaint of itchiness. The patient was given the same internal treatment as in Case I. Externally, calamine lotion was applied for a time, but latterly a weak ammoniated mercury ointment has been used.

I believed this case to be erythema bullosum on account of the acute course of the disease, the symmetry of the eruption, and the presence of erythematous and circinate lesions on the palms of the hands.

CASE IV.—This was a patient of Dr. John Hunter, to whom I am indebted for these notes, and for an invitation to examine the case. The patient was a boy, ten years of age. Like the preceding case, vaccination had been performed about a month previous to the appearance of the rash. When I examined the patient the eruption was roughly symmetrical and was very extensive, covering at least one half the body. The arms and legs were nearly covered with vesicles, blebs and pigmented areas. The great majority of the lesions were grouped, and the concentric arrangement was well marked. In some of the groups three or four concentric rings of bullæ could be made out. The pigmented areas remaining after the lesions had healed also showed the concentric arrangement, and reminded me of a target. The patient completely recovered six weeks after the appearance of the eruption. There was a slight elevation of temperature during the early stages of the disease. Dr. Hunter diagnosed the case as erythema bullosum, and I believe that the diagnosis was correct.

## INFANT FEEDING.

BY DR. McKEE, TORONTO.

The sole object of this paper is to arouse discussion. I do not suppose that I will be able to say anything about the subject that most of you do not already know, either from practice or reading, but I hope to draw attention to some points that sometimes slip the memory of the busy practitioner, and to others that are not given the attention they deserve. In fact, the whole subject of infant feeding is given too little attention by a medical man as a rule.

It should hardly be necessary to repeat here, that cow's milk, modified by the addition, in varying proportions, of cream, sugar and water, and these only, should be the only food given to infants who are artificially fed, up to the age of nine months, and the chief food until they are one and a half years old. This is one of the things too often forgotten.

Sometimes we hear it said that this or that baby cannot take cow's milk. That is not the fault of the baby, but of the modification of the milk. That it is difficult in many cases to modify milk so that it will agree with the given case is shown by the many patent foods on the market, each of which claims that, if used according to directions, with or without the addition of cow's milk, it will make a perfect substitute for human milk. That in some cases these foods do seem to agree better than cow's milk is true, but if any thought is given to the question it will be seen why they do so, and why they are so much used even by physicians, although the results are usually so unsatisfactory in the end. It is possible to so modify cow's milk that it will agree with any infant, with whom it will agree if one of these foods is added, and at the same time give them a much better chance of growing into healthy children, and escaping in great measure the illnesses too common in infancy.

I well know that parents often use these foods without asking the advice of the physician, simply because some friend's baby has been fed that way and looks fat and rosy, but too often they use one or the other of them on the advice of their physician, and once they begin to use the patent food we usually have nothing more to do with the feeding of that baby, unless some illness follows. In no branch of practice do we let so many patients, who would be good paying ones, slip away from us, to be guided by the directions on the labels of some patent article, when, if time and care were only given to the work we would be able to hold them, and in nothing does care and attention to detail give such results as in the artificial feeding of infants.

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There are many methods for the modification of cow's milk for infant feeding. The more easily this can be done, in order that the resulting mixture will resemble human milk as nearly as possible, the better. As is seen by comparing analyses of cow's milk with human milk, the proteids and salts in the former are in too great proportion, the fat and sugar too low.

Human milk.				Cow's milk.			
Fat.	Proteid.	Sugar.	Ash.	Fat.	Proteid.	Sugar.	Ash.
4.13	1.3-1.5	7.	.2	3.75	3.76	4.42	.68

If nature intended that anything else should be given the infant than what is contained in milk, we have not been told of it, and if given in proper proportion these constituents are all that it is necessary or proper to use. In using cow's milk the chief difficulty is with the proteids, and these are the chief elements in the food, as they alone are able to replace the constant nitrogenous waste going on within the body. The fats are closely associated with them as they save nitrogenous waste, and the whole energy of the proteids is enabled to go towards building up the body. Fats are also necessary for the proper formation of bone and nerve cells and fibres, besides being stored up in the body as fat. Fat is necessary as the chief source of animal heat, being even more useful for this than the sugars. The sugar is also stored up in the body as fat. The salts are chiefly of use in the growth of bone, and as sodium chloride is deficient in cow's milk, it is in many cases advantageous to add some. How is it possible to modify cow's milk, easily, so that we will have all the constituents in their proper proportion? The method I find most useful in practice is as follows:

For example, take of

Whole milk . . . . .	4 oz.
Water . . . . .	12 oz.

and in the mixture we have practically

Fat.	Proteid.	Sugar.	Ash.
.94	.94	1.10	.18

Now, ordinary skimmed cream, from good average milk, contains 16 per cent. fat.

If we take

Whole milk . . . . .	4 oz.
Cream . . . . .	1 oz.
Water . . . . .	11 oz.

we have

Fat.	Proteid.	Sugar.	Ash.
1.94	1.18	1.42	.22

all the constituents being increased  $1/16$ , cream being the same as milk, except for the extra amount of fat. If two ounces of cream are added we have

Fat.	Proteid.	Sugar.	Ash.
2.94	1.42	1.74	26.

Always remembering that each ounce of cream added increases everything  $1/16$ . Also that the quantity must be kept at 16 ounces, and if cream is added an equal amount of water must be left out. If the proteids are desired in a greater proportion use more milk and less water, and if a smaller proportion, use less milk and more water. Cane or milk sugar may be used to obtain the proper amount of sugar. One ounce of lime water in the 16 ounces of the mixture is plenty for alkalinity. Have the whole quantity for the day mixed at one time and put in separate bottles on ice, to be warmed before using. In the summer time it is often necessary to sterilize the milk, but avoid that if possible.

This method does not give the proportions scientifically exact, but even breast milk is varying all the time. If good average milk is used it is possible to get any necessary combination, and the variations will be so slight as to be ignored in the majority of cases. The main thing is to begin always with the percentage of proteids low.

As to the quantities to be given at a time, they vary with the infant. A good working rule for minimum amounts is one ounce for each month of the infant's age up to six months, after that increasing more slowly until eight or nine ounces is reached at twelve months.

The number of meals in a day depends on the amount taken at a time, and on the baby; some at four months requiring the same intervals and amounts as others at six months. Two-hour intervals in the day time and two night meals in the first month, two and a half-hour intervals and one night meal in the second and third months, three-hour intervals and one night meal in the fourth and fifth months, three hour intervals and no night meal after that.

Insist upon regularity in the feeding. Watching each case carefully is the only way in which it is possible to tell the amount of food required and the intervals. Have the baby weighed weekly. For the first six months there should be an average gain of five to six ounces a week, three ounces a week for the balance of the first year. If the gain is too slow, and the food is being digested, the sugar is likely too low, other things being equal. If the proteids have been kept at a low percentage very long, it may take a long time to make up the average gain. It is impossible to avoid some temporary



troubles in artificially fed children. The most common of these are :

*Vomiting.*—Due to too much food at a time. If it comes on an hour or two after taking the food, the fat is probably too high. If the vomited matter consist of or contains much sour mucus, and is at all constant, hydrochloric acid is either deficient or unable to do its work properly. Lactic and butyric acids and other products of fermentation are present, and we have most probably a catarrhal gastritis to deal with. The presence of mucus in the matter vomited is too often not bothered with. If the warning were heeded much trouble might be avoided.

*Colic.*—This may be due to too much of any of the constituents of the food. Usually, however, to too much casein.

*Constipation.*—This may be due to too little fat or sugar. Too little food or too much casein. Lack of water between meals is one of the commonest causes.

*Diarrhea.*—To too much sugar or casein usually. It may be, however, due to too much fat. In those cases so commonly met with where the infant is irritable and cross, and has two or three green motions daily, the probability is that it has been overfed. It is often possible to render artificial feeding easier, if it is insisted upon that infants must have plenty of water between meals.

It is impossible here to describe methods which are to be used in those cases which are very difficult to feed artificially, whether the difficulty is due to a naturally feeble digestion or to bad feeding in the beginning. The above method will give results satisfactory in the majority of cases, but no method will give good results unless careful attention is given to detail, and each case careful watching, at least until it is well started. And the more cow's milk is used alone, the less often will anything else have to be used or added to the milk.

# THE OPERATIVE TREATMENT OF PROCIDENTIA UTERI IN ELDERLY WOMEN.

BY A. LAPHORN SMITH, B.A., M.D., M.R.C.S., ENG.

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The condition of an elderly woman, of between fifty and seventy-five years of age, with her womb hanging outside of her body is a pitiable one, and has doubtless attracted the sympathy of the physician from time immemorial. She may be otherwise, in excellent health, but the remaining twenty-five years of her life are embittered by her infirmity. As is well known, the perineum is so relaxed that no pessary, except a cup and stem one, will remain in place, and this latter is not without danger. A large ring pessary, it is true, can be kept in by the aid of a perineal bandage, but this requires a good deal of looking after, otherwise it may cut its way through the vagina, while the perineal bandage has to be removed and replaced every time the woman attends to the calls of nature.

The majority of these cases have a lacerated cervix, and in fact this and the laceration of the perineum were the initial lesions which brought about the prolapse. The laceration prevented involution of the uterus, and the latter organ, instead of becoming small and light, remained large and heavy. Owing to the too general practice of keeping women lying on their backs after confinement, the sub-involuted uterus becomes a retroverted one by gravity, and when the woman gets up the bowels fall in front of the womb, and the round ligaments are unable to pull the fundus forwards again, so that the uterus is forced on to a lower plane in the pelvis. There being no perineal support to oppose both gravity and intra-abdominal pressure, the cervix appears at the vulva, bringing the bladder and rectum with it, causing a chronic cystitis and a dragging pain in the back. If the laceration of the cervix is a severe one the consequences are more serious, for the scar tissue in the angle of the tear is not suited for the rough usage to which it is subjected, and every time the woman sits down it is bruised and bleeds, and often sticks to the clothing. It is no wonder, therefore, that I have on many occasions found cancer developing in the angle of the tear in a prolapsed uterus, and for that reason alone, have had to remove it; while in other cases I have found a large chronic ulcer covering the whole of the cervix, and bathed with a foul smelling purulent or bloody discharge. I believe that there are several thousand such women in Canada, and it is with the hope of rendering the remaining years of these women's lives happier that I desire to bring the very satisfactory modern treatment of this condition, by

operation, before the profession. For I feel certain that any woman who has been cured by them, or any physician who has seen the results of the operation, will have little difficulty in persuading others to avail themselves of them. The only difficulty lies in the prevailing notion that a woman of fifty or sixty or seventy has seen her best days, and that it is not worth while doing anything to make more comfortable the short time she still has to live. There are several errors in this belief, the first of them being that a woman of seventy has only a short time to live. For instance, I was called, a little over twenty years ago, to attend a lady of seventy-four who had fallen on the icy pavement and broken her thigh bone. As much care was taken in setting it as though I had expected her to live to be ninety. And it was well that I did so, for she is now ninety-four years old and apparently in the best of health, and taking keen enjoyment in life.

Several women from whom I have removed the uterus for elongation of the cervix or prolapse, after they had reached the age of sixty-five, have already lived from one to five years in perfect comfort, and will probably live as many more. And even if we knew beforehand that they were only going to live five years more, still it would be well worth while to operate on them in order to make them comfortable for that length of time.

A few months ago I removed from an old lady of seventy-five, a uterus which had been out of her body for more than twenty years. There was a large malignant-looking ulcer on it, due to its adhering to the clothing every time she sat down. After removing the uterus, which was five inches long, I repaired the perineum. Although her arteries were very hard and there was an *arcus senilis* in her eyes, she bore the operations remarkably well; she was only on the table half an hour for the two of them, and did not bleed more than three ounces of blood, most of which was lost during the perineorrhaphy. I have seen this patient many times since, and she assures me that she feels like a young woman.

We have two operations to choose from, according to the degree of the prolapse and the size of the uterus. If the latter is small and not far enough out of the body to become ulcerated, the safest operation is to make a small incision in the abdomen, and catching the fundus with the bullet forceps, draw it up to the incision and scarify the whole anterior surface of the fundus, and then to sew it to the abdominal wall with buried chromicized catgut; after which the vaginal outlet is narrowed by a large anterior and posterior colporrhaphy.

If, however, the uterus is very long, so that sometimes the sound measures seven or eight inches deep, and especially if it is badly ulcerated, it is better to amputate all but the upper two inches of it and then to narrow the outlet.

In one of my cases the first and simpler method of ventrofixation failed completely to cure the trouble, although, technically, the operations were perfectly successful; that is to say that the fundus remained firmly attached high up to the abdominal wall, although the cervix soon appeared at and eventually protruded through the vulva. At the operation the sound had entered four inches, and though an inch was taken off the cervix then, yet, four months later, the vagina with the bladder and rectum seemed to have dragged the cervix down and elongated it until the sound entered five inches. Then when I tried to remove the uterus by vaginal hysterectomy, I found it impossible to detach the fundus from the abdominal wall, it had become so adherent; so I had to be content with removing the lower three inches of the uterus, and fastening the vagina to the remaining two inches. This was a very long and difficult proceeding, but the woman made a good recovery. In the second case I profited by my first experience, and did not attempt to detach the fundus, but merely amputated the lower half of the uterus and stitched the vagina to the upper half, and she has also made a good recovery. But I learned two things from these two cases: first, that ventrofixation is, sometimes at least, really a fixation, and, if properly done, a most reliable means of fastening up the uterus: and, second, that it must not be depended upon when the uterus is elongated, in which case there must be a preliminary amputation of the cervix. Although I have removed quite a number of prolapsed uteri, yet, in the majority of cases, it is better to amputate the cervix and ventrofix it.

There is one advantage which ventrofixation and amputation of the cervix possess over removal of the uterus namely, that the bladder and vagina are drawn up by ventrofixation better than when the uterus is removed. However, by doing a Stoltz operation to narrow the anterior vaginal wall, and a Hegar to narrow the posterior one, the vulvar outlet generally becomes quite small enough to keep the cystocele and rectocele in. I say generally, for the cure of cystocele is sometimes one of the most difficult results to obtain. Martin, of Berlin, says he has had these patients return again and again for recurrence of it, although he adds that they were mostly working women who had to return to their arduous occupations rather too soon. It is advisable, therefore, to keep these patients in bed six weeks instead of three, in order that the plastic adhesions may have time to become strong. As I have already stated in several of my articles, ventrofixation has given me the most satisfaction of any operation I have ever performed, especially when combined with amputation of the cervix and anterior and posterior colporrhaphy.

# Progress of Medical Science.

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## MEDICINE.

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IN CHARGE OF W. H. B. AIKINS, J. FERGUSON, T. McMAHON, H. J. HAMILTON,  
AND INGERSOLL OLMSTED.

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### Etiological Relations between Traumatism and the Formation of Neoplasms.

On account of the varying opinions as to the etiological value of traumatism in the production of neoplasms, Lengnick has studied 579 cases of malignant tumors treated in the surgical clinic of Königsberg. Out of thirty-one cases in which the patients attributed the origin of the tumor to a trauma, seven times this statement seemed wholly improbable; twelve times the influence of the trauma was evident; in the remaining twelve cases there was doubt. The following observation seems very significant: A young man, aged thirty, fell and received a severe contusion of the genital organs. There was formed a swelling of the left half of the scrotum. This was tapped three weeks after the accident, and half a litre of dark blood was drawn from it. This was followed by a purulent infection, making it necessary for the man to enter the hospital of Eiselsberg. An incision was made, and this afforded proof that the testicle was necrotic and that the spermatic cord was perceptibly thickened. The testicle was removed and the wound plugged. The microscopical examination of the cord showed that it was a case of myxosarcoma. This diagnosis was confirmed by the clinical course of the affection, since, on the surface of the wound, there appeared numerous nodules which were not long in presenting the characteristic features of a relapse. Another operation showed that the neoplasm had already invaded the abdominal cavity, following the spermatic cord. Five weeks later the patient died, and the autopsy confirmed the diagnosis of sarcoma of the cellular tissue with metastasis in the lungs and liver.—Translated from *Giornale Internazionale delle Scienze Mediche*, by Harley Smith.

### Absorption of Iodides by the Human Skin.

During two days, Gallard immersed his arms for thirty minutes a day, in a receptacle containing eight litres of the iodid of sodium (3%). The amount of the iodide in his urine showed that the quantity of that substance which was eliminated, increased rapidly, and that from 0 gr. .066, which was the amount on the first day, after the twentieth bath it reached

3 gr. .863. The elimination continued for 72 hours after the last immersion. From these experiments we may conclude that the human skin permits the absorption of considerable doses of the iodide. Translated from *Giornale Internazionale delle Scienze Mediche*, by Harley Smith.

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## LARYNGOLOGY AND RHINOLOGY.

IN CHARGE OF J. PRICE-BROWN.

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A discussion on the Indications for Intranasal Treatment in Diseases of the Ear.—DRS. PETER MCBRIDE, CRESWELL BABER and DUNDAS GRANT. (*Abstracts from the "British Medical Journal," September 8th, 1900.*)

Peter McBride opened the discussion, under two headings; 1, the conditions of the ear liable to be affected by nasal changes; 2, pathological conditions of the nose which may tend to involve the ear. It must be understood that the term "nose" includes the naso-pharynx as well. Many forms of middle-ear disease are markedly benefited by treatment of the naso-pharynx. Thus, recurrent attacks of acute otitis media may be made to cease by the removal of the adenoids. The same operation may also materially improve certain cases of chronic suppurative, although the results are not so certain. In the chronic non-suppurative middle-ear deafness of children, where the complication of hereditary syphilis is absent, the effects of removing adenoids are often little short of marvellous.

In chronic non-suppurative middle-ear disease of adults, the position is not by any means so clear. True, there are certain cases where adenoids extend from cushion to cushion, just as in children, and in which their ablation is followed by very satisfactory results; but unfortunately there is a large class of cases of progressive deafness in which the results are much more hopeless. There is a tale of gradually increasing hardness of hearing, in which tinnitus is a common symptom, and in which the sense of hearing is more acute in a crowd. In these cases the drum membrane may be indrawn, and there may be patches of thickening upon its surface. In some of these cases there may be a degree of eustachian obstruction, but in others the tubes are free. Usually, the more marked the changes in the membrane, the more likely is the tube to be narrowed.

In all his ear cases, McBride makes it a rule to carefully

examine both the anterior and posterior nares of his patients, and he divides his cases of progressive middle-ear deafness into two classes.

1. Those in which the anterior and posterior nares are either normal or somewhat anemic, and the eustachian tubes standing out with prominence, but without swelling or congestion, the outline of the whole being sharply defined.

2. Those in which there is congestion of the whole naso-pharyngeal tract, including the eustachian orifices. There may also be a certain amount of turbinal hypertrophy, deviation of septum, or presence of spurs; but as a rule these are not sufficient to attract the patient's attention. Added to these there are cases of distinct obstruction, hypertrophic, septal or adenoid, but he considers that they are not frequently found.

Another interesting point is that a normal or nearly normal membrane is usually associated with a normal or nearly normal naso-pharynx; while a diffuse congestion of the upper respiratory tract is often accompanied by indrawing, thickening, or atrophy of the drumhead. Where there is a progressive deafness in the first of these conditions, it is commonly due to changes in the region of the stapes, often associated with lesion of the osseous capsule of the labyrinth; while in the second condition, the progressive deafness is ascribed to chronic middle-ear catarrh. He therefore contends: 1. That the aurist is now in a position to distinguish the two classes of cases, the sclerotic and the catarrhal. 2. That in the former it is questionable whether operating upon the nose can ever be of benefit, but may do harm. 3. That in the latter it is better to operate upon any gross nasal or naso-pharyngeal lesion that may be causing symptoms. Speaking of the naso-pharynx, McBride draws the line distinctly between two forms of adenoid enlargement, which have a bearing on middle-ear disease. When the mass of tissue is central, situate in the vault of the pharynx, but leaving a clear space between its lateral margins and the eustachian orifices, its removal will have little or no influence upon the affected ear; neither will its presence produce ear disease. When, however, the adenoid tissue, even if limited in amount, extends from side to side, overlapping or compressing the tubal orifices, its removal will almost invariably be beneficial in ameliorating any existing middle-ear trouble.

Cresswell Baber was the second speaker. He said that diseases and abnormalities of the nose and naso-pharynx affect the ears chiefly in four ways.

1. By interfering with the proper ventilation of the tympanic cavity, either from obstruction in the nasal cavities, from closure of the mouth of the eustachian tube by secretion or

swelling of its walls, or from actual blocking of the tube by a new growth, or the pathological enlargement of a normal structure.

2. By catarrh or other inflammatory affections of the nose or naso-pharynx, spreading along the eustachian tube.

3. By the actual passage of pathogenic organisms, such as those of tubercle, diphtheria, etc., up the eustachian tube.

4. By interference with the normal action of the tubal muscles, either from paresis or paralysis of the palatal muscles, or general thickening of the mucous membrane of that part.

It is the duty of the surgeon to prevent, as far as possible, the occurrence of any of these conditions. Baber then takes the different diseases of the ear *seriatim*, stating his views on the indications for intranasal treatment.

In diseases of the auricle and external auditory meatus, there are no indications for intranasal treatment. Acute inflammation of the middle-ear, whether catarrhal or suppurative, requires no intranasal treatment, except careful cleansing of the nose by a saline solution. Exceptions do, however, arise, in which obstruction of the eustachian tube might require immediate intranasal treatment.

Chronic affections of the middle-ear are divided into non-purulent and purulent. In non-purulent cases, simple means should be taken to relieve catarrh, and to remove any specific organisms from the nose and naso-pharynx. In cases of chronic non-purulent disease, in which inflation will produce temporary relief, the removal of existing nasal obstructions should be still more beneficial. But when simple inflation is followed by no relief whatever, nasal operation is not likely to improve the impaired hearing, although it may help to preserve the amount of hearing power which still remains.

In purulent middle-ear disease it is better, if possible, to arrest the discharge before operating on the nose or naso-pharynx.

*Internal Ear*—Diseases of the internal ear require intranasal treatment only as far as they are dependent on middle-ear lesions, and to them the previous remarks are applicable. He has found no benefit from intranasal treatment either in auditory vertigo or tinnitus, excepting where these depended on tympanic troubles.

Dundas Grant said that the belief that inflammation or other obstructive conditions in the nose and naso-pharynx had an injurious effect upon the middle-ear, was accepted as a fact by a large majority of observers. In his own practice, a large proportion of patients affected with nasal obstruction were at the same time the subjects of middle-ear catarrh; and inversely, out of a number of cases of catarrh of the middle-ear, a large proportion were affected with nasal obstruction to a very definite degree.



The reason why nasal obstruction should have this effect is that behind it, inspiration produces a sort of negative pressure or suction upon the soft tissues of the nose, naso-pharynx and eustachian tube, leading at the same time to indrawing of the membrana tympani itself. It is not difficult to realize how these conditions may be induced, when there is continued presence of the obstruction, and how its removal may lead to an improved condition of the ear.

The forms of disease of the middle-ear, attributable to nasal and naso-pharyngeal obstructions, are chiefly those characterized by congestion and indrawing of the boundaries of the tympanum, and particularly the various forms of moist catarrh. From these must be distinguished the typical cases of dry catarrh, which constitute the approach of aural surgery. In them the essence of the disease is a thickening of the tissues, and ossification of the tissues surrounding the footplate of the stapes in the fenestra ovalis, which is essentially of an osteo-arthritis nature, and, like chronic osteo-arthritis of other joints, is inexplicable as regards etiology. In these cases nasal operations would be of little practical utility in removing the aural trouble.

The most typical cases of improvement after operation are those of chronic eustachian catarrh, associated with adenoid vegetations. In these the indication admits of no dispute. In deafness arising from lowering of the nerve-tone on the one hand, or from chronic suppurative disease of the middle-ear on the other, persistent obstructive lesions either in the nose or naso-pharynx should, as a rule be removed.

Dundas Grant believes in dispensing with plugging after nasal operations as much as possible. For this purpose it is advisable that the bleeding be allowed to expend its violence, before the patient gets beyond the reach of the surgeon. Again, in view of the possibility that the nasal mucous possesses some bactericidal properties, it is advisable that the smallest amount of mucous membrane possible should be removed, compatible with the removal of the obstruction.

In operations in the nose, all precautions should be taken to diminish the possibility of the occurrence of suppurative inflammation of the middle-ear. In doubtful cases, nasal operations should be avoided, unless there are other indications apart from the affection of the middle-ear.

## OBSTETRICS AND GYNECOLOGY.

IN CHARGE OF ADAM H. WRIGHT, JAMES F. W. ROSS, ALBERT A. MACDONALD,  
H. C. SCADDING AND K. C. McILWRAITH.

### The Resuscitation of Apparently Dead Newborn by Laborde's Method.

F. E. Fronczak, A.M., M.D. (*Philadelphia Med. Jour.*, February 24, p. 462).

In 1892 Prof. Laborde communicated to the Paris Academy of Medicine a new method of resuscitating the apparently dead by "rhythmic traction of the tongue." It consists in traction of the tongue by two fingers covered with a handkerchief, at the (respiratory) rate of 18 to 20 per minute in adults, a little more rapidly in the newborn. He explained its success by reflex stimulation of the respiratory centre by the motions at the base of the tongue. The method was first used exclusively, and even now is used principally in cases of arrested respiration from chloroform poisoning, drowning (*Review*, Vol. II, pp. 226, 498), and hanging. Later it has been used successfully in asphyxia neonatorum. For a long time Laborde collected statistics and reports of cases of revival of the apparently dead. But German obstetricians ridiculed the method, and for a time it appeared that his labor would be in vain. Now, however, the method is being brought into vogue, and is gaining a well-deserved reputation.

Two degrees of asphyxia neonatorum are distinguished, the livid or lesser degree, in which the skin is cyanotic and the cardiac pulsations though slow are forcible, and reflex movements are easily produced by irritation of the skin; the pallid, or greater degree of asphyxia, in which the pulsations of the heart are very feeble and of the cord are almost or quite imperceptible. The child is pale and no reflex movement is possible. Schultze's method of resuscitation is the most commonly used. It answers the purpose in removing the foreign bodies from the respiratory tract, and bringing about artificial respiration, and most efficiently aids the circulation of the blood, but there are several objections to it. It is very tiresome, it cannot be used when there is a fracture of the clavicle, as it may injure the pleura, or even cause penetration of the lung, though Schultze says that in proper use there is no danger; it can hardly be used if there is a fracture of any of the limbs; it does not give good results in prematurely born children; in small rooms the ceilings are so low that it is almost impossible to use it. Schultze's method of swinging the child requires certain technic which is seldom learned by midwives. Laborde's method has not any of these faults, but has several points in its favor.

There is no doubt that in mild asphyxia, when the sprinkling of cold water will bring about respiration, Laborde's method will also give good results; and it has also been proved that the rhythmic traction of the tongue will resuscitate a child apparently dead and in deep asphyxia. Schultze doubts if it can be applied in very deep asphyxia, when there is no pulsation of the heart or cord, unless his or some other method be used at the same time.

The following cases show that Laborde's method is sufficient under these circumstances:

CASE 1.—*Prolapse of the Arm and Version under Chloroform.*—The leg was pulled down and all went well until the coming of the head, which seemed to be almost immovable. The infant was delivered in deep asphyxia, and the Schultze method was used with no results; the Prochownik feet-suspension method was tried, but the result was negative; the child was put in a warm bath. Laborde's rhythmic traction of the tongue at the rate of 25 per minute was made, and after 10 minutes it slowly revived.

CASE 2.—*Transverse Presentation with Prolapse of the Cord: Version: the Child Born in Deep Asphyxia.*—Sprinkling with cold water and putting the child in a warm bath gave negative results; the pulsation of the heart was not apparent. With Laborde's method, at almost every traction of the tongue there was slight respiratory movement, which ceased as soon as the tractions were stopped. After several minutes, gradually the child began to breathe.

CASE 3.—*A Forceps Case, the Child in Deep Asphyxia.*—Schultze's method, insufflation, feet-suspension, warm bath and cold-water sprinkling were tried all in vain; traction of the tongue, at the rate of about 20 per minute, was continued for 20 minutes; the child gradually began to breathe irregularly and spasmodically, and finally regular breathing ensued.

CASE 4.—*Tedious Delivery with High Forceps Operation; Child in Deep Asphyxia.*—The Laborde method was adopted, tractions being made at the rate of about 22 per minute, with the child in warm bath; after 10 minutes the child was resuscitated.

In using Laborde's method the tongue at first gives no resistance; after awhile it resists positively; soon very slight respiratory movement occurs, then all is quiet. In a short time the breathing becomes stronger and the child begins to cry, move, etc.

Laborde's method is better than Schultze's, because the child does not become chilled, being all the time in a warm bath; the beating of the heart can be noticed; it does not tire the operators as easily as Schultze's method; and it can be used in cases in which the latter cannot.—*The Medical Review.*

### A Case of Tubal Abortion.

Dr. Galabin (*Transactions of the Obstetrical Society of London*, xli, part ii) showed a specimen of tubal abortion from a patient aged twenty-three, married two years; no previous pregnancy. She used to suffer from dysmenorrhœa. The history of the case was as follows: On October 1, 1898, menses came at the expected time, but lasted only one day, the usual duration being four to five days. Two days after, while turning a wringer, she felt faint for a minute, but continued at the wringer.

On October 12th, while sitting at needlework, she was attacked by acute pain in the abdomen below the umbilicus, lasting for four hours. It was relieved by hot fomentation. The pain recurred every day, but she daily got up and did her work. On October 19th, while she was out, pains came on, accompanied for the first time with vomiting, and she had to be taken home in a cab. On examination there was a yellowish vaginal discharge; no blood. The breasts were enlarged and painful, and the areolæ darkened. Coughing gave great pain, and there was difficulty in micturition. The pain was greatest in left groin. From this time she was kept in bed, and remained in a similar condition. On October 26th she was attacked again with intense pain, accompanied by collapse and pallor, and followed by constant vomiting. For a time she was pulseless. Internal hemorrhage, probably due to ruptured tubal fetation, was diagnosticated. Temperature, 97°. Abdominal section was arranged for early the next morning. There was still no discharge of blood *per vaginam*.

At the operation a very large quantity of clot and blood was found in the peritoneal cavity. The clot was partially adherent to the peritoneum, and could not be entirely removed. The ovum, a mass of chorionic villi infiltrated with clot, about two inches in diameter, was found sticking to the fimbriated extremity of the left tube, but not firmly adherent. The left tube and ovary were removed. Among the blood removed from the peritoneal cavity was found the embryo inclosed in the intact amnion. It was about a third of an inch in length, and therefore of not more than about four weeks' development.

The abdomen was closed without drainage, and the patient made a good recovery, except that vomiting continued for two days after the operation. Menstruation recurred on October 30th. The tube removed showed no rupture, and no indications of the spot where it had been dilated. The ovary contained a corpus luteum of pregnancy.

The notable points of the case were that the symptoms appeared as severe as, and indistinguishable from, those of ruptured tubal fetation; that repeated hemorrhages appear to have

occurred; that the tubal abortion was accompanied by no sanguineous discharge from the vagina; and that neither the pregnancy, the abortion, the hemorrhage, nor the operation interfered in any way with the normal rhythm of menstruation, except that the period which occurred during pregnancy was very short.—*N. Y. Med. Journ.*

### Pruritus Vulvae.

This annoying and so often obstinate disturbance justifies frequent reference in journals. Herman (*British Med. Journ.*) makes the following classification, which is most excellent:

1. Adventitious, due to dirt, pediculi, worms or pessaries.
2. Skin diseases—eczema, herpes, or furuncle, follicular urticaria and diabetic dermatitis.
3. Irrigating discharges, such as gonorrhoea, cancer, senile endometritis; also cases in which no visible discharge is apparent.
4. Venous congestion, due to heart, liver and lung diseases.
5. Nervous affections.

For each division the following treatment is recommended:

1. White precipitate ointment for pediculi. For the other causes, absolute cleanliness and changing of the material of pessaries.
2. For eczema, usually affecting fat, elderly women and those pregnant, when due to pruritic organism, warm hip baths, with liquor carboni detergents added, and the parts powdered with boric acid. When due to diabetes, general treatment. Herpes zoster did not respond to treatment. For follicular pruritus it is recommended to squeeze out the contents of follicles and apply corrosive sublimate, 1 to 2000.
3. Antiseptic and sedative douches, and sedative dusting powders on the vulva, as a saturated solution of borax and solution of boric acid. In case of failure with these, try 1 to 7 solution of carbolic acid.
4. The same local treatment as for class two with general constitutional treatment.
5. Pruritus, when occurring in aged women, is frequently a symptom of degenerate changes, and treatment usually fails.—*Buffalo M<sup>o</sup>. Journ.*

### Cancer of the Uterus.

McMurtry, as a prophylaxis (*Amer. Prac. and News*, March 15, 1900) in cancer says more operations ought to be done for lacerations of the cervix. A woman between forty and fifty years of age, who has borne children, ought invariably to be examined, and, when the physician finds she has a laceration of the cervix, a deep ulceration in the neck of the uterus, it ought

to be repaired. Here is the greatest field of usefulness there is in connection with this disease. It is a very simple operation, it has no mortality, and it brings about a great deal of relief to the patient. All women who have the slightest disturbance of the menstrual function, or any hemorrhage from the uterus after the age of forty, ought to be very carefully examined, with a view of finding an old laceration of the neck of the uterus, and, if such a condition be found, it ought to have immediate attention.

Sterile women and unmarried women who have never borne children do not, as a rule, have cancer of the uterus; multiparous women, who have borne a large family of children, are the ones especially prone to cancer of the uterus. The only way this can be explained is upon the hypothesis that there is some connection between laceration of the cervix and cancer; that there is something about the lacerated uterine neck which invites the morbid process.—*Buffalo Med. Journ.*

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## OPHTHALMOLOGY AND OTOTOLOGY.

IN CHARGE OF G. STERLING RYERSON, J. T. DUNCAN AND J. O. ORR.

### Pterygia, Pathology and Treatment.

A valuable article on Pterygia by Weymann (*Annals of Ophthalmology*, July), may be thus summarized:

1. The origin of a pterygium is a chronic inflammation of the conjunctiva of that locality.
2. That this inflamed portion of conjunctiva may ultimately shrink, causing the eye to turn. (Strabismus.)
3. That the pterygial degeneration having begun in the conjunctiva, a "head" is formed on the cornea.
4. That this "head" consists of the anterior elastic lamina. (Bowman's membrane) with its super-posed epithelium.
5. That, on account of the kerato-scleral angle, each lateral excursion of the eye tends to pull off more and more of Bowman's membrane.
6. That thus the pterygium progresses until it reaches the centre of the cornea, when it ceases, as the kerato-scleral angle is now effaced.

In regard to treatment, the removal of *all* pterygia is advised.

1. Because pterygia are almost always progressive.
2. Because if it is allowed to reach the cornea a cicatrix will invariably be left.
3. If that cicatrix is in the pupillary space the visual acuity will always be impaired.

4. Undue procrastination may result in serious complications (tendency to relapse, etc.).

While the aim of treatment is to destroy the "head," this may be accomplished so much more easily in some than in others, that pterygia may be divided into two classes.

1. Those which are small and non-vascular.
2. The large, vascular, "full-fledged" pterygia.

In regard to the first class, it is sufficient to destroy the "head." This may be accomplished in various ways, but the author prefers the use of a very thin galvano-cautery knife, with the blade bent about 45° to its insertion. With this the "head" is repeatedly "stroked" until it is thoroughly removed, and the surface made smooth. For the second class, excision, properly performed, of both the "head and body," is the only treatment to be recommended.

#### Treatment of Conical Cornea (Keratoconus).

Herman Knapp (*Jour. Amer. Med. Assoc.*, August 18th) advises the use of the galvano-cautery. He applies the convex disc electrode to the point where he wishes the subsequent cicatricial contraction to be, which should be so placed as to spare one half or more of the pupillary space. He avoids too deep a cauterization at first, preferring to operate again if necessary. In progressive cases, the operation should be performed as early as possible, but great care must be taken not to operate while any septic condition of the eye or its conjunctiva is present.

#### A Diagnostic Point in Third Nerve Paralysis.

C. A. Wishart (*Ophthalmic Record*, June) quotes Knies, "the motor-oculi nucleus of each side contains the nuclei of those muscles which take part in the movement of both eyes to the opposite side, *i. e.* the internal, superior and inferior recti of the same eye, and the inferior oblique of the opposite eye."

A paralysis of the third nerve may be first, central; second, nuclear; third, of the trunk; fourth, intra-orbital. Leaving out of consideration the first and fourth classes, is there any constant symptom by which we can decide whether the nucleus or the trunk of the nerve is the subject of a lesion?

If the nucleus of one side is destroyed, there will be paralysis of the muscles supplied by this nerve on the same side as the lesion, with paralysis of the inferior oblique of the opposite eye. But the inferior oblique of the eye first spoken of will still act fully.

But if the lesion affects the trunk at the base of the brain, all the muscles supplied by the nerve (including its inferior oblique) will be paralyzed, while the inferior oblique of the opposite eye will not be affected.

J.T.D.

# Society Reports.

## CANADIAN MEDICAL ASSOCIATION.

The thirty-third annual meeting of the Canadian Medical Association was held in the Academic Hall of the University of Ottawa, Ottawa, Canada, on the 12th, 13th and 14th of September, 1900, under the presidency of Dr. R. W. Powell, of Ottawa, Dr. F. N. G. Starr, of Toronto, acting as secretary.

### The Present Status of the Eliminative and Antiseptic Treatment of Typhoid Fever.

Dr. W. B. Thistle, of Toronto University, in contributing this paper, stated that it was now seven years since he introduced this plan of treatment of typhoid fever to the profession. Dr. Thistle claimed that this form of treatment had been misrepresented by Professor Osler and others, as he had never held to the opinion that the eliminative and antiseptic plan could rid such organs as the liver and spleen of the bacilli lodged in them. When once the typhoid germ gains access to the alimentary tract, the multiplication of them occurs with extreme rapidity and the intestinal contents teem with countless numbers of them. These are not confined to the intestines, but are to be found in the walls, and, in fact, in almost every organ of the body. He held to the opinion that the draining of the intestinal walls, following upon the action of a purgative, such as calomel and mag. sulph, would tend to get rid of some of these bacilli in the intestinal walls, but did not claim to effect their exit from the liver, etc. In many instances he thought the treatment had been imperfectly applied, without a clear conception of the underlying principle. Under this plan Dr. Thistle has never had a fatal case of hemorrhage, what hemorrhage occurred having been always very slight. He has also had few perforations. Twenty per cent. of the death rate is from perforation and hemorrhage. In Toronto this plan of treatment is universally adopted. Statistics at the Toronto General Hospital show that, from 1893 until the present time, there have been 833 cases in that institution, with 56 deaths—a mortality of 6½ per cent. under this plan of treatment.

In discussing the paper, Dr. McPhedran stated that he had watched Dr. Thistle's work from the time of the appearance of his first paper on the subject, but could not agree with all his



conclusions. He did not think that it lessened diarrhea, tympanites, fever or delirium. He considered that Dr. Thistle was harboring the idea that purgatives in typhoid was a new discovery with him; this was not so. Twenty-five years ago he gave these for the first ten days at least. In addition to this he used to give carbolic acid and iodine, and in a certain class of cases he thought he had the exact treatment. Another class would then come along in which that treatment had no effect whatever. He considered that the general toxemia that existed could not be eliminated through the bowels. It had to be done through the kidneys and skin.

In replying, Dr. Thistle emphasized the fact that he was *not* trying to eliminate bacilli and toxins from the glands; in clearing out the bowels he is trying to eliminate toxins from the body and not bacilli.

#### **A Case of Sarcoma of the Right Nasal Fossa, with Acute Sinusitis and Orbital Cellulitis.**

This paper and case was presented by Dr. Perry G. Goldsmith, of Belleville, Ont. The patient was a man of thirty-eight years, a farmer with an unimportant family and personal history. He consulted the doctor on the 4th of August, with severe frontal headache. Growths and some bone were removed from the nose. After this the swelling and pain in the eye rapidly increased, so that it was seen to project far forwards, downwards and outwards. The growths in the nasal fossa were curetted and sent to Professor Anderson, of the Trinity Medical College Pathological Laboratory, who pronounced them of sarcomatous nature, of small round cell variety, with the walls of the blood vessels thin and poorly developed. The discharge from the nostril was of an odor similar to that emanating from cancer of the uterus. Up to ten years ago Bosworth had collected forty of these cases.

Dr. R. A. Reeve, Toronto, stated that a number of years ago he had presented a paper before the Association on the same subject. He directed attention to the importance of examining the naso-pharynx in diseases of the orbit. He instanced a similar case to Dr. Goldsmith's. In his case there was little pain, but an examination of the nose revealed the tumor.

#### **PRESIDENT'S ADDRESS.**

The hall was well filled on the afternoon of the second day when the president, Dr. R. W. Powell, arose to deliver the annual presidential address. He recited a few reminiscences when on former occasions the Canadian Medical Association had met in the Capital City, in 1871, 1881, 1889 and 1893.

Reference was made to the South African war in order to show the unsatisfactory condition of affairs which permitted other colonial surgeons practising their profession in that land without hindrance, whilst Canadians were debarred from the same privilege. An earnest and united effort on the part of the profession throughout the entire Dominion of Canada in an endeavor to bring about inter-provincial registration, would facilitate matters in the direction of securing these privileges for our Canadian profession in other parts of the British Empire. The hackneyed subject of tuberculosis was lightly touched on, whilst a very important matter relating to the profession, that of a Medical Defence Association, was dealt with at considerable length. Dr. Powell favored the formation of such association, and later on in the proceedings nominated a committee to look into the question, and report on the advisability and practicability of forming a Dominion association of this character.

#### Some of My Experiences in the South African War.

Dr. G. S. Ryerson addressed the gathering on the above subject. He dealt first with the experience gained of modern bullets. The very latest returns show that 936 officers, and 11,701 non-commissioned officers and men, had been wounded, of whom only 733 have died of wounds received in action, which is ascribed to the aseptic character of the bullet and the prompt attention and antiseptic treatment. Dr. Ryerson then dealt with these wounds, which are familiar to all. Referring to poisoned bullets being used, this was not the truth, as the tarnish or verdigris probably accumulated in transit through the barrel. He also doubted the fact of explosive bullets being used. The Boers made use of thousands of Martini-Henry, a heavy bullet, which caused great destruction of soft parts, necessitating amputation. There were few amputations in this war, and quoted Kendal Franks, who performed 30 operations in 2,000 cases. Whilst abdominal section in wounds of the abdomen was mainly inadvisable, he saw one case where the results were excellent. He spoke highly of the magnificent work of the R. A. M. C.

Dr. Roddick spoke of the sacrifices of Dr. Ryerson in proceeding to South Africa at his own expense, to carry out the work of the Red Cross Association. While in England recently, he stated he made it his special business to enquire of returning Canadian soldiers as to the hospital management in South Africa, and although he had spoken to many of these, he had failed completely to find a single Canadian who had anything but praise for the hospital arrangements in that country.

### Our Race and Consumption.

Sir James Grant, Ottawa, delivered himself of an able paper with the above title. He considered it an important fact, and one worthy of consideration, that races had been born on this continent, lived, and entirely disappeared, leaving mounds in the West and other traces in Florida and elsewhere of their undoubted existence. Thus far there is no information as to the exact cause of the disappearance of these races. It remains for the Anglo-Saxons to see whether they will prove more successful than their predecessors in establishing themselves on this continent. He referred to the loss of 3,000 lives in the fair Province of Ontario in 1898 by consumption alone, and deplored the fact that the people were not as yet alive to their danger. Sir James endorsed the legislation at the last session of the provincial parliament, designed for the purpose of assisting municipalities in the erection and maintenance of sanatoria for consumptives.

### Recognition and Management of *Tabes Dorsalis*.

Owing to the unavoidable absence of Dr. Allen McLane Hamilton through illness, the President read this paper. As an etiological factor, syphilis was not referred to by the early writers on this disease. While some would attempt to divide the symptoms of the disease into the leg and eye types, the writer would consider that to be unwarranted. He considered there was a close resemblance, or rather relationship, between the different forms of cerebro-spinal sclerosis. There was no disease of the nervous system which had drawn forth so many plans of treatment, and little or no good had resulted from any one thing. Most tabetics are favorable subjects for expectant attention, and many derive temporary benefit from some new drug. Looking back over a number of years, he finds that most good has been done where little or no medicine has been given. He has found rest by suspension and persistent cauterization of the back good treatment. In the opinion of the writer, syphilis cannot be traced in more than fifty per cent. of the cases. For the arthropathies of the great joints there is little to be done. Perforating ulcer is a rare feature of locomotor ataxia, and most obstinately resists treatment. He has seen three cases of this unusual condition in ataxics, and the ulcer rarely exceeds two to three centimeters in diameter. One authority quotes five cases cured by means of nerve stretching. Throughout the course of the paper, numerous cases were cited, with their symptoms and treatment.

### The Physician's "Vaster Empire."

The subject matter of this paper, read by Dr. John Hunter, of Toronto, dealt with the questions of Sanitary Science, Education, Social Purity and Medical Missions. As regards sanitary science, the purport of the paper was a plea for the broader and freer attainment of principles of sanitary science and their application in the building and construction of our homes, schools, churches, etc. No house for dwelling in should be constructed except under the supervision of an architect and a physician versed in sanitary science. In the matter of sanitary science, architects had improved wonderfully in the past ten years. Another important question was that of our educational system—the mental and physical health and development of our school children. The best way to secure physical vigor and high mentality was surely within the province of the physician to grapple with and study. In all forms of social purity and impurity, physicians should speak *ex cathedra* against every form of vice and immorality. The boys and the girls of the family should be enlightened as to their sexual proclivities at proper periods, by the fathers and mothers respectively. In medical missions he referred to the vast field for medical missionary work in foreign countries.

### Address in Surgery—Tuberculous Lesions from a Clinical Point of View.

At the evening session of the first day, before a crowded assembly hall, Mr. Edmund Owen delivered a masterly address. At the very outset he stated that his remarks would deal with tuberculous lesions as the surgeon meets them day by day in the hospital ward, in private practice and in the operating theatre. Discussing the origin of the word—clinical—κλινη—a couch or bier, and if a bier, why not a mortuary table. Referring to the pathologists, he considered his (the pathologist's) thought to be only of the dead tissue. The surgeon sees the human tree during its life, but rarely follows it after death. The student does clinical and pathological work at different times, and he is enabled to follow the case straight from the ward to the laboratory. Study of the fresh specimen is best, for the specimen taken from formalin is no more like the condition than canned salmon is like fresh-run fish. He would not hinder experimental research work—it is absolutely essential. The life of a man is of more value than a sparrow or many guinea pigs. It would be almost impossible to over-estimate the direct value of experimental laboratory work. Strumous and scrofulous are terms devoid of meaning, and we now call tubercle by its proper name. There are three great factors in connection with tuberculosis which the public must be made

acquainted with. 1st. The disease is communicable, but they must be allowed a little time before they accept this statement and fact. 2nd. The disease is preventable; this follows almost as a corollary to the first statement. 3rd. The disease is curable. Years ago, the subject of tuberculosis was regarded as well nigh hopeless. Tuberculosis is not necessarily of the untractable nature that it was formerly considered to be. Tuberculous lesions are exactly what they used to be, and Mr. Owen has worked at the largest children's hospital in London, Eng., for over a quarter of a century. We now take a much more hopeful view of these lesions. Many of you have studied tuberculous lesions under these skies and also in the mother country. Do you find that the tuberculous lesions are the same in the two hemispheres? One rarely hears now of *vis medicatrix nature*—surgery has rendered it superfluous. All have noticed old cases of long-standing hip joint disease, where in time the boy actually grows out of his trouble. This is a popular superstition, but like most erratic beliefs it is founded upon a stratum of truth. In children these chronic diseases are always tuberculous. Where chronic abscesses occur, it will not do to open and drain, but they must be scraped out, its unhealthy lining destroyed. In the treatment of these diseases, the learned surgeon stated that he had failed to find any value whatever in iodoform. It is an irritant and a poison, and it is apt to be septic, as germs can grow on it. Mr. Owen condemned the forcible correction of spinal deformities, and considers that this deformity does not lend itself to operative treatment. There may, perhaps, be a small class of cases where it may eventually be found applicable, as where pressure of bone or organized inflammatory deposits press upon the cord so that the patient has lost movements of the lower extremities. He considers that the plaster-of-Paris jacket must be held responsible for much of the deformity of Potts' disease. He considers that the proper treatment of these cases is rest in the horizontal position, with plenty of good fresh air and sunlight. At the conclusion of his highly able and instructing address, he was accorded the hearty thanks of the Association on motion by Professor Shepherd, of McGill, seconded by Professor Cameron, of Toronto University.

#### Excision of the Knee Joint in Tuberculous Disease.

Dr. A. Primrose, of Toronto, described Kocher's method of dealing with tuberculous knee joint, and recited the histories of a few cases, in which he had obtained excellent results. The operation was made clear by blackboard illustration, and at the conclusion of the demonstration Dr. Primrose was highly complimented by Mr. Owen.

### Recent Pathologic Studies of the Blood.

Dr. L. H. Warner, Brooklyn, contributed an able paper on the above subject. He premised his statements by asserting that there was a necessity for experiments for the progress of pathology. His experimental researches were directed along three lines of enquiry, viz., experiments, observation and individual observation at clinics in hospitals. The examination of the blood, in most cases, is of more importance than the examination of the urine. Dr. Warner gave the formula of a new staining solution which he had found very practicable. The blood specimen should be prepared in the regular manner. The slides are heated in a hot oven to 98 degrees. Immerse it for one minute in a one per cent. aqueous solution of methylene blue, washing in water, then in one per cent. alcoholic solution of eosin, washing again with water, and then in a one per cent. solution of Bismarck brown.

### Some Experiences in the Treatment of Hernias.

Dr. F. J. Shepherd, Montreal: It is now some twenty years since surgeons began to do these operations by the open method. Older methods in vogue before that date were touched upon and described. He spoke of a large hernia where the man could not put on his trousers. The methods of operation are almost as numerous as surgeons, but there are certain general principles underlying all operations. 1st. The necessity for excision or obliteration of the sac. 2nd. Closure of canal. 3rd. Union by first intention. Some also hold that alteration in the direction of the canal is necessary. Bassini's is the operation performed by Dr. Shepherd, although not always successful. He has used all kinds of sutures. Absorbable sutures are the best, and if antiseptic are to be preferred. A suture that will last for three weeks is all that is wanted. He has used chromicized catgut for some time. He never washes out the wound, and thinks it better to dissect out the sac with the knife than to tear it with the fingers. He never uses a drain. For the last two years he has used rubber gloves in all his surgical work on the abdomen, and he considers his results have been better since he used them. In these operations, the mortality is practically nil. Operations on children are now our most successful cases. Formerly they were not advised except in strangulated cases.

In discussing this paper and the cases recited, Dr. Laphorn Smith stated that his experience lay mostly in ventral and umbilical hernias, some of them being so large as to require twenty stitches. During the past two years he has abandoned silk and resorted to catgut, chromicized, which he always prepares himself.

Dr. Shepherd, in replying, said if there was a little oozing in the wound he introduces between the edges of the wound a probe and lets out the accumulated serum, and he finds that this is quite efficacious, as by this method you minimize the chance of any germs entering.

#### **A Case of Syphilitic Gummata of the Spinal Cord Successfully Treated by Enormous Doses of Iodide of Potash.**

This case, reported by Dr. F. W. Campbell, of Montreal, was a very interesting one. The patient was a highly neurotic individual, and some time before had suffered from insomnia of an aggravated character. Retention of urine and loss of power in the lower limbs were noted. The patellar reflex was about normal. The loss of power in the lower limbs was absolute. The pulse varied from 80 to 96; the temperature never above 99. The stomach remained in fairly good condition all the time. A consultant from New York was brought on, and a diagnosis was established of tumor of the spinal cord, situated about the first lumbar vertebra, which might be sarcomatous or syphilitic. The advice of the consultant was to give 500 grains of iodide of potash per day, at first commencing with a drachm three times a day. Dr. Campbell recited the daily history of the patient while getting under the large dose and its gradual withdrawal. The patient is alive to-day and in good health, having recovered complete control of his lower extremities.

#### **Address in Gynecology.**

Dr. William Gardner delivered a very practical address upon the mistakes in diagnosis and treatment in midwifery and gynecology. We often learn more from our mistakes than from our successes. Correct and accurate diagnosis depends mainly upon the sense of touch only to be attained by long and patient practice. The advantages of examining on a firm table instead of on a couch or bed were emphasized. The patient's rectum should always have been emptied before presenting for examination. It is best to empty the bladder by catheter when the patient is in position, as it is in this way that you will notice any discharges, etc. Then the physician will have to do this because there are many women who are not able to do it through nervousness. And, again, we get an uncontaminated specimen for examination. Where tension is present in the muscles of the abdomen, if you make a series of circular movements over the lower abdomen, gradually narrowing your circle, you will be able to overcome whatever rigidity may be present. In physical examination Professor Gardner urged caution in the use of the sound. He rather considers it a dangerous instru-

ment, that its use ought to be extremely limited, and is on the opinion that many women have lost their lives through this instrument. There is the danger of infection and injury of the uterine canal. The sound is a great deal too much used by the general practitioner. Mistakes in diagnosing displacements he considers the most common. The uterus is a very movable organ, and a distended rectum or bladder may cause it to be diagnosed as a retroversion. It may be also moved out of place through vomiting, coughing, etc. In pelvic examinations Dr. Gardner has made it a point to examine the position of the kidneys as well. Referring to examination by the Sims method, it is necessary to have the patient in proper position. If you have not a Sims speculum, a bent table fork or the finger may be used to distend the perineum. In the diagnosis of pregnancy mistakes are often made here. The patients are few in which the diagnosis cannot be made by careful examination of history, signs, etc. Many women are probably inaccurate as to date. Dr. Gardner illustrated all his points by reciting cases to the point. He instanced one in particular, where he once found a woman in his office on her hands and knees in the throes of a twin pregnancy, which a fellow-practitioner had failed to recognize and had tapped the gravid uterus and drawn off a considerable quantity of liquor amnii. The paper closed with an interesting account of mistakes in extra-uterine pregnancy. At the conclusion, he was accorded a hearty vote of thanks for his valuable and practical paper.

#### **An Unnoticed Factor in the Production of Abdominal and Pelvic Disturbances in Women.**

Dr. Clarence Webster contributed this paper. He first spoke of symptomatology in women often overlooked by the general practitioner. He then took up the normal relationship of the abdominal and pelvic contents and proceeded to account for interabdominal pressure, the pelvic organs being to a large extent maintained in their respective positions by reason of the pressure of the abdominal and pelvic walls. The average specific gravity of the viscera was very little more than that of water, the liver was 1.5 sp. gr. There is no proof that the mesenteries act as constant supports or were ever meant to be such; and the main factor in sustaining the viscera is the strength of the abdominal wall and pelvic floor. Local weakness of the abdominal wall has been fairly well described under hernia, while general weakness of the abdominal wall has been described as pendulous belly; and general weakness in his experience is an exceedingly rare condition. As to the question of etiology, the condition is found in women who have borne children; and that on examination of the great majority of women



there is some degree of separation of the recti muscles in the region of the navel. All evidence later on may disappear, but permanent widening remains. The results of all this is unavoidable enteroptosis; and it is generally to be found in women who have worn corsets. A common displacement is that of the right kidney. Dr. Webster dwelt upon the diagnostic symptoms of these conditions, and then proceeded to describe the operation he performs for their relief. This consists in bringing the edges of the two recti into apposition. He first performed an operation for the relief of the condition in November, 1898; and since that time forty-one cases have been operated on and the results have been most satisfactory.

Mr. Cameron took exception to Dr. Webster using the word "unnoticed" in the title of his paper, as he thought the condition had been recognized before.

Dr. W. S. Muir, Truro, N.S., asked what effect leaving off the use of the binder after pregnancy and confinement had to do with producing these conditions.

Dr. Webster in reply held to the opinion that this had not been noticed except by himself. The absence of the binder had not made any special difference.

#### Address in Medicine.

"The advance in knowledge," said Prof. S. F. Shattuck, of Boston, in his opening remarks, "has brought about our relation to things. There is noticed a subdivision of labor in every branch of industry. Specialization has taken place in the science and art of medicine. In specialization lies the cleavage between medicine and surgery; and nowhere has the line been more closely drawn than in England. Anesthesia greatly enlarged the bounds of surgery. Twenty-five years ago there was not a pure surgeon in America. Bellyache is now a surgical disease. The heart is practically the only viscus which remains the exclusive organ of the physician. In this country the general practitioner is clinging to obstetrics for family practice. In some of the larger centres there is a tendency to the specialist in obstetrics, who will preside at the accouchement and the family physician then steps in as attendant throughout the puerperium. Pure gynecology scarcely exists to-day; and pelvic tinkering is suffering from a rapid decline. The great bulk of major gynecology belongs to abdominal surgery, which in turn belongs to the general surgeon. Gynecologists should study general surgery and become general surgeons first. The field in medicine is so large that no man can grasp it all in a lifetime. Professor Shattuck referred to specialism in neurology and dermatology. Nose and throat should comprise one specialty. Desire on the part of some to escape the hurly-burly of

general practice may be a cause in throwing them into specialism; and then special knowledge draws larger fees. Ophthalmologists get more for removing a speck of dust from the eye than the general practitioner. When we have specialists for the diseases of young life, why not also have a speciality for the diseases of old age.' Professor Shattuck closed his able address by affirming that specialism in medicine had come to stay.

### **Gastric Hemorrhage.**

Dr. George E. Armstrong, of Montreal, in reading this paper, stated there was a fairly well-determined field in which surgical interference may be of use in hemorrhage of the stomach. Hemorrhage occurs in fifty per cent. of gastric ulcers and is fatal in eight per cent. These cases are arranged in two groups, the acute and the chronic. Rodman has reported thirty-one operations for frequently recurring or chronic hemorrhages with six deaths. Dr. Armstrong has operated five times for gastric hemorrhage, one being a chronic case. In one of these cases the patient was getting along nicely after the operation, when the patient expired suddenly, and on post mortem examination thrombi were found in the branches of the pulmonary artery.

### **Some Cases in Stomach Surgery—Gastrostomies, two cases; Gastro-Enterostomies, two cases. Pylorotomy.**

Dr. A. E. Garrow, Montreal, reported these cases. In one patient operated on, he was fed before he left the operating table. Another was a woman of fifty years, who had a persistent, hacking cough. Gastrostomy was performed and the patient discharged, able to feed herself through a tube. In another, a man aged 33, who had vomiting and blood in the stools, the patient developed acute pain, with a pale face. Duodenal perforation was present, and when the abdomen was opened gas escaped from the incision. When discharged, on July 24th last, he was feeling well. Six of these cases were reported.

### **The Modern Treatment of Retroversion and Prolapse of the Uterus.**

This was presented in an able paper by Dr. A. Laphorn Smith. It referred to the proper and most successful management of procidentia uteri in elderly women, between seventy and seventy-five years of age—a most pitiable condition. She may be otherwise in excellent condition, and the perineum is so relaxed that no pessary will remain in place. Then the majority of these cases have an ulcerated cervix. After confinement, the

uterus remained large and the pernicious habit of keeping women too long on their backs has a tendency to produce backward displacement. Dr. Smith feels certain that women who have been cured of this distressing condition will have little difficulty in persuading others to avail themselves of the treatment. He removed a woman's uterus a few months ago which had been out of her body for over twenty years, and the patient now assures him that she feels like a young woman. In correcting this deformity, Dr. Smith makes a small incision in the abdomen and performs ventrofixation. After that the vaginal canal is narrowed by a large anterior and posterior colporrhaphy. In selected cases he also amputates the lower half of the organ and stitches the vagina to the upper half. He considers ventrofixation, if properly performed, a most reliable means of fastening up the uterus. The operation has given him the most complete satisfaction of any operation he has ever performed, especially when combined with amputation of the cervix and posterior colporrhaphy.

#### **Gasoline as a Surgical Detergent.**

Dr. Bruce Riordan, Toronto, contributed something highly original, that is the use of gasoline for cleansing dirty, greasy hands before stitching etc., and also advocated its employment for preparing the field of operation before surgical procedures. It was away ahead of soap and water and brushes; and he now constantly carried a small bottle of the substance in his surgical bag. A report from Dr. Wm. Goldie, Toronto, showed its effects upon germs and germ life. One word of caution was thrown out in its use: As it is a highly inflammable substance, it should not be used in any quantity near an exposed light; and then it is painful in the eyes and ears. It is useful in cleansing sutures of accumulated blood and dressing powder, as it enables one to locate the stitches better.

Dr. J. C. Mitchell, Enniskillen, Ont., stated that he had tried gasoline recently as a detergent in two very severe threshing-machine accidents, where the parts were all smeared over with oil and grease and dirt, and it was very satisfactory, as he was able to get perfect cleanliness and both wounds healed by first intention.

#### **Dilatation and Prolapse of the Stomach.**

A paper with the above title was contributed by Professor McPhedran, of Toronto University, which dealt principally with prolapse. This condition rarely occurs alone but is associated with prolapse of other abdominal organs. There is generally present as well some degree of dilatation, and the abdomen may be prominent, or flat, or even retracted. He recited the case of

a man aged 51 years, a manufacturer, who had been ailing for two or three years. The stomach was below the umbilicus. He was directed to massage the abdomen very thoroughly and to practise abdominal gymnastics. Through this treatment, combined with dietetics, he has been restored to health and is able to resume business. Another case, of a woman aged thirty-five years, was reported, who had been the subject of recurrent attacks of vomiting for two years. The symptoms were detailed, massage and abdominal gymnastics ordered with satisfactory results. The different ways of examining the stomach were described, and in concluding Dr. McPhedran spoke of the benefits of a change of scene in treating these cases.

#### **Physical Training: Its Range and Usefulness in Therapeutics.**

Dr. B. E. McKenzie, of Toronto, gave a very interesting account of the methods employed by him in correcting deformities in his orthopedic hospital in the city of Toronto. The paper was illustrated by lithographs showing improvements in spinal deformities and other abnormalities. The paper embraced the results of his observations for thirteen years past, and was ample justification of the benefits derived from gymnastics in the correction of lateral curvature, club-foot, etc. He had found physical training also especially valuable in hysteria and chorea.

#### **Inter-Provincial Registration.**

Dr. T. G. Roddick read the report of the committee having this matter in hand. A new feature was that allowing of representation on the proposed Dominion Council of Homeopaths, as according to the law of Ontario, these had their vested rights, and so must have similar interest in any Dominion Council. The Homeopaths then will be allowed three representatives, which will be equivalent to the representation from any one province of the Dominion. Their term of office will be four years. This will not, however, be inserted in the Bill as such, but will appear under "any other school of medicine having legal recognition throughout Canada," as the British Medical Council would not recognize any such body. Dr. Roddick stated that the Bill would be introduced at the next session of Parliament; and that the respective members of the committee must bestir themselves before their respective Provincial Parliaments, as these must sanction the measure before it could be finally acted upon by the Dominion Parliament.

#### **Cerebral Abscess.**

Dr. James Stewart reported two interesting cases of abscess of the brain situated in the temporo-sphenoidal lobe, and

referred to the unusual existing aphasia which was present in both of these cases, viz., simple inability to name objects. The first case occurred in a young man of thirty-three years, who had otitis media following an attack of influenza. Some six weeks afterwards an abscess formed. The abscess was diagnosed as confined to this area simply on account of the peculiar aphasia, the simple inability to give the name of a pen when that object was presented to him. The patient was operated on by Professor Bell, who secured two czs. of pus. Meningitis, however, set in and the patient succumbed. The second case was a girl of twenty-one or twenty-two years. She had had ear trouble for a great many years, with very severe pain at times. She, too, had difficulty in naming objects, and she could not name any object whatever, finally. She died suddenly a few hours before the operation was to be performed. On a post mortem being held, two abscesses were found, one skirting the upper border of the lobe and the other about the centre of its substance.

In reply to a question of the President, Dr. Stewart stated there is what they call the naming centre, and when this is destroyed that particular form of speech defect is present. The cases were aptly illustrated by a diagram.

#### **Gangrene of the Leg Following Typhoid Fever.**

Dr. H. H. Chown, Winnipeg, reported two cases of gangrene following an attack of typhoid fever, which had recently come under his observation. In the first case, the patient had the classical symptoms of typhoid, the spots appearing at the end of the first week and being very numerous. Great pain set in, in the calf of the leg, with collapse, while the limb was cold and bloodless. Cutaneous sensibility was lost over the leg. The third day after the complication set in, the part involved included the lower third of the leg on inner side, and lower half on outer. Operation was performed at upper and middle third of femur. Patient stood the operation well. The temperature before the operation was 103.6; pulse, 120: on the following day the temperature was normal and the pulse 110. On the tenth day the flaps were united. There was a rise of temperature a few days later—a relapse, with hypostatic congestion of the lungs. On the fifth day hemorrhage of the bowels. The patient is now the picture of health, weighing 200 pounds. The second was a somewhat similar case, in which the blood reacted early and promptly to the Widal test. The gangrene began in the first case on the eleventh day of the disease; in the second, on the ninth. Keen reports gangrene on the fourteenth day. The gangrene in the second case extended

to upper and middle third of leg. The leg was amputated and prompt union took place throughout.

In discussing the cases, Dr. R. B. Nevitt, Toronto, mentioned a similar case coming under his observation during the past summer. Here, gangrene occurred about the third week of the fever; and he was seen about a week or ten days afterwards. Amputation was performed through the middle third of the femur. He also referred to a case of gangrene of the arm, following an attack of pneumonia, recently observed by him.

#### Notes on Atropine.

Dr. R. D. Rudolf, Toronto, read an interesting paper with the above title, illustrating by means of a chart the action of the drug on animals, and inferences drawn therefrom of its therapeutic uses. He finds that the drug directly stimulates the heart, and thus the blood pressure is markedly raised. He considered that the maximum single dose, as laid down by Witherstine, of one-twentieth of a grain as too large unless used as an antidote; and we ought never to give more than one-hundredth of atropine sulphate at one time except in emergencies. He also referred to its action in catarrhal pneumonia of children, and its employment before anesthesia to ward off danger.

Dr. A. D. Blackader discussed the paper and congratulated Dr. Rudolf upon it, and hoped that he would pursue his studies further upon the same subject, to find out the effect it would produce in controlling vomiting after anesthesia. He considered, however, that strychnine and not atropine was the most powerful heart tonic we possessed. He thought that late experiments would throw doubt upon atropine being a direct stimulant to the heart muscle; and he thought it questionable to administer a drug, when we wanted to stimulate the heart's action, that would paralyze nerve endings.

#### Lantern Slide Demonstration of Skin Diseases.

Dr. George H. Fox, New York, conducted this demonstration, which the members of the Association appreciated most highly. The great majority of the skin lesions shown were of syphilitic origin, and, as they appeared on the canvas. Dr. Fox described the histories of the cases. One in particular attracted attention from its disfigurement of the nose and face—a huge mass of excrescences, which Dr. Fox was able to get rid of in the course of two or three months, leaving only a slight superficial scar. He laid down a timely word of caution in treating these conditions, that when the patient was run down and emaciated through large doses of mercury or iodide of potash, not to

keep on pushing these drugs, but to desist for a period and endeavor to build up the patient's general condition. Then return to the specific treatment, and the results would be found to be more material. At the conclusion of the demonstration, which will rank as one of the features of the meeting, Dr. Fox was accorded a hearty vote of thanks by the Association.

Dr. F. J. Shepherd showed an interesting case, a boy of sixteen, who, at the age of six, sustained a severe cutting of the nerves of the brachial plexus, below the cords of the brachial plexus. At that time, ten years ago, Dr. Shepherd dissected out each nerve and united their respective ends by suture. All did well with the exception of the musculo-spiral, and, as a consequence, the lad has very little control over the extensors of the fore arm.

#### **The Successful Treatment of Two Important Cases of Disease of the Eyes by the Combined Methods of Mercury and Iodide of Potash Internally and Pilocarpine Hypodermically.**

Dr. George H. Burnham's method of treating syphilitic and other diseases of the eye is described in the title of his paper. Under this method no such result follows in other plans of treatment, and with this a permanent curative result is got. The treatment has a wide application. Whether iodide of potash and mercury, or the iodide alone, is given internally in suitable cases without satisfactory results, if the pilocarpine be added good results will follow.

#### **Mental Sanitation.**

Dr. R. W. Bruce Smith, physician to the Brockville Asylum for the Insane, contributed a scientific paper with the above title. It was a plea for prophylaxis in insanity, and he thought that much would be accomplished in this direction in the twentieth century. He stated that insanity was on the increase in Canada, and thinks it can be duly ascribed to the fact that there have been no preventive measures employed. In order to accomplish good in this direction, we must seek either to lessen the demands on, or to strengthen the resisting power of, the brain. He condemned inter-marriages in families, and also amongst those of a deranged mentality; and as fifty per cent. of the cases of insanity were hereditary, the descendants of these should be careful in contracting marriage ties. He referred to a portion of one county in Ontario alone, where indiscriminate marriage and inter-marriage has become most fruitful, and he has seen several members of one family from that locality inmates of the same institution at the same time. He

considers that the day may yet dawn when we will give the same attention to the rearing of children as we now give to the breeding of horses. Speaking of farm life and the tendency it has to melancholy, he thought this class of the community should receive education in participating more in the enjoyments of life, and not continue to rot in domesticity. An upheaval in the sentiment and surroundings of the rural homes would work wonders in prophylactic principles.

The Treasurer's report showed that 153 members were in attendance, and that there was a balance of \$240.65 in the treasury.

#### **Election of Officers.**

President, H. H. Chown, Winnipeg; Treasurer, H. B. Small, Ottawa; General Secretary, F. N. G. Starr, Toronto.

Next place of meeting, in 1901, Winnipeg.

Vice-Presidents for the Provinces—Prince Edward Island, H. D. Johnson, Charlottetown; Nova Scotia, A. J. Maiter, Halifax; New Brunswick, T. D. Walker, St. John; Quebec, A. Laphorn Smith, Montreal; Ontario, A. A. Macdonald, Toronto; Manitoba, J. D. Macdonald, Brandon; N. W. T., J. D. Lafferty, Calgary; British Columbia, S. J. Trinstill, Vancouver; Yukon, J. N. E. Brown.



## Editorials.

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### CARE OF HORSES IN WAR.

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Many and pitiful are the stories we have heard as to the sufferings of war horses in the war in South Africa. Frequently they were overworked and underfed. In this respect they perhaps fared no worse than the soldiers. We find, however, there was much needless suffering among the horses and oxen on account of the immature condition of the army veterinary. From an article published in *The Nineteenth Century*, we learn that with 150,000 animals in South Africa, valued at £4,000,000 Sterling or more, there were only forty-seven army veterinary surgeons, and these had no military status. All orders to them had to come through the Quartermaster-General. In the early part of the war many horses were lost in transport through want of skilled veterinary supervision. Many horses had to be abandoned for such simple conditions as saddle sores which had grown "hideous" because they were not treated in the initial steps.

The writer thinks "the present system in the so-called Army Veterinary Department should be abolished, and supplanted by a self-contained Army Veterinary Department. The veterinary hospitals, as in the Indian army, should be in the charge of veterinary officers, who alone should give orders on the management, feeding and exercise of sick animals. These officers should have attendants, dressers and farriers under their command. The Director-General of the Veterinary Department should have power to move his officers and the subordinates within the United Kingdom, informing the Quartermaster-General of what he has done, instead of, as at present, having to ask him to have it done. The arrangements for the treatment of sick and wounded animals in service, on board ship, and in the field, should be made by a veterinary officer without his having to get the sanction of a regimental officer."

## A CAMPAIGN OF CALUMNY.

The *British Medical Journal* protests very strongly against what it calls the campaign of calumny which has been waged in the British press for some time. Mr. Lees Knowles, M.P., appears to enjoy the distinction of being one of the most active participators in the campaign. The following is one of the statements quoted and endorsed by him in the *Times*: "I am given to understand that the senior officers Royal Army Medical Corps, with few exceptions, are so taken up with their own importance as combatant officers, and their rank as colonels and majors, that they leave much to be desired."

Sir Redvers Buller writes in reply to the *Times*. In his letter he asks: "Was ever a more shameful accusation more shamelessly published?" He goes on to state that there were only three colonels of the Royal Army Medical Corps in Natal outside Ladysmith. One of them, Colonel Galloway, organized the most complete hospital ever provided for an army in the field. Another, Colonel Clery, had charge of a hospital which was justly referred to in the *Times* of Natal as a model of what a hospital should be. Another, Colonel Allin, was Senior Medical Officer of the Field Army, and superintended the collection and subsequent removal of the wounded and sick from the front. Sir Redvers Buller believes this duty has been accomplished by him more rapidly, and with less discomfort to the sufferers, than has been the case in any previous campaign.

Sir Redvers concluded by challenging Mr. Lees Knowles and his "correspondent of high position" to say which colonels they referred to, and either prove their accusations or withdraw their slander. The *Journal* adds that Mr. Knowles chose the latter alternative, and published in the *Times* a singularly meek explanation, together with expressions of regret.

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A scheme is now in formulation by which the ratepayers will be asked to vote \$50,000 towards the erection of an arts and science building for Queen's University. Additional room is urgently required, and the college authorities are desirous of beginning the work of construction this fall.

## SIR WILLIAM STOKES.

In our last issue we referred to the death of Sir William Stokes, but were not possessed of details. The following, taken from *The British Medical Journal*, will be interesting to those who admired the great Irish surgeon.

Writing in the *Dublin Journal of Medical Science*, Sir John W. Moore, President Royal College of Physicians of Ireland, says: Shortly before his departure for South Africa at the beginning of last January, Sir William Stokes had been unwell, suffering from an attack of catarrhal pneumonia supervening on a chronic left interstitial pneumonia. The voyage to the Cape proved most beneficial, and he continued in good health until the beginning of June, when he was in hospital for a fortnight with cough and jaundice, the result—in his own opinion—“of overwork, cold, and the ‘bully beef’ diet.” He was then sent down to Durban to recruit. Under date June 28th, 1900, he wrote home: “Thanks to the ideal climate we have here (that is, at Durban), and the very good food, I am getting quite well again, though still weak and easily tired. But next week I hope to get back, as there are cases waiting for me, both at Maritzburg and at Newcastle.” He added: “Next month (that is, July), I hope to return home, as I am confident the war will be over then, and the journey home will—I am sure—make me as well as ever.” Alas! for the uncertainty of human hopes and aspirations—all that was mortal of William Stokes finds a last resting place in that distant land, which has cost the British Empire so much in blood and treasure to win it as a jewel in the Imperial crown. . . .

Stokes was a classical writer. His introductory addresses on surgery were models of English composition. He was the author of probably one hundred contributions on clinical and operative surgery, which enriched the pages of this Journal as well as those of the *Lancet*, the *Medical Press and Circular*, and the *Transactions* of the Royal Academy of Medicine in Ireland, the Clinical Society of London, and the Royal Medical and Chirurgical Society of London, of all of which bodies he was a Fellow. His last published work was a touching and truthful memoir of his father, which appeared in 1898, as one of a series of volumes, entitled *Masters of Medicine*.

In private and social life Stokes had a personality which was all his own. His favorite recreations were music and travelling, the latter assuming a pathetic interest when we remember that he sleeps well more than eight thousand miles from his native land, to which he was so devotedly attached, and of which he was so faithful and loyal a son. Yet be it so,

Awake him not, surely he takes his fill  
Of deep and liquid rest, forgetful of all ill.

A short eight months ago Stokes, like a soldier, responded to

the call of Queen and country to serve as consulting surgeon to Her Majesty's forces in South Africa, and now, like a soldier, he has fallen at the post of duty.

We deeply mourn him whom we have lost. We treasure as a priceless heirloom the record of a noble life spent in the relief of human suffering and disease. As we ponder on the heroism and devotion of such a life, the famous words of Cicero come into mind :

Homines ad Deos nulla re proprius accedunt quam salutem hominibus dando.

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Dr. Montizambert, director-general of public health, returned to Ottawa September 27th, from an official trip which extended as far as Dawson City. The immediate object of the doctor's visit to the Yukon was on account of an outbreak of smallpox at Dawson, there being seven cases altogether. Speaking to the correspondent of the *Toronto Mail and Empire*, the director-general said that he had only words of praise for the action of the local authorities. The sufferers were removed to an island down the river from Dawson, and every effort taken to prevent the spread of disease. The result was that there had not been a single new case since July 20th.

Returning to British Columbia from the Yukon, Dr. Montizambert inspected the Government quarantine station at William's Head. He ridiculed the idea of ill-treatment to the passengers of the San Francisco steamer *Walhalla*, which arrived at quarantine with a smallpox patient on board. The station is most thoroughly equipped. At Victoria there is an inspection of every steamer arriving from the United States ports. Smallpox has been rampant in the tier of Northern States from Montana westward. It was rife at one time in the Republic camp, but the authorities have now got the upper hand of it, and Dr. Montizambert is disposed to think that the inspection regulations, so far as Canada is concerned, might be relaxed.

For some weeks past at every point at which the American railways enter Canada medical men have boarded the trains looking for smallpox suspects, but with the disappearance of disease from the mining camps, the director-general does not consider train inspection any longer necessary.

Asked about the reported existence of bubonic plague in San Francisco, Dr. Montizambert said there was reason to believe that the disease does prevail in the Chinese quarter. As a measure of precaution, an order had been issued that at the only point at which plague from the United States could enter Canada, Victoria, there shall be detention of fourteen days. He has no fear of the dread disease gaining a footing in Canada from Glasgow, where the local health authorities have acted most promptly and efficiently.

## Personals.

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Dr. R. S. Broad (Trin. '99) has commenced practice in Barrie.

Dr. H. O. Simpson (Trin. '98) has commenced practice in Toronto.

Dr. Frederick Fenton, of Toronto, was married August 21st to Miss Mary Irving.

Dr. C. A. Page (Trin. '99) has gone to New York to spend a year in post-graduate work.

Dr. W. Harley Smith, of Toronto, spent a portion of the summer on the coast of New Jersey.

Dr. L. G. Parker, of Toronto, returned to his home September 26th, after a four months' trip to Europe.

Dr. Charles O'Reilly returned from Detroit, where he had been paying a short visit, September 19th.

Dr. E. S. Hicks, of Port Dover, has been appointed associate coroner for Norfolk county, in the place of Dr. Walker.

Dr. E. Herbert Adam, of Toronto, after spending a month in Newfoundland and in the St. Lawrence, returned to the city September 26th.

Dr. C. R. Dickson, of Toronto, attended the meeting of the American Electro-Therapeutic Association, in New York, September 25th to 27th.

Mr. Edmund Owen, of London, Eng., paid a visit of a few days to Toronto, after attending the meeting of the Canadian Medical Association at Ottawa.

Dr. Thomas B. Fitcher (Tor. '93), Johns Hopkins Hospital, during his summer holiday spent a portion of the time in Toronto and other towns in Ontario.

Dr. George W. Badgerow (Tor. '94), of Toronto, will leave on October 9th for England. He will be engaged in post-graduate work in London for nearly a year.

Dr. W. W. Jones (Tor. '96) has also passed the conjoined examination of London, and now holds a position in the General Hospital of Birmingham, England.

Dr. Herbert J. Hamilton, of Toronto, went to Manitoulin Island, Georgian Bay, for a holiday, accompanied by Mr. Joe Graham. They returned September 24th.

Mr. Archibald H. Anderson, a third year student of Trinity Medical College, and brother of Professor H. B. Anderson, went to South Africa with the first Canadian Contingent. He returned to Toronto September 25th, and was met at the station by a number of Trinity Professors and the whole student body, who gave their comrade a very enthusiastic reception.

Dr. Norman Macleod Harris (Tor. '96), Johns Hopkins University, spent a portion of the summer visiting his friends in Toronto, and returned to Baltimore September 3rd.

Dr. Bruce L. Riordan, of Toronto, and Dr. Alex. Hutchinson, of Montreal, visited St. Alban's, Vermont, in August, and were the guests of Mr. Fitzhugh, manager of the Vermont Central Railway.

Dr. Donald McGillivray (Tor. '97) has passed the conjoined examination in medicine and surgery of London, and has been admitted to membership. He is at present a resident in term in Brighton, England.

Prof. Osler, of Baltimore, who came from England in August to see his brother, returned to England August 15th, as announced in our last issue, but only remained for a short time. He again visited Toronto, Sept. 16th.

Dr. James F. W. Ross left Toronto September 17th to attend the meeting of the American Association of Obstetricians and Gynecologists, held in Louisville, Kentucky, September 18th to September 21st, and returned September 24th.

Dr. Andrew Haig, of Campbellford, has been appointed Superintendent of the Kingston General Hospital, in the place of Dr. Third, resigned. Dr. Haig graduated in Queen's, B.A. 1888, M.A. 1889, M.D. 1891, and was a successful practitioner for years in Campbellford.

The following medical gentlemen from Toronto were present at the meeting of the Dominion Medical Association: Drs. Reeve, Thorburn, R. A. Pyne, Ryerson, Rudolf, Cameron, O'Reilly, McPhedran, Britton, Malloch, Nevitt, Anderson, Sylvester, Elliott, Macdonald, Barrick, Scadding, Dickson, Burnham, Primrose, F. N. Starr, Young, Riordan, Thistle, B. E. McKenzie and Bryce.

Dr. Thomas McCrae (Tor. '95), John Hopkins University, spent part of the year in London, England, and passed the examination for the double qualification in medicine and surgery. He returned to Baltimore early in August, and remained there while Dr. Fitcher was taking a holiday. He passed through Toronto on his way to Guelph, Sept. 25th, and after spending a few days with his friends, returned to Baltimore.

We have much pleasure in offering our hearty congratulations to Dr. Thomas H. Middleboro, Owen Sound, who became in August last, by examination, a Fellow of the Royal College of Surgeons of England. He is the fourth ex-member of the house staff of the Toronto General Hospital who has received this Fellowship, the others being Drs. George A. Peters, Herbert A. Bruce and Donald Armour. Dr. Middleboro passed through Toronto, September 6th, on his way to Owen Sound.

## Obituary.

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### WILLIAM FREEMAN, M.D., M.R.C.S. (ENG.)

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Dr. Wm. Freeman, of Toronto, formerly of Georgetown, died at his residence, 66 Sullivan Street, Sept. 25th, aged 70. He graduated (M.D., Univ. N.Y.) in 1857, and after spending a year in London he received his M.R.C.S. When he came back to Canada he commenced practice in Georgetown, and very soon met with signal success. This success continued for nearly forty years, at the end of which time he decided to take a well earned rest. He came to Toronto a few years ago, and lived in retirement. Although he was not engaged in any active work, he took much interest in the progress of medicine, and frequently visited the General Hospital. The remains were removed to Georgetown and buried September 27th.

### JACOB DA COSTA, M.A., LL.D.

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Dr. Da Costa, of Philadelphia, died from heart disease September 11th, aged 67. He was a native of the Island of St. Thomas, Danish West Indies. He received his preliminary education in Germany, his professional education at Jefferson, from which he graduated in 1852. After this he spent two years at post graduate work in Vienna and Paris. He was best known in Canada as the author of "Medical Diagnoses."

### HUNTER HOLMES MCGUIRE M.A., M.D., LL.D.

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Dr. Hunter McGuire, one of the most distinguished surgeons of the *Sunny South*, died at his country home near Richmond, Va., September 20th, from the effects of paralysis following apoplexy, which occurred some months ago. Born in 1835, he graduated in 1855. When the Civil War broke out he enlisted as a private in the Confederate Army, and shortly after was made medical director of "Stonewall" Jackson's forces. In May, 1863, when Jackson was mortally wounded, Dr. McGuire was relieved of his duties by order of General Lee, that he might be constantly at the dying General's bedside. After the war he practised in Richmond, and was made Professor of Surgery in the Medical College of Virginia. He was elected to many positions of honor in various medical societies; and was well and favorably known to the profession at home and abroad.

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**DR. EUGENE J. FREEL.**

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We learn from the *Toronto Mail and Empire* that Dr. Eugene Freel died at his home in Durham, Ont., September 7th.

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**RICHARD H. WHITE, M.D.**

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Dr. R. H. White, of New York, died September 22nd, 1900, of tuberculosis. He was born in Millbrook, Ontario, and received his medical education in Trinity Medical College, Toronto. He graduated in Trinity University in 1891, and went the same year to New York, where he engaged in post-graduate work. He subsequently became one of the physicians to the New York Throat, Nose and Lung Hospital. He commenced practice in New York in 1892, confining himself chiefly to diseases of the lungs.

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**ALLAN CARY SLOANE, M.B.**

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We announce with deep regret the death of Dr. A. C. Sloane at the age of 60. After taking his student course in the Toronto School of Medicine he graduated (M.B. Tor.) in 1868. He immediately commenced practice in Annan, and continued in active work until the latter part of 1899, when he had a stroke of apoplexy, followed by paralysis. He was thus compelled to give up his practice, and removed to Owen Sound with his family. After months of suffering he had a second stroke, after which death ensued in a few days, August 23rd, 1900. During his thirty-two years in Sydenham Township he won the confidence and esteem of his fellow-citizens, including the physicians of that locality, in a marked degree. He was the father of Dr. J. G. M. Sloane (Tor. '95), who is now practising at Lion's Head, near Owen Sound.



## Correspondence.

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To the Editor of the CANADIAN PRACTITIONER AND REVIEW :

SIR.—An article from the *British Medical Journal*, in August number of the PRACTITIONER AND REVIEW, entitled “Live child delivered by forceps after death of mother,” reminds me of my dereliction of duty in neglecting to report my unusual experience in dealing with a similar case.

On August 15th, 1876, I was called to attend the accouchement of Mrs. D. McC., wife of a farmer in Township of Southwold, County of Elgin. Her previous confinement, which I attended, was uneventful, but in the interim I had attended the patient for advanced heart disease—valvular insufficiency and dilatation. On this eventful morning I very promptly responded to the professional call with much, but, I think, well-concealed, forebodings. After my arrival the patient and myself partook of a light lunch in a most cheerful mood, soon after which effective labor began. I soon proceeded to make my examination, found os thin, patulous and dilated about two and a half inches; *first presentation*. While thus engaged, to encourage my patient, I assured her of the prospect of safe and speedy delivery, to which she replied in most alarming tones, “I am dying, doctor, I am dying.” I began to rally her on her unusual timidity, when she again exclaimed, “I am dying.” With my disengaged left hand I felt her pulse and at once told her mother and sister that she was dead. Unfit to swallow the brandy attempted to be given, a strychnin hypodermic was promptly given—without avail, no sign of life was present.

Their first outburst of grief having subsided, I told the friends that there was a chance to save the child. They naturally objected to any handling of the body, and proceeded to fold the hands over the breast, close the eyes and mouth, in anticipation of *rigor mortis*. Having waited as long as I thought it safe to depend on the foetal circulation, I urged, as firmly as my sympathy would permit, our duty of saving a human life. A tacit assent given, I proceeded, and instantly determined on pedalic version, instead of using the forceps, to which I believe they would have objected. Such, however, was the complete flaccidity of all the parts, that I reached the feet as readily as I could have applied the forceps under the most favorable conditions. With unusual facility, version and delivery were effected as promptly as could have been done by forceps. A little effort restored suspended respiration of the babe, a female,

well-nourished, and weight six and a half pounds. She is now a vigorous young lady of twenty-four.

The practical point involved is the prompt action—fœtal circulation not likely to continue, independently, more than five minutes—preferring version to forceps as being more readily assented to—time being of the essence of success.

My experience leads me to infer that such opportunities occur oftener than the infrequent reports of *delivery* of a living child from its dead mother would indicate. I hope, Mr. Editor, you will secure reports of as many such cases as possible with the view of presenting them to your readers.

Yours,

JNO. CASCADEN.

Durros, Aug. 21st, 1900.

## Book Reviews.

*Progressive Medicine.* A quarterly digest of advances, discoveries and improvements in the Medical and Surgical Sciences. Edited by H. A. Hure, M.D., and C. A. Holder, M.D. Vols. I. and II. 1900: Lea, Brothers & Co., Philadelphia and New York.

These volumes review the progress made in surgery of the head, neck and chest, and the work on infectious diseases, children's diseases, pathology, ear, throat and nose, abdominal surgery, gynecology, diseases of the blood, diathetic diseases, diseases of the glandular system, and ophthalmology. These quarterly volumes are now familiar to the eye of most physicians, and ought to be to all. They contain a great amount of useful information in condensed form, and well arranged for ready reference. The physicians and surgeons to whom the work of collecting the best that has appeared during the quarter, have performed their tasks in a very creditable manner. The volumes are well printed on good paper and well bound. They are in the very best style of Lea Brothers.

W. B. Saunders & Company, the well-known publishers of Philadelphia, are about to establish a branch of their business in Great Britain. Mr. Saunders has recently spent several weeks in London, where all the arrangements preliminary to the opening of an English house have been completed.

The London branch will be operated in immediate connection with the home establishment, and the same methods that have

been so successful in building up the business in this country will be employed in the conduct of the new branch.

They also announce that they will shortly have ready "The American Illustrated Medical Dictionary," by W. A. N. Dorland, editor of "The American Pocket Medical Dictionary." This is an entirely new and unique work for students and practitioners. It contains more than twice the matter in the ordinary students' dictionary, and yet, by the use of clear, condensed type and thin paper of the finest quality, it forms an extremely handy volume only one and one-half inches thick. The price of the work will be \$4.50 net, indexed \$5.00 net.

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*Atlas and Abstract of the Diseases of the Larynx.* By L. GRUNWALD, of Munich. Authorized translation from the German, edited by Charles P. Grayson, M.D., Philadelphia, with 107 colored figures on 44 plates. Philadelphia: W. B. Saunders, 1898.

This work, the author says, is intended to help the beginner in the study of diseases of the larynx, and the English editor says that the book is so good that it needs no preface. The general plan of the work embraces some introductory remarks on the anatomy and physiology, then a description of the different methods of examination, and then some general remarks on the causes and treatment of disease in the larynx. This is followed by an account of the causes, symptoms, pathology and treatment of the various affections which are met with in this organ. Considering the field which this section of the work covers, the space devoted to it (66 small pages only) requires that the style should be most concise, practical and to the point, but in fact on many subjects it is quite the opposite and not at all suitable for a beginner. Then finally, occupying about two-thirds of the volume, there is a long series of beautiful pictures (107 of them) of the larynx in health and in various states of disease, and accompanying each plate is a short account of what it is intended to represent. Thus the examiner may always find a parallel picture to whatever condition he may observe in his patient's larynx. Unfortunately, this is quite impractical. These plates are certainly well executed, but however natural they may appear to the experienced eye acquainted with the original, they convey but a poor and inaccurate impression to the unaccustomed eye of the beginner, and can never be more than a weak substitute for clinical experience. The book is well printed in clear, readable type, and the plates are particularly good, and will form a valuable addition to the series of hand atlases.

## Selections.

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### **The Anatomic-Pathologic Diagnosis of Cancer of the Larynx.—**

PROF. B. FRAENKEL, Berlin.

The microscopic examination of a removed portion of the tumor is of fundamental importance in the diagnosis of cancer. If the result of the examination is negative, a certain conclusion cannot be drawn; on the other hand, where the examination is positive, the diagnosis is certain, and the treatment of the case indicated. The only difficulty lies in the fact that the portion removed is ordinarily too small for the purposes of microscopic examination. The specimen should be imbedded in paraffin and cut in serial sections, which should be stained after the method of Van Gieson or with picro-carmin.

The diagnosis is not established by finding epithelial cells in the preparations, although this is suspicious, but by finding collections of epithelial cells in places where normally they are not found. Where the epithelium of the surface penetrates the deeper structures, great circumspection must be exercised in making a diagnosis, in view of the fact that a number of pathologic processes, such as syphilis, may occasion an analogous epithelial hypergenesis. Irregular structure of the epithelium is a characteristic symptom of cancer.—*St. Louis Medical Record.*

### **Pathologic Anatomy and Diagnosis of Singer's Nodules.—**

PROF. O. CHIARI, Vienna.

Various laryngeal lesions are described under the name of singer's (or vocal) nodules. In this paper only the following are studied: These nodules are round or slightly elongated, and lie upon the free border of the vocal bands, more frequently at the junction of the anterior with the middle third. They are always symmetrical. In color they are yellowish white, or reddish white. Ordinarily they have a glistening surface, and are sessile and opaque. In size they may become as large as a pin head. Special characteristics distinguish them from fibromata, cysts, papillomata, and other neoplasms, likewise from tubercular or syphilitic nodules. They never ulcerate, and seldom disappear spontaneously.

Authors have different opinions as to their frequency. Chiari has observed them in  $\frac{1}{3}$  to 1 per cent. of all laryngeal cases, and about double as often in the female as the male. Perhaps this is due to the fact that the former pay more attention to the voice than the latter. Above all, these nodes are to

be observed among singers, although they are not uncommon in children.

The following are causes: Acute and chronic catarrh of the larynx, overstrain of the voice, and perhaps defective method of singing. Most writers consider these nodules a form of hyperplasia of the epithelium and of the superficial fibres of the vocal band. This opinion is confirmed by histologic observations, which are considered in the report. Finally, Chiari gives his personal observations resulting from his investigations, and comes to the conclusion that the mucous glands only very exceptionally take part in the formation of these nodules.—*St. Louis Medical Record.*

#### Progress in the Treatment of Fractures Since the Introduction of the Roentgen Rays.—PROF. V. BERGMANN, Berlin.

In the past ten years two very important steps have been taken in connection with the treatment of fractures, viz, the operative (bloody) treatment of fractured bones, the ends of which cannot be brought into juxtaposition by other methods, and the employment of radioscopy and radiography. There are at times relations which prevent the healing of fractured bones, as for instance, muscle or other tissue between the two ends. Though this cannot be determined with certainty through the radiograph, there is always a justification for this conclusion when a space is noted between the two ends of the bone. Other local causes of the hindrance to healing are readily revealed by the radiograph. This is especially well demonstrated in patellar fractures, where three points are noticed which have a tendency to prevent healing: (1) the difference in size between the two fragments; (2) splinters of bone are often seen between the two ends, which must be removed or pushed aside before healing can occur; (3) the lower fragment sometimes turns so completely on its axis that the coapting surfaces cannot be brought together. Through this means the plausibility of an operation is always revealed. In Bergmann's clinic twenty-five cases have been operated upon with silver sutures, after the radiograph had revealed the true state of affairs, and in every case bony union took place. Fractures of the tarsal and metatarsal bones, that were formerly so completely hidden through swelling, etc., are now very well understood. Before the use of the Roentgen rays these cases were almost invariably treated with massage, and the bones thus more widely separated; now the fragments can be precisely located and treated accordingly.—*St. Louis Medical Record.*