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Maritime Medical News

A MONTHLY JOURNAL OF

MEDICINE AND SURGERY.

Vol. XIV.

HALIFAX, NOVA SCOTIA, APRIL, 1902.

No. 4.

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The sixth special course of special instruction for general practitioners has been arranged by the members of the Medical Faculty of McGill University. This course begins Monday, April 28th and continuing for six weeks, closes June 7th, 1902.

The course will consist of :—

(a) LABORATORY COURSES.

Systematic Laboratory instruction is given from 9 to 10.35 every morning on Microscopical Methods, Clinical Microscopy, Clinical Chemistry and Clinical Bacteriology, including diagnosis of Diphtheria, Tuberculosis, etc., the histology of blood in disease and serum diagnosis. These courses are conducted by Profs. Ruttan, Adami and Martin, assisted by Drs. N. D. Gunn, Nichols, Anderson, Yates, Williams, Fraser and Fisk. A course of Operative Surgery on the cadaver is given by Prof. Armstrong from 8 to 9 a. m., during the second, third and fourth weeks of the course.

(b) LABORATORY AND SPECIAL DEMONSTRATIONS.

These demonstrations are given daily from 10.30 to mid-day, and will consist of one or more of the following: Modern treatment of Tuberculosis, Prof. Finley; Operative Midwifery, Prof. J. C. Cameron; Mental Diseases, Dr. Burgess; Medico-Legal and Sanitary Toxics, Prof. Wyatt Johnson; Clinical use of Roentgen Rays, Prof. Girdwood; Demonstration of the actions of certain important and new drugs, Dr. J. T. Halsey; Medical and Surgical Anatomy, Drs. Springle, Henderson and Tait McKenzie; Clinical Chemistry and Urinalysis, Prof. Ruttan; Morbid Anatomy of certain diseases, Prof. Adami and Dr. MacTaggart; Treatment of Diarrhoeal Diseases of Infancy, Prof. Blackadar; Treatment of deformities, Dr. Tait McKenzie; Medical Examination for Life Insurance, Prof. Wilkins.

(c) MEDICAL AND SURGICAL CLINICS.

For four days each week during the first two hours of the afternoon, there are clinics on groups of cases in the wards of the Montreal General and Royal Victoria Hospitals. Those given in the Medical Wards of the Montreal General Hospital are given by Profs. Blackadar, Finley and Lafleur, in the Surgical Wards by Prof. Shepherd and Dr. Elder; in the Royal Victoria Hospital Medical Wards, by Prof. Stewart, Prof. C. F. Martin and Dr. Hamilton; in the Surgical Wards by Prof. Bell and Dr. Garrow. In addition two or three ward classes are given weekly.

(d) CLINICS IN SPECIAL DEPARTMENTS OF MEDICINE AND SURGERY.

One or more of these clinics are given in the Hospitals each afternoon after the regular Medical and Surgical Clinic, and during the entire afternoon on Wednesday and Saturday of each week, the following special Clinics are given: Ophthalmology, including demonstrations of the use of Ophthalmoscope in the Royal Victoria Hospital by Prof. Buller and Dr. Byers; in the Montreal General Hospital by Dr. J. J. Gardner and Dr. Sterling; Dermatology, Prof. Shepherd; Genito-Urinary Surgery, Prof. Bell; Orthopedics, Dr. C. W. Wilson; Laryngology, Prof. Birkett and Dr. H. D. Hamilton. Special Demonstration on Diseases of the accessory nasal cavities by Dr. Hamilton, Gynecology, Prof. Wm. Gardner and Dr. Chipman in the Royal Victoria Hospital, and Dr. Lockhart and Dr. J. D. Cameron in the Montreal General Hospital; Diseases of Children, Prof. Blackadar and Dr. G. G. Campbell; Obstetrics, Prof. J. C. Cameron and Dr. Evans. The use of the Cystoscope and Urethroscope, Dr. Springle.

The above courses of instruction are given wholly apart from the regular lectures, clinics, etc., for undergraduates in medicine. Physicians may enter on the course at any time after April 28th.

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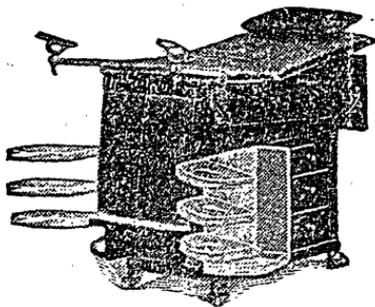
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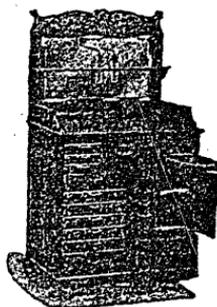
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HALIFAX, NOVA SCOTIA.

Thirty-Third Session, 1901-1902.

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E. H. LOWERISON, M. D., Lecturer on Ophthalmology, Otolary, Etc
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_____, Lecturer on Botany at Dalhousie College

ANDREW HALLIDAY, M. B., C. M., Lecturer on Zoology at Dalhousie College.

JAMES ROSS, M. D., C. M., McGill, Lecturer on Skin and Genito-Urinary

The Thirty-Third Session will open on Tuesday, September 3rd, 1900, and continue for the eight months following.

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(Pass Primary M. D., C. M. examination).

3RD YEAR.—Surgery, Medicine, Obstetrics, Medical Jurisprudence, Clinical Surgery, Clinical Medicine, Pathology, Bacteriology, Hospital, Practical Obstetrics, Therapeutics.

(Pass in Medical Jurisprudence, Pathology, Therapeutics.)

4TH YEAR.—Surgery, Medicine, Gynecology and Diseases of Children, Ophthalmology, Clinical Medicine, Clinical Surgery, Practical Obstetrics, Hospital, Vaccination.

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Fees may now be paid as follows;

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Three of	100 00

Instead of by class fees. Students may, however, still pay by class fees
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1902.

Medical Society of Nova Scotia.

34th ANNUAL MEETING.

The Annual Meeting will be held in New Glasgow, Wednesday and Thursday, July 2nd and 3rd, commencing at 2 p. m. on Wednesday. All who intend reading papers or presenting cases at this meeting must notify the Secretary before June 3rd. 1902.

JOHN W MACKAY, M. D.,

President,
New Glasgow, N. S.

JOHN STEWART, M. B.

Hon. Secretary,
Halifax, N. S.

1902.

Maritime Medical Association.

TWELFTH ANNUAL MEETING.

The Annual Meeting will be held in Charlottetown, P. E. I., on Wednesday and Thursday, July 9th and 10th.

Extract from Constitution:

“All registered Practitioners in the Maritime Provinces are eligible for membership in this Association.”

All who intend to read papers at this meeting will kindly notify the Secretary as early as possible.

F. P. TAYLOR, M. D.,

President,

CHARLOTTETOWN, P. E. I.

GEO. M. CAMPBELL, M. D.,

Hon. Secretary.

HALIFAX, N. S.

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A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

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DR. JAMES ROSS,
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CONTENTS FOR APRIL, 1902.

ORIGINAL COMMUNICATIONS.

Skin Manifestations in General Diseases.— Geo. G. Melvin	115
Eclampsia.—M. A. Curry	124
The Medical Features of the U. S. Immigration Law.—Victor G. Heiser	130

SELECTED ARTICLES.

The Suprapubic and Vaginal Methods of Treating Pelvic Suppuration	132
Correspondence	137

EDITORIAL.

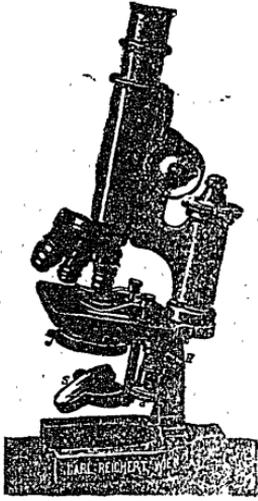
Message of Condolence from Nova Scotia Branch British Medical Association	142
The Muir Memorial	142
Dr. Bissett's Letter	143
Canadian Medical Association	144
Editorial Notes	144

SOCIETY MEETINGS.

Nova Scotia Branch British Medical Association	147
Medical Council of New Brunswick	149
Personals	149
Book Reviews	150
Books of the Month	150
Notes	150

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THE
MARITIME MEDICAL NEWS.

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

VOL. XIV.

HALIFAX, N. S., APRIL, 1902.

No. 4.

Original Communications.

SKIN MANIFESTATIONS IN GENERAL DISEASES.*

By GEO. G. MELVIN, M. D., Treas. N. B. Medical Society; Vice-President St. John Med. Society; Dermatologist to Home for Incurables; Examining Surgeon to U. S. Immigration Commission, St. John, N. B., etc.

I have been led to select this title in consequence of the excellent and interesting paper presented to the Society last spring by Dr. G. R. J. Crawford upon "Eye Complications in General Diseases." Although, of course, I cannot hope to rival the inimitable manner in which that learned gentleman placed his observations before you, yet in a modest way, and following "afar off," I beg to direct your attention to some of the more notable manifestations of skin irritation met with in the course of which, from a dermatological standpoint, we call "general" diseases.

To one approaching this subject, the very first obstacle he encounters is the question, what are "general," as distinguished from dermatological diseases? Indeed, this is a somewhat difficult problem to determine, when viewed from any "special" standpoint. St. Paul's remark, that "we are all members one of another," and that "when one member suffereth, all members suffer with it," although not made with respect to the human body, in fact, being only a figure of speech indicating the various individuals comprising the early Christian Church, is yet strictly true in a medical sense. There is,

* Read at meeting of the St. John Medical Society, Oct. 4th, 1901.

after all, no such thing as a "local" disease. A flea-bite will cause inflammation in the affected part, and more or less poisoning of the whole body. But while this is true, we cannot forever be so dogmatically scientific. Convenience, as opposed to literal truth and mathematical exactness, is continually crying for consideration and will not be comforted. Therefore we *do* speak of local diseases; of diseases of the eye, the ear, the lungs, the stomach, and finally of the skin. Certainly, if one cares to take the trouble, he may readily determine the extent of the empire of dermatology, by going through the contents of any standard work upon the subject. Yet, even then, he would meet with difficulty. Shoemaker classes measles, scarlet fever and rotheln, as diseases demanding his attention, while Crocker, as good an authority, wholly omits reference to them. Personally, I have half a suspicion that those diseases, in this city at least, are not considered by the profession as belonging to the domain of the specialist. Still, they are so near the border-line, that, in common with roseola, I shall omit them. Of course regarding smallpox and syphilis there is no question. These are pure and simple dermatological, and are so regarded the world over.

With this rough and incomplete outline of the area of our subject settled, it is proper to say that I do not intend going in anything like an exhaustive manner into the discussion. Only a few of the more commonly met with diseases will be touched upon; just enough to awaken thought upon the matter, and to elicit that discussion, which is always much the more valuable part of our exercises, especially when the present humble writer comes before you. Neither shall I attempt to make any classification. The nature of the subject scarcely admits of it; and the diseases having skin-symptoms will be mentioned just as they happen to present themselves to the writer's mind, due regard being paid to their frequency and importance.

In any consideration of this subject, perhaps the first disease occurring to the majority of us, would be *typhoid fever*. The "rose colored" spots have, for ages, been a classical symptom of this disease. They were among the first points mentioned as diagnostic signs, in nearly every text-book upon the practice of medicine. Their mention is so universal, that it at once becomes to the young practitioner the first disillusioning fact which tends to shake his faith in the infallibility of his teachers and his library. This is because, although religiously looking for these objective signs, he rarely finds them.

Typhoid is one of the most insidious of all diseases in its approach, stealing upon the patient like a "thief in the night," occasionally totally intermitting for twenty-four hours, and at times assuming other guises, in a way "to deceive, if it were possible, even the very elect." This is the interval when the budding Janeway looks for and fails to find the "rose-colored spots" and moralizes upon the vanity of looks and diagnostic signs. So far as I know, no statement has been tabulated as to the frequency of their appearance, but it is certain that their appearance at any time during the course of the disease is far from constant. The following facts will, perhaps, exhibit about all that is known concerning them as a sign of typhoid.

- (1) They appear about the seventh day of taking to bed; the latter itself being a very uncertain date.
- (2) The abdomen, rather than the chest, is their favorite primary location. From there they spread to the chest, sometimes the thighs, and more rarely to the back.
- (3) They are more common in adults than in children.
- (4) They are more common in town than in country—a very curious fact, and one admitting of all sorts of speculation.
- (5) They number from half a dozen to two dozen; exceptionally, many more.
- (6) They are "rose" colored only in the sense of the color of the centre of a white rose.
- (7) They are not spots—that is, macular, at all, but papules, slightly raised in the centre, and so, palpable to the light touch.
- (8) Once out, they persist during the whole course of the disease. This applies, however, only to the papules as a whole, and not to the individual lesions. These latter may disappear after a few days' life, being succeeded by a new crop, springing up not as a crop but one by one.
- (9) Their number, or time of appearance, bears no relation to the character of the disease as regards severity and so forth. It is next to useless to speculate upon their cause, the singular uncertainty of their appearance, or the remarkable predilection they show for city patients. This latter peculiarity is too occult for the present writer, but it has occurred to him that their appearance after a week in bed may be due to the long continued constant temperature obtained by reason of this position. If a reason might be hazarded for their favoritism for city patients, the fact of the more constant sponging and bathing of the latter might possibly be etiological. The above facts being borne in mind it will be seen that their value as a diagnostic sign is but small. Certainly when they do appear, it is a valuable and oftentimes

comforting corroborative evidence, as it is pretty generally admitted that no other disease with which we are acquainted exhibits an eruption at all comparable to this.* Another point of great value is, that as they are as likely to appear upon very mild as upon very severe cases; their advent upon the former often relieves the physician of a delicate and embarrassing position.

It is a short, and, to every general practitioner, a very familiar step from inflammation of Peyer's patches to inflammation of the parenchyma of the principal organs of respiration, known as pneumonia, or more properly, as Flint pointed out, pneumonitis. Here again the skin comes into play, and this time with a very valuable diagnostic sign. It differs radically in almost every point from the corresponding symptom of typhoid. In pneumonia there is no lesion, in typhoid there is. The skin serves but as a glass through which we see, not "darkly," but very clearly indeed, the nature of the trouble underlying it. Again, in pneumonia the skin-sign appears early, often indeed with the very first of the subjective symptoms. Also, in the respiratory disease it is always in evidence; we do not have to uncover the patient; it is in his face. Again, while it cannot be said to be so certain a sign, being simulated by opium poisoning or hæmorrhage into the base of the brain, yet it is sufficiently so, in connection with other manifestations almost always present, to be extremely valuable. Unlike the papules of typhoid, also, there is nothing mysterious in its causation. It is what we would naturally expect, knowing as we do the exact pathological history of pneumonitis. Again, unlike the sign of typhoid, it does bear a relation to the gravity of the disorder. In only one particular does it correspond with the typhoid symptom; it is not always present. But its absence is a congratulatory condition, as it shows a moderate onset of the disease. I need scarcely say that I refer to the pneumonic "blush"; really not a blush at all, but the characteristic dark, almost blue-red area that appears on the cheek of the victim of pneumonia. Every one knows it is due to the non- or insufficient aeration of the blood, consequent upon the non-activity of one or more of the pneumonic lobes. Little more need be said about it. It is, perhaps, more pronounced upon those with transparent complexions than upon those

[*Note. I desire to modify above statement to the extent that, occasionally, a hæmorrhage into the cerebellum may produce an eruption liable to be confounded with it.]

with features affected by exposure to the weather. But this is not also so, as I have repeatedly observed it upon almost physically perfect laborers, as lumbermen, tanned by a whole winters' exposure to the snow-reflected sun, and by the wind and smoke of a typical woodman's shanty. Just why it should not always remain during the course of the full force of the disease is not readily apparent, but the fact is that it often does not. Frequently, as the disease progresses, going on to involve lobe after lobe, the blush disappears. It is to be presumed, owing to the well observed law of "accommodation." The system here as elsewhere accustoms itself to new and untoward conditions; and the whole surface, perhaps, takes on a somewhat dusky hue, so rendering less apparent the primarily affected area.

Which of us, in thinking upon this subject, would fail to remember the skin changes consequent upon child-birth and pregnancy? Here is a fertile and most interesting field for medical philosophy and speculation. The *striæ* upon the abdomen, following child-bearing, are among the most constant and valuable in the whole range of dermatological signs, yet while comparatively constant, they are not incurable. Women have borne children and have been left with virgin-like abdomens. The cause is thought to be two-fold; it is either in the small size of the child, or in the exceptional pelvic capacity of the mother, or in both combined. It is generally taken that no question attaches as to the cause of *striæ*, but with all due deference to authority, there has always remained a suspicion with myself that stretching or overstretching has been too readily assigned as the universal factor. Scores of times have I observed a like, in fact, an identical series of *striæ* upon the upper and interior aspects of the thighs. This is a site of course altogether beyond the direct mechanical influence of the foetus, and hardly ever affected with anasarca. The feet, the ankles and the lower legs are repeatedly swollen and distended—nothing is more common—but it is rare, indeed, to see the thighs, near the body, enlarged to any extent. I have satisfied myself, in the course of repeated deliveries, dating from the first one, that such *striæ* do occur without the slightest intervention of stretching of the part. Pathologically, I admit, they may not be the same, as I have never made a section from any of them for the microscope, but clinically they appear identical, and I am certainly inclined to regard them so. I have no theory to offer to account for it, but would be glad indeed to hear it explained by any of the members present. The darkening

and widening of the areola about the nipples, the formation of papules in the same region, and the increased size and erectility of the nipples themselves, are, all of them, suggestive and all pretty constant, and all undoubtedly due to the normal increased activity of these organs, so essential to child-rearing, or rather which nature intended to be so essential—the breasts. None of these changes, are, of themselves, radical. These conditions, the areola, the papules, and the erectile tissue, all existed prior to fecundation, the latter accident but endowing them with new life and vigor. Vastly different is it with yet another skin manifestation in the pregnant woman. I refer to the darkened and pigmented maculæ and plaques so often observed upon the face. Here, unlike the sign in pneumonitis, a real tissue-change takes place. A real lesion is formed by the deposit of pigment in the Malpighian layer of the skin. A multitude of interesting and obscure questions springs up about this fact. Why is the pigment deposited? Of what does it consist? Where does it come from? What are the organs concerned in its manufacture and deposit? Why should the face be selected as the favorite site of the deposition? These are a few, a very few, of the questions suggested by this strange metamorphosis, questions that, so far as I am aware, have never been satisfactorily answered. We are in a measure, reasonably familiar with the deposit of pigment. But, apart from its deposit in foetal life in the colored race its causation by the exhibition of drugs, it is almost in every instance a pathological process. Yet, pregnancy is not, or should not be, pathological. All evidence goes to show that, in a normal case, pregnancy is for the well-being of the mother. What then is the cause of the pigmentation? If an answer might be hazarded, it results from the necessary excess of blood in the mother consequent upon the needs for nutrition and growth of the foetus, and the lack in the latter, to a proportionate amount of the coloring matter of the blood. The excess, therefore, of this coloring matter is deposited in the maternal tissues. But why those tissues should be the conspicuous ones of the face is too occult for the present writer's speculation.

Addison's disease furnishes a fertile field for the discussion of skin complications, but as this article is directed to those diseases in which the skin plays but a very subordinate part, I have thought well to omit it.

Tuberculosis in the lower and human families is at present a subject of wide spread interest. It has received an astonishing fillip in consequence of Koch's declaration of the fundamental difference of habitat between the human and bovine species of bacillus. Therefore anything in this direction is of surpassing interest. Tuberculosis may be said to attack man under three guises. (1) As phthisis pulmonalis; (2) as lupus vulgaris; and (3) as struma or scrofula. The other sites and pathologic methods of the bacillus are minor and generally secondary to some one of the three foregoing—nearly always to the first.

Beyond mere blanching of the dermal covering, phthisis pulmonalis has no marked or notable effect upon the skin differing from that upon other organs not locally assailed. This blanching is so open and apparent an effect of anæmia—a result of the destruction of the red blood corpuscles, that it is scarcely worth referring to. Lupus vulgaris is so essentially a disease of the skin itself, that it is, at once, out of court in this paper. It is in the third method of tubercular attack that we find an interesting phase of skin lesion—a lesion playing an important and yet subordinate part. Struma, or scrofula—for I see no reason for abandoning the older term—is essentially a disease of the glands, not of the skin. It is, indeed, very questionable if the skin is ever primarily attacked. Here is one of the profound mysteries of pathology. We may rest assured that we are yet very ignorant of the life history and methods of the bacillus tuberculosis or else that a huge mistake has been made in connection with this parasite, as regards its work in the glands, or in the skin, or in both. The pathology of lupus vulgaris has shown us that the bacillus has an express predilection for the skin, perhaps making little or no distinction between the cutis vera and the lower Malpighian layers. We also know, or think we know, that the same micro-organism has a similar taste for glandular tissue, and that it affords a peculiarly comfortable and appropriate nidus for the bacillus. Yet, when seated in one tissue, it hardly ever attacks the other. In other words, lupus is rarely seen in connection with scrofula, and scrofula almost never leads to lupus. Neither, and this is equally wonderful, do either of these diseases predispose to tuberculosis of the lungs. I am aware that the latter statement is weaker than the former. Scrofula and pulmonary consumption either in the same individual or in the same family is not an extremely infrequent event. But what shall we say

of a tissue so closely connected with an effected one, as that of the skin covering a scrofulous gland? Even when the process of inflammation and suppuration has succeeded in making a lesion in the dermal envelope of the gland, that lesion is almost never lupoid in character. I am not prepared to say that it is never so, absolutely, but I have never met with a case, or, indeed, read of one. The skin lesion possesses no interest other than that attaching to any ordinary suppurating process. Though the solution of continuity of tissue in these cases is essentially chronic, it heals at once, when the source of the suppurating and irritating products is eliminated. The same strange independence is seen between lupus vulgaris and pulmonary consumption. Repeatedly have I seen extensive lupus infiltration and ulceration at the outlet of the anterior nares; at the very gate of the respiratory tract; at a place where never a breath can be drawn without it gliding directly over the parasite-haunted region. Yet the lungs almost invariably remain free from the effect of the bacillus. At the same time we go into hysterics if an unfortunate victim of consumption happens to spit upon the floor of a car, in a cab, or even upon the same street with us! These are, to the humble mind of the writer, mysteries. Certainly it is very easy to talk of immunity to tubercular action when once the tubercular lesion is seated anywhere within the system, but this immunity does not prevent tuberculosis of the intestines following as a very frequent result of the pulmonary lesion. But I am wandering from my text. Little indeed, remains to be said regarding the skin lesions of scrofula. Perhaps, if any generally constant effect is obtained other than the 'breaking down of the dermal tissue, a direct result of suppuration, it is the general thinning of such tissue over the whole of the affected gland. This I have repeatedly noticed, and ascribe it entirely to the stretching of the skin covering, consequent upon the enlargement of the gland. Another pretty constant feature is the presence of varicose veins through such skin-envelope, resulting, sometimes, when the abscess is opened, in protracted, though not often alarming, hæmorrhage.

I find, as I proceed, that this subject promises to be almost an endless one. I have but mentioned three diseases, and already have written more than is fair to impose upon the society. The subject merits more and better discussion than I think it has ever received. Almost unconsciously, it may be, yet to most of us, the skin offers the

most ready, safest and most frequently referred to avenue of diagnosis and prognosis at our disposal. Our first introduction to the patient is invariably followed by a close and rapid scanning of his countenance, and what is the countenance but the skin of the face? True the muscular and bony systems lie beneath it, the former especially being subject to the influence of disease, but only when such disease is of some continuance.

It would be easy to grow eloquent over the close relationship of a healthy body and a sound skin. No better thought could be selected to form the peroration of a medical address or a medical paper. But the modest writer never attempts peroration, and is satisfied to conclude, if he thinks he has uttered one original thought, or said that which will give rise to one in the minds of his hearers.



ECLAMPSIA.*

By M. A. CURRY, M. D., Professor of Obstetrics, Gynæcology and Clinical Medicine, Halifax Medical College.

Asked by the Secretary to write a paper on Eclampsia I decided to do so in order to elicit a discussion on the causes, prevention and treatment of this too common and very serious condition. I shall not apologize if I have nothing new to offer you on this subject, because I believe that subjects of such great importance to the general practitioner should be frequently discussed and kept fresh in our minds.

In this paper, as an introduction to the subject, I shall merely outline the accepted facts as to the causation, and the best methods of treatment for the prevention and the cure of attacks of eclampsia.

By eclampsia I mean puerperal convulsions, coming on prior to, during or after labour.

As to the exact causes of eclampsia, there exists a great diversity of opinion to-day. It was long held, and almost unanimously, that the chief predisposing cause of eclampsia was a condition of *uræmia* or *urinæmia*, which resulted from a diminished excretion of the nitrogenous elements of the urine, and consequent accumulation of these in the blood. This was thought to result from pressure on the kidneys, renal vessels or ureters by the gravid uterus in the later months of pregnancy. This was given, too, as an explanation why eclampsia occurred more frequently in primiparæ than in multiparæ, the pressure on the urinary organs being greater in the former. The fact, however, that large ovarian and fibroid tumours do not predispose to eclampsia, shows that pressure effects have little or nothing to do with its production.

The generally accepted theory to-day is that eclampsia is due to a toxæmia, which results from a deficient excretion of toxic products, not only by the kidneys, but also by the liver, skin and intestines. In short, a deficient action of all the emunctories. It is well-known that in the pregnant woman cell-activity is increased, which gives

* Read at a meeting of Maritime Medical Association, Halifax, July 3rd, 1901.

rise to an increase of excrementitious material; added to this, is the excreted material of the foetus. If, now, the balance between production and excretion of this material be disturbed, by the inactivity of any one of the excretory organs, it must accumulate in the system and give rise to a toxæmia.

This broader view of the chief cause of eclampsia has done much toward adopting a rational method of treatment, in the prevention of eclampsia as well as in the treatment of an attack.

Another important cause, probably, is the hydræmic condition of the blood, for it is well known that the blood becomes altered in quality during pregnancy. It becomes more watery, the white corpuscles being greatly increased, while the red are diminished.

It is also thought to be due to a neurosis, predisposed to by an excessive irritability of the nerve centres that takes place during pregnancy.

While these three theories are probably correct, there can be no doubt that the most important predisposing cause of eclampsia is insufficiency of the kidneys, by which are retained in the system certain poisons which are normally excreted in the urine. Because in the large majority of cases, before the attack, urinary insufficiency is marked, being found greatly diminished in amount in 24 hours, and with diminished amount of the solid constituents of the urine. Besides, albumin in considerable quantity will be found, and possibly casts. These changes in the urine furnish us with the first and most reliable symptoms of impending eclampsia.

Hence the physician should systematically examine the urine of the pregnant woman in the latter months, not only for albumin but also for casts, the quantity of urine passed in the 24 hours and the amount of urea present. If this routine be followed, a physician will not be surprised by an attack of eclampsia in his practice.

Besides these changes in the urine, other well marked prodromal symptoms are usually complained of which are of great importance and which we should always enquire for. These are pains in the head, dizziness, defects of vision, drowsiness, depression, epigastric pain and various dropsies, of the feet and ankles and especially of the face and hands.

Rarely is eclampsia unheralded. In the large majority of cases one or more of the symptoms mentioned will be present, and they should lead us to make frequent and careful examinations of the

urine, both quantitative and qualitative. If the urine be diminished in amount, or if it contain a diminished amount of its solid constituents, or if albumen in considerable amount be found, it should arouse our suspicion. A persistent headache, unrelieved by the usual remedies, defects of vision or the occurrence of dropsy should put us on our guard.

Having then outlined the causes and the most prominent precursory symptoms how are we to ward off an attack? If our patient complains of any of the symptoms mentioned, or if marked changes in the urine are discovered, we should endeavour to get rid of the toxæmic condition, which, if allowed to continue, may precipitate an attack of eclampsia. If the pregnant woman is carefully watched after the fifth month, and her urine frequently examined, eclampsia will rarely occur, because in the large majority of cases, we can institute certain prophylactic measures by which the toxæmia will be diminished, and thus the underlying cause be removed. Our attention must be directed to the organs of assimilation and excretion. The diet is very important. It should be easily digestible, and should not leave a toxic residue in the intestines to be absorbed by the blood. Hence milk is the best diet, being very nourishing, easily digested and does not leave any toxic residue. Our patient should take two or three quarts a day, and be limited to it, as far as possible. Some mineral or ærated water may be given with it. This diet should be kept up till our patient is free from any of the symptoms that threaten an attack. Thus we diminish the supply of toxic material and lessen the work of the emunctories. At the same time we must give special attention to the excretory organs. They are not getting rid of the excreted material as fast as it is being produced. We must see that the liver, bowels and skin, which are complementary to the kidneys, are acting freely. The liver should be stimulated and the bowels moved once or twice a day by means of laxatives. I am in the habit of giving at bedtime one or two of Upjohn's anti-constipation pills, which have one-eighth grain of podophyllin in them, followed in the morning by a dose of Hunyadi or Apenta water. These seem to act on the liver and the whole intestinal tract.

The skin should be stimulated to act by frequent hot baths and warm clothing. The patient should be directed to take large quantities of liquid to flush out the kidneys and assist diaphoresis. In this way, acting on the liver, bowels, skin and kidneys, we get rid of the

accumulated poison in the system. If the patient is anæmic, a non-astringent and easily assimilable form of iron should be given. By these means, in the large majority of cases, we will be able to carry our patient to term without any alarming symptom.

If, however, the symptoms are more urgent and an attack seems imminent, more active measures will be necessary. The bowels must be acted upon promptly and freely by a hydragogue cathartic, as calomel and jalap followed by an enema in a few hours. The skin should be made to act freely by a hot bath or hot pack and our patient wrapped in blankets. Saline irrigation may be resorted to, by which a large quantity of normal salt solution is injected into the rectum and subcutaneously. This produces free diuresis, profuse sweating, and also acts on the bowel.

If notwithstanding our efforts an attack comes on, how are we to deal with it? Our efforts must be directed to stopping the fits and preventing complications. The earlier we can stop the fits the more favorable the prognosis, because each successive fit makes the coma deeper, and is more likely to be attended by serious complications.

For this purpose two distinct lines of treatment are advised. Chloroform and chloral have long been the sheet anchors in overcoming the fits. Chloroform being inhaled so long as the fit lasts, and chloral ʒss to ʒi injected into the rectum. This may be injected every three or four hours, giving three drachms in the twenty-four hours. Chloroform is repeated as often as the fits recur.

Another line of treatment is by morphia given hypodermically. Half a grain is injected, as soon as the fit occurs, and is followed up by one-fourth of a grain every two hours until the fits cease; not more than two grains being given in the twenty-four hours.

The morphia advocates hold that chloroform and chloral depress the heart and favour heart failure, that morphia promotes diaphoresis and lessens the excitability of the nerve centres. The most recent article I have seen on this subject appeared in May number of the *Lancet*, written by Prof. Lyle, of the University of Durham. He says "In order to control the convulsions in eclampsia it is necessary to allay the irritability of the cerebro-spinal system. Morphia, chloral, veratrum viride and chloroform have all been used. Chloroform is undoubtedly bad, as its action is very temporary, and very depressing to the patient. The action of chloral and veratrum is more lasting but they are both cardiac depressants; while morphia judiciously

given, is quite free from any disadvantage and has the following advantages; 1st. It controls the convulsions by allaying the irritability of the cerebro-spinal system. 2nd. It does not weaken the patient. 3rd. It prevents excess of waste product being thrown into the blood. 4th. It does not injure the child. 5th. It has no effect on the kidney. 6th. When the patient is under its influence, labor often commences, and quickly terminates, without causing more convulsions. Should labor not supervene under morphine, it will generally control the convulsions and the patient go on to full term without any recurrence of the attacks."

These are the two lines of treatment for stopping the fits. Together with these we must get rid of the poison. A strong purgative to bring about free action of the bowels must be administered. If the patient is conscious calomel and jalap; if not two or three drops of croton oil may be administered, followed by a good enema. We must stimulate the skin to act freely by hot packs or steam and our patient should be surrounded by blankets. Saline irrigation may be administered to assist the emunctories to act.

The complications that we must guard against are preventing the patient from injuring herself, especially biting the tongue. This is best done by putting a towel between her teeth. Let the patient lie on her side instead of on her back, so as to allow the saliva to run out of her mouth instead of into the larynx. If the heart becomes weak and rapid, we may give a hypodermic of digitalis and strychnine.

Venesection in eclampsia is still a disputed point. Those who advise it say that it removes a certain amount of the toxic agent and lessens the congestion of the nerve-centres. Those opposed to it hold that it dangerously lessens the patient's strength. I do think, in a strong plethoric patient, with a full tense pulse, the withdrawal of one or one-half pint of blood will be followed by excellent results. Some of the advocates of venesection advise that the withdrawal of the blood should be followed by sub-cutaneous injection of normal salt solution, which, by filling the vessels and stimulating the heart counteracts the bad effects of the bleeding.

Others again advise that *veratrum viride*, given by the mouth or hypodermically, until the pulse-rate is reduced to sixty, will accomplish the same results as venesection. By depressing the circulation, it bleeds the woman into her own vessels, and thus relieves the congestion of the cerebro-spinal centres. It is also powerfully

sedative to the motor tracts of the spinal cord. It is also held that it lessens the spasm of the renal vessels, causing a marked increase in the flow of urine. The dose is ten drops, repeated every hour till the pulse reaches sixty.

The advisability of inducing premature labour in a severe attack of eclampsia is still a matter of dispute. Those who favour it argue that pregnancy is the cause of the eclampsia; that in one-third of the cases of eclampsia the convulsions cease when the uterus is emptied. Hence labour should be induced.

Those against it hold that the convulsions may continue after delivery, and the irritation consequent on inducing labour is likely to make the convulsions more severe or bring them on. Parvin's advice is "take care of the convulsions and let the uterus take care of itself." Prof. Lyle in the same article I have quoted says: "As soon as the patient enters the second stage of labour she should be delivered by the forceps, but any mechanical interference, (induction of premature labour, mechanical dilatation of the cervix, version, or *accouchement force* during the first stage of labour, is extremely unsuccessful treatment, as evidenced by the experience of many authorities."

If labour has begun spontaneously, as it will in the large majority of cases, if the convulsions are severe, we should endeavour, as much as possible, to shorten its duration, without using enough violence to irritate the nerve-centres. Any operation under these circumstances, must be performed under complete anæsthesia, so as to lessen the shock to the patient.



THE MEDICAL FEATURES OF THE U. S. IMMIGRATION LAW.*

By VICTOR G. HEISER, M. D., United States Marine Hospital Service.

For convenience the law may be summed up to consist of two simple provisions, viz: all idiots or insane persons or those suffering with a dangerous contagious or a loathsome disease shall be excluded. All persons likely to become a public charge are to be excluded.

The advantage of putting the law in the above shape are that it makes it elastic. Just as soon as a certain disease appears to be a menace to the public health or an unnecessary charge upon the community, that disease can be placed on the excluded list by administrative action, thus avoiding the long and tedious delays incident to legislative action. The constant aim has been to build upon practical rather than upon theoretical grounds. From year to year as our experience increases it has been found desirable to constantly increase the list of diseases that come under the provisions of the law. The principal diseases excluded as likely to become public charges are the chronic organic diseases; heart disease furnishes one of the best examples of this class. In making rejections under this clause many things must be taken into consideration. The age, the occupation, the ability of the immigrant's relatives or friends to furnish bond that the person in question will not become a public charge, etc.

The list of diseases coming under the head of dangerous or contagious is also slowly lengthening. Favus was one of the first to be placed on the list. Then came a general appeal from the eye specialists that trachoma be placed on the list. They pointed out that the free eye clinics of nearly all the large cities were over run with these cases. The impossibility of curing them and the contagious nature of the disease constantly augmented the number. They crowded out many cases that could be relieved. The cost of treating the trachoma cases was a heavy item of expense to the community. Often a case of trachoma introduced into a crowded tenement district would spread like wild fire. Many became totally blind every year, thus making

* An abstract of some remarks made before the St. John Medical Society at St. John, March 12th, 1902.

them the costliest of public charges. With this mass of evidence there could be little doubt that trachoma should be placed on the excluded list.

The most recent addition has been tuberculosis of the lungs. Every case of tuberculosis that is excluded will mean that there is just that much less danger of infecting others as well as to remove a heavy item of expense from the community that would be obliged to care for the afflicted one.

Another profitable as well as highly desirable object from a medical standpoint is the weeding out of a great number of immigrants suffering from temporary ills. These people are placed in a hospital, at the expense of the transportation company bringing them, until they have recovered. Under this head are included enteric fever, pneumonia, malaria, fractures, infected wounds, skin affections or any disease which would prevent the immigrant from becoming immediately self-supporting. Unless the immigrants afflicted with these diseases were detained they would find their way to the charity hospitals and thus become a charge upon the state. At one of the ports during the past year there were inspected in round numbers 25,000 immigrants. The hospital charges paid by the transportation companies for those temporarily ill was \$5,000. If that sum can be saved to the state on this small number of immigrants on only their temporary ills, what must be the saving on those permanently disabled and deported?

The practical part of the inspection is perhaps something of which the profession at large has had no experience. Many factors must be taken into consideration. For instance if a steamer brings a thousand immigrants it is manifestly impossible to give each individual the physical inspection that the ordinary methods of physical diagnosis would indicate. The expense and delay would make this impossible. Practical experience proves that it is unnecessary. From five to ten persons can be inspected per minute, and reasonably accurate results obtained. Favus, trachoma and hernia can be detected at this rate almost with certainty. An immigrant who has an organic disease well enough marked to warrant rejection will present enough symptoms to justify putting the case aside as a suspect, who can be thoroughly examined later on at the inspectors leisure. The immigrants themselves do not resent being inspected in this manner. For the detection of those diseases which require only temporary treatment, experience and familiarity with immigrants habits alone can insure a reasonable degree of accuracy.

The law also provides that those persons who have become a public charge within the year following their landing be deported, which gives an opportunity of deporting those who have escaped detection at the primary inspection.

Selected Articles.

THE SUPRAPUBIC AND VAGINAL METHODS OF TREATING PELVIC SUPPURATION.*

By W. R. PRYOR, M. D., New York.

It seems to me that very much of the discussion upon this subject arises from the "personal equation" of those who operate for this condition; and were it not for the partisan spirit shown by the advocates of one or the other method, we would be much nearer the truth than we are. Every man should operate by that method which will give him the best results. That is the personal; the scientific is apart from that. There are still some problems to be solved and we can all find sufficient glory in their explanation. I shall not take up your time in boasting of my results in vaginal work, nor in drawing a contrast to the detriment of any colleague who prefers to do laparotomy. I shall attempt to lead you into a discussion upon the principles which should govern us.

I will take first the acute cases, those in which the infection has but recently and for the first time passed outside of the uterus to tubal walls, ovary or peritoneum. It is an undoubted fact that the accepted routine and established method of treatment with by far the greater portion of the profession is let these case alone while waiting for a balance to be established between the infection and the tissue-resistance. You all recall the arguments pro and con regarding the question whether or not the gonococcus could cause peritonitis. We now know it can, but that it is not particularly irritating to the peritoneum. It is to the membranes lined by glandular or columnar epithelium that it does its damage. We also have begun to believe that where gonorrhoeal infection destroys one tube it also infects the other; that is, that it is always bilateral. We also know how prone such an infection is to cause pyosalpinx or at least occlusion of the tube and such disintegration of tubal walls as to render them useless for any normal function. For instance, I have never heard of an undoubted and well authenticated instance where a woman who has

*Read before the Section of Obstetrics, Buffalo Academy of Medicine, Jan. 28, 1902.

had gonorrhœal salpingitis has subsequently conceived and borne a child. The question then is whether there is any possibility of checking this infection once it has passed outside the uterus, or are the tubes doomed? Now it is a significant fact that we can open the posterior cul-de-sac, remove ectopic sacs, ovarian cysts, sever adhesions and drain with gauze, without subsequent pregnancies being prevented or interfered with. Therefore a pelvic drainage is not damaging to the functions of the ovaries and tubes. We have also shown that such incision of the lowest pouch of the peritoneum is devoid of danger. It is well understood that the invasion of a locality by pyogenic cocci depends for much of the damage it can do upon retention of the products of inflammation. In other words, a free escape of the results of the inflammation as fast as they are produced is inimical to the progress of the inflammation, and that the latter does not proceed to that degree which it would reach were the discharges retained. The tissue-resistance and repair are greatest where drainage is best. That I believe is axiomatic.

For many years I have felt the necessity of placing gonorrhœal ovaries and tubes under the benefits of these laws. Can we through the abdomen secure such good drainage of acutely inflamed gonorrhœal tubes? If we attempt it through the abdomen is there not risk of producing a more general infection of the peritoneum? This conservative work upon inflamed tubes at the very beginning of the infection, for the purpose of limiting the infection and preventing pyosalpinx, I am most enthusiastic about. But I believe it is useless unless tried through the vagina, and worse than illogical if attempted through the abdomen.

Let us leave the instance of gonorrhœal and pass to acute sepsis, the other most frequent cause of suppuration in tubes and ovaries. I believe it is proven beyond doubt that this form of infection always follows some trauma inflicted upon the uterus; therefore, a raw surface is necessary for its inception. Why? Because sepsis travels to and produces lesions in remote organs not by direct continuity of lining membranes, but through the medium of the lymphatics. It in this way has a tendency to spare the essential structures of the tubes, and pyosalpinx may be termed an indirect result of this infection. Again the question arises, cannot something be done to arrest sepsis in its course, or is it better to let the patient alone? If drainage is of benefit in the less virulent cases of gonorrhœa, does not the experi-

ence of all of you tell you that in other parts of the body, the flesh, the joints, the serous pleural cavity, it is of inestimable value and often as a sole agent is curative.

I have instituted certain experiments with the assistance of the pathologists. We have examined the uterine discharges in septic cases, we have opened the peritoneal pouch and from that have collected fluid, and we call septic for the purpose of this discussion only those cases in which streptococci are found in the peritoneal cavity. After subjecting these cases to a certain line of treatment we have removed and examined the dressings.

It is significant that in no instance have we failed to destroy the causative streptococci and in no instance has death ensued where lesions in remote organs have not been present at the time of the operation. Furthermore, very many of these women have conceived and borne children. We have succeeded in checking the sepsis and a restoration to physiological activity has resulted. Such are the results I have found to follow my treatment through the vagina of acute septic salpingitis and peritonitis it is advisable to open the abdomen for purposes of merely treating the infection?

Possibly you have not asked me here to discuss this phase of the subject, but those cases in which the sacculation of pus has already taken place. Let us further classify these cases and their treatment. We have those in whom we perform a merely evacuative operation and those whom we seek a restoration to health by the removal of diseased structures.

Many of you will recall the days when we used to feel large pus foci reaching to the abdomen; how we would pass down to them probes or needles seeking to furnish a very small channel through which a few days later we could evacuate the pus extraperitoneally. In no day of the past or present has any surgeon ever succeeded in evacuation through the abdomen such pus pockets unless he did so by rendering the tract extraperitoneal. But how unfortunate the results usually were. Only in the case of broad ligament abscess were the results anything like satisfactory. Furthermore, the entire length of such drainage tracts were infected and all the organs touching them were involved. The vagina does not absorb pus. Pelvic pus is below the pelvic brim, usually completely locked in. To evacuate it through the vagina is to let the abdominal cavity alone; is to secure escape of

the pus at the lowest point and through a natural drainage tract which does not become infected by the discharges.

But you will ask me to pass to the question of removal of pus foci. So far as gonorrhœal pyosalpinx is involved, I have to again express my belief that it is always bilateral though of differing degree on the two sides. Therefore the indication is to remove the adnexa of both sides. But would you leave the uterus? Gonorrhœal endocervicitis has been shown to be one of the most difficult diseases to cure. The uterus robbed of its supports may become displaced, it is forever becoming reinfected and is a constant source of infection to others. Therefore, whenever I remove the gonorrhœal adnexa I take away also the uterus. This being my position, the only question is how the operation shall be done. I find it easier for me and safer for my patients to remove a purulent mass through the vagina, than through the abdominal cavity between the abdominal contents and through an abdominal incision which I hope will unite properly.

But in septic pyosalpinx and ovarian abscess the lesions are very often unilateral. To successfully remove a pus tube we must dig it out of the cornu. It will not suffice to tie it close to the cornu any more than to so treat the suppurating vermiform appendix. Can this be done through the vagina? Undoubtedly not. I am therefore an uncompromising advocate of abdominal section for the removal of unilateral pyosalpinx and ovarian abscess. How frequent this is I do not know. Surely not in 10 per cent. of the cases. But in all cases of bilateral septic tubo-ovarian suppuration I ignore the so-called value of the uterus and perform vaginal ablation.

But we have found that these advanced septic cases follow abortion and labor, conditions in which the uterus is large. Large uteri may reach above the pelvic brim and suppuration about these is apt to lead to important abdominal lesions, such as appendicitis. When such complications are found to exist we must undoubtedly approach the case from the abdominal side.

So then, gentlemen, we find that as an operation to prevent supuration and check septicæmia, the vaginal section stands alone.

As an operation of a purely evacuative character, again vaginal section is the choice.

As a procedure seeking the removal of uterus and both tubes the vaginal operation is far superior to abdominal section, except where high abdominal complications are found.

For the removal of one purulent set of adnexa, there is no operation equal to the abdominal, and the vaginal operation is not to be thought of.

These are my views, and they are substantiated by my experience in their application.

But the great question is, why let suppuration occur? Blameworthy indeed is he who nowadays can sit idly by and see an infection running riot among a woman's most precious organs. As blameworthy as he who would permit a fulminating appendicitis to destroy life without an effort to save. Much criticism is heard of him who removes great gross pockets of pus, "thus ruining the woman." Is not the greater measure of this blame to be laid at the feet of him who permits them to form?

Nowhere else in the body would one dare to adopt such a policy of procrastination, and it is time that we seek answers to these two questions: can suppuration be prevented, and how?

To my almost complete satisfaction I have answers for them, and they are sufficiently indicated in what I have said. It rests with some one to discover that agent which will destroy the gonococcus without injuring the pelvic tissues. My use of iodine compounds I find kills the streptococci.

We have passed far beyond the technique of operations and mortality. It is the morbidity we must in future control. The man who first sees these cases is the one we must instruct and appeal to; for upon the first treatment depends the fate of the involved organs.—*Buffalo Medical Journal*.



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TO THE EDITOR MARITIME MEDICAL NEWS :

DEAR SIR:—At your suggestion I will give a desultory and hasty description of my visit to Johns Hopkins Hospital. My purpose was to get a little laboratory work and witness the doing of operations and absorb some of the clinical medicine done and taught by authorities with whom we had become familiar. I was not disappointed. Four weeks, however, soon ran away, and made me realize that the time was short after coming in contact with so much that was interesting and instructive.

One of the distinctive features of Johns Hopkins is the extensive laboratory work in biology and surgical pathology carried on in that institution. The rooms in the bacteriological building were always full, and Professor Bloodgood's room in the hospital was always crowded during classhours. Professor Bloodgood although a young man is becoming a peer among teachers. He is certainly laying the foundation of the building of good and efficient surgeons.

Johns Hopkins realizes as much or perhaps more than any other institution on this continent the necessity of preparing its students with a good and ample ground work in bacteriology as a requisite and highly essential factor in the armamentarium of the practitioner.

Of surgical operations in the hospital there was no dearth. Drs. Halstead, Finney and their assistants were always busy. Dr. Kelly and his assistants in the gynæcological operating room were kept busy with a large supply of subjects. Dr. Kelly gave ample evidence of the great fame that has preceded him—a brilliant and successful operator. Here as well as in the other surgical rooms were used and left buried in the tissues at an operation iron dyed silk ligatures as well as the chromicised gut. All of the hysterectomy operations which I saw done by Dr. Kelley were by abdominal incision. The normal salt effusion was often made use of in exhaustive anæsthesia and with good results. The examination of a tumor or suspicious mass was expeditiously done in the laboratory and its character made known to the operating surgeons before the completion of the operation.

Clinical medicine in the class room and at the bedside by Dr. Wm.

Osler is unique. His grasp and thorough knowledge of the subject in hand is superb. The hospital physician who had stood the fire of questions in reply to Dr. Osler when making a differential diagnosis, whether in chlorosis, rheumatism, sclerosis, aneurism, anæmia, or tuberculosis, on one day would find sooner or later in going over the same ground that the doctor had a reserve which was great and unusually instructive.

There is not the interest manifested in the contagiousness of tuberculosis as exists in Canada. The careless handling of tuberculous lungs in the hospital clinic and the indifference manifested in the laboratories when and after examinations of specimens containing tubercle bacilli were somewhat disappointing. The state of Maryland is not yet aroused to the necessity of building and equipping sanatoria for the care and isolation of consumptives.

This may be accounted for to some extent for the reason that three hundred thousand people in the District of Columbia have no voice in the legislation of the state owing to disfranchisement. The state needs a Trudeau to wake it up to the necessity of sanatoria for its consumptives.

A few days in New York gave me an opportunity to visit some of the hospitals and the New York Polyclinic. Many of the teaching staff in the latter institution whom I knew in '86 had passed away. Others and good men had taken their places. Vaginal instead of abdominal hysterectomy was being done in the Polyclinic Hospital. An involuntary sigh escapes as one sees so much and realizes that he knows so little. Another cause for sadness is that time is quickly flying and we are growing old and never will know much in comparison to what may yet be known.

In Boston, in the Harvard Medical School and in the City Hospital, the changes are great and striking since 1870—thirty-two years ago. Only one of the surgeons I knew then is active now. Chenes, Holmes, Shattuck, Jackson, Bigelowe, Hodges, Bowditch, Stowe, Lusk, all have gone. But they were peers in their day.

Yours truly

G. E. DEWITT.

A HALIFAX DOCTOR ABROAD.

Madrid, March 11th, 1902.

DEAR SIR.—I believe I promised to report on the treatment of "mal de mer" by the remedy which you suggested to me "Armour's Nutrient Wine." I may say that the test was hardly a fair one. For the first two days out my meals were taken in saloon; then came two days of rougher weather during which I was decidedly uncomfortable and the nutrient wine taken on crushed ice seemed to be of service; but I think there was no day on which some other food was not taken and after the two days spoken of I was able to go to the saloon again, I was on deck the greater part of every day and was only really "sick" on one occasion—and that was just before reaching port, and due to going to cabin after dinner to do some packing. The passage was a smooth one and the ship very steady, so it is hard to say how much the remedy had to do with my good fortune. I may say that I gave some of the preparation to a lady passenger who was pretty sick, and she thought it helped her considerably.

As I am writing, perhaps you would like to hear something of my medical experience in Spain. In Seville I visited two hospitals. The first, the "Cairdad" seemed to be chiefly an asylum for chronic cases of pulmonary disease, no surgery being done. It is particularly celebrated for the pictures in the chapel, of which two by Murillo—"Christ feeding the multitude" and "Moses bringing water from the rock" are best known.

The Civil Hospital is a large institution having 800 beds. It is built round a square court in the centre of which is a large chapel surrounded by orange and other trees, making the open balconies on each story of the hospital pleasant resorts.

I made the morning visit with one of the attending surgeons, and afterwards saw him do a tracheotomy for inoperable cancer interfering with respiration.

Wards were dark with but few windows, and stone floors and walls made them chilly. Beds very far from clean. Patients, surgeons and visiting surgeon all smoked cigarettes most of time of visit—

exploration of a wound or pus cavity and rolling a cigarette followed each other indiscriminately.

The operating room was small but fairly up to date. Instruments were in a separate room, numerous and beautifully kept by one of the sisters. Operation well done. Surgeon blamed Government for dirty beds and all short comings, as does everybody for everything in this country.

Here in Madrid I have been at the Facultad de Medicina and at its Hospital Clinical, and also at the Hospital General near by.

Arriving at the Medical School about nine a. m., I joined a number of students and passed in without challenge. Following the procession I finally found myself in the operating room of the Clinical Hospital—which was a novelty to me, though I remember having read of it. A long, well lighted room is completely divided at about the centre by a glass partition into the operating room proper and the students quarters. Along the lower part of partition is a row of small gas jets to prevent condensation of vapour on the glass. The partition did not at all interfere with view, but no sound could be heard from inside, and it is to be hoped the reverse is true for students kept up a constant stream of talking interspersed with college songs during operation. At one end of partition a tube passed through the wall ending on one side in a large curved "ear" and on the other in a trumpet like extremity. At close of operation a plug was removed from the ear and the professor spoke into it. The voice was somewhat indifferently heard on the students' side.

The operation was an abdominal section for tumour in region of liver, which was decided to be inoperable, the wound being closed, with drainage.

Surrounding the operator, and apparently all taking part, were about fifteen assistants, all in gowns. The apparatus, instruments and all details of an antiseptic (rather than aseptic) operation seemed to be well provided for.

The operating room ceiling was decorated with frescoed figures of angels and round its walls were painted various mottoes such as—*'Nec temere nec timide,'* *"Tuto cite et jucunde,"* *"Pereat vi morbi non vi medici,"* etc.

After the operation I made friends with one of the students, whom I found could speak a little French. He took me all through the Hospital General, an immense structure having fourteen hundred beds, built

around a central court with flagged floors, stone steps and walls. Wards, each having about fifty beds, are devoted to the various forms of disease—tuberculosis, urinary diseases, nervous diseases, diseases of women, etc. In a very perfectly appointed small operating room belonging to the urinary ward I was introduced to a surgeon who was removing a testicle.

From here we passed to the general surgical ward and to a fine operating room adjoining, where I saw another surgeon amputate for tubercular disease of elbow. In neither of these rooms was there any provision for students, and as far as I could understand they only see operations from the other side of the glass partition aforesaid.

Everyone was excessively polite, but bad French on both sides made conversation difficult.

Evidently tubercular disease is very prevalent in this country. In medical wards most of cases seem to be of a pulmonary nature, and in surgical wards tubercular cases seemed most common.

I notice that while I am comfortable without an overcoat most of the Spaniards in the streets have their cloaks muffled up to the ears. The climate also is said to be very changeable though—delightful at present.

By enquiring at instrument shops, which are numerous and contain all up to date appliances, I learn that the instruments come chiefly from England and France.

Madrid is a fine city with all modern improvements, and it would not seem that the Spaniard is quite so effete as we are apt to imagine.

As I am only making a short stay in each of these cities of course my medical experiences are limited, but they have been quite novel to me, and I hope these hurried notes may not be without some degree of interest.

There is so much to see that one's time is very fully taken up and certainly it seems strange that Spain is not more visited than it is, and as it well deserves to be.

Yours,

J. F. B.

THE
MARITIME MEDICAL NEWS.

A MONTHLY JOURNAL OF MEDICINE AND SURGERY.

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HALIFAX, N. S., APRIL, 1902.

No. 4.

Editorial.

MESSAGE OF CONDOLENCE FROM NOVA SCOTIA BRANCH
BRITISH MEDICAL ASSOCIATION.

The committee appointed by the N. S. Branch British Medical Association, consisting of Drs. Walsh, C. D. Murray and G. M. Campbell, to draw up a memorial to the late Dr. W. S. Muir, adopted the following resolution :

“That the members of the Nova Scotia Branch of the British Medical Association desire to record the esteem in which the late Dr. William Scott Muir was held by the Branch, both on account of his personal merit and his high professional character, and to record the profound feeling of regret with which they mourn his premature loss. They also wish to convey to Mrs. Muir and family the expression of the deep sympathy which they feel for them in their sad bereavment.”

THE MUIR MEMORIAL.

As many of our readers are aware, a movement has been set on foot in Truro to raise a memorial to the late Dr. W. S. Muir. Subscriptions are, at present, limited to one dollar, and, from what we hear, the response of the public of Truro and its vicinity has been very gratifying.

The exact form which the memorial should take is not yet decided, but the general wish is that it should be a hospital. It is scarcely

likely that a sum sufficient to build and equip a hospital can be raised, but it is hoped that at least sufficient may be collected to equip an operating room, or to furnish a ward, which should bear the name of the Muir Memorial.

Doubtless when the stream of dollar-subscriptions begins to slacken, it may be open for those who desire to contribute larger sums.

There could scarcely be a more appropriate memorial to any member of our profession than a hospital for the sick and suffering poor, and it would be especially appropriate in the case of one, who, like our lamented friend, was so generous and so self-denying.

We feel sure there are many of our confreres in these provinces who would like to contribute to this memorial of Dr. Muir, who was a personal friend of so many of us, and who, at the time of his death, was the President of our Maritime Association.

Contributions may be sent to E. A. Randall, Esq., D. D. S., Truro, or to Geo. Stewart, Esq., Mayor, Truro.

DR. BISSETT'S LETTER.

In our last issue we published a terse and stringent letter from Dr. Bissett, of St. Peters, C. B., commenting upon the ethical relations of members of the profession in Halifax and particularly referring to surgeons on the visiting staff of the Victoria General Hospital.

While we are compelled to admit that Dr. Bissett has some grounds for his strictures, we think that were he more closely in touch with medical politics in Halifax he would be aware that the condition which he notes, and comments on so severely, is very far from general.

Thanks to the constant friendly contact which results to a large extent from the meetings of the Branch of the British Medical Association, there is to-day very little friction among the mass of the local profession, and even with some of those against whom the profession has general grievances, social relations remain unaffected. This happy condition is not however quite universal. Among fifty or sixty doctors usually an Ishmealite will be found whose hand will be against every man, and whose professional and personal relations cannot be controlled by those beneficent influences which guide the actions of other men.

We make this reference more for the purpose of explaining the

situation than excusing it. We hope that members of the profession throughout the maritime provinces will not believe that the relations of the profession in Halifax, or even of the staff of the Victoria General Hospital, are to any large extent affected by the unfortunate combativeness of one or more individuals.

CANADIAN MEDICAL ASSOCIATION.

The annual meeting of the Canadian Medical Association will be held in Montreal on the 16th, 17th and 18th days of September, 1902. The president is Dr. Francis J. Shepherd, 152 Mansfield St., Montreal, the local secretary, Dr. C. F. Martin, 33 Durocher St., Montreal, and the general secretary, Dr. George Elliott, 129 John St., Toronto. Dr. William Osler, professor of medicine in Johns Hopkins University, will deliver the address in medicine, and Dr. John Stewart, Halifax, Nova Scotia, the address in surgery. Arrangements are already well in hand for a very large meeting.

EDITORIAL NOTES.

AMERICAN MEDICAL ASSOCIATION.—The Committee on Pathologic Exhibit for the American Medical Association is anxious to secure materials for the coming session at Saratoga, June 10th to 13th inclusive.

This exhibit was accorded much praise and comment during the sessions at Atlantic City and St. Paul respectively, where were collected valuable exhibits from all parts of the country. The materials included not only pathologic specimens but the allied fields, bacteriology, hæmatology, physiology and biology were well represented.

It would also be desirable to secure exhibits of new apparatus, charts, etc., used by teachers of pathology and physiology in medical colleges.

This exhibit has already become a permanent feature of the annual sessions of the American Medical Association, and the committee is desirous of securing its list of exhibits as early as possible, and to this end asks those having desirable materials to communicate with any member of the committee.

To contribute to the value of the work, it is suggested that as far

as possible each contributor select materials illustrative of one classification and by such specialization enhance the usefulness of the display

Those lending their materials may feel assured that good care will be given their exhibits while in the hands of the committee, and due credit will be given in the published reports.

Very respectfully,

F. M. JEFFRIES,

214 E. 34th St., N. Y. City.

W. A. EVANS,

103 State St., Suite 1403, Chicago, Ill.

ROGER G. PERKINS,

West. Res. Med. School, Cleveland, O.

Committee on Pathologic Exhibit, American Medical Association.

INTERNATIONAL CONGRESS OF GYNÆCOLOGY.—Dr. Laphorn Smith, of Montreal, has received a letter from Professor Pestalozza, of Florence, on behalf of the Committee of Organization of the Fourth International Congress of Gynæcology, begging him to announce to the profession of Canada that the Congress will meet in Rome from the fifteenth to the twenty-first of September of this year. The committee of organization consists of Professors Pasquali, Morosani and Mangiagelli, who wish to extend a hearty welcome to their Canadian brethren. The subscription fee is five dollars for gentlemen and two dollars for the ladies accompanying them. The treasurer is Dr. La Torre, 8 Via Venti Settembre, Rome. The subjects chosen for discussion are: 1.—The medical indications for the induction of labor. 2.—Genital tuberculosis. 3.—Hysterectomy in puerperal septicæmia. 4.—Inflammatory changes in the neck of the uterus. 5.—The surgical treatment of cancer of the uterus.

It is the earnest wish of the committee to have a large attendance of gynæcologists and obstetricians from Canada.

AMERICAN MEDICO-PSYCHOLOGICAL ASSOCIATION.—The fifty-eighth annual meeting of the American Medico-Psychological Association will be held in Montreal, the third Tuesday, Wednesday, Thursday and Friday in June, (17th, 18th, 19th and 20th,) 1902. The meeting follows that of the American Medical Association at Saratoga, which occurs in the second week in June. The matter of transportation has been placed in the hands of the committee of the latter Association, and it is hoped to obtain special railroad rates for both meetings.

The headquarters of the Association will be the commodious and

comfortable Windsor Hotel, delightful in all its appointments and especially well adapted for convention purposes. Special rates have been secured for members and their friends. The committee, under the chairmanship of Dr. Burgess, has taken up the matter of arrangements for the meeting with much enthusiasm, and, with the large attendance expected, a profitable meeting from every point of view is assured.

The annual address will be delivered by Dr. Wyatt Johnston, Lecturer on Medical Jurisprudence, McGill University Law Faculty, Assistant Professor of Hygiene, the Medical Faculty, Pathologist to Montreal General Hospital, etc., etc. SUBJECT—"The Medico-Legal Appreciation of Trauma in its Relation to Abnormal Mental Conditions."

A large number of papers have been promised including one by Dr W. H. Hattie of this city.

A GOOD MOVE.—The firm of Parke, Davis & Co., manufacturing pharmacists, has adopted the policy of other large corporations of encouraging its employes to become shareholders. This company proposes to issue 4,000 shares of its capital stock, and permit the oldest among its employes, especially those in important positions as managers, superintendents and foremen, to purchase this new stock at \$55 a share. The present market value of the stock is \$70 a share, and face value \$25.

The company announces that it is not taking this action for philanthropic reasons, but because it considers it good business judgment to have its men in important positions interested in the profits of the business.

THE CLEVELAND MEDICAL JOURNAL.—This journal which has been formed by combining the *Cleveland Medical Gazette* and the *Cleveland Journal of Medicine* cannot but meet with well merited approval if we can judge by perusal of the first number. The Journal contains about seventy pages embracing many interesting articles, the paper and type is excellent, while the department of therapeutics will serve a useful aid to its readers.

THE JOURNAL OF ADVANCED THERAPEUTICS.—At the beginning of the year the *New York Lancet* combined with the journal above mentioned. The different departments—ten in number, are edited by well-known observers in some particular branch of medicine. The plan of this excellent exchange should commend itself to thinkers and seekers after medical knowledge.

Society Meetings.

NOVA SCOTIA BRANCH BRITISH MEDICAL ASSOCIATION.

Jan. 22nd, 1902.—Dr. T. W. Walsh, President, in the chair.

Dr. M. Chisholm read an interesting paper on "Intubation of the Larynx."

Dr. Mader said he had only used intubation for the last two years; previously he had done tracheotomy. He referred to the use of antitoxin and the short time it took to give relief. Coughing up of membrane was generally within twelve hours after a full dose of antitoxin.

Dr. M. A. B. Smith mentioned two cases in which Dr. Chisholm had intubated and which had given him a very favorable impression of intubation. In one case nurse neglected to remove tube as instructed and child died.

Dr. Murphy felt grateful to Dr. Chisholm for his paper. He referred to the importance of using antitoxin as well. He thought tracheotomy had not had a fair chance with antitoxin. In a recent case he gave 8000 units with a good result. He believed in larger doses of antitoxin than usually advocated.

Dr. Goodwin referred to an original idea of Dr. Chisholm's, mentioned two or three years ago, that was, feeding intubation cases with the head down. He (Dr. G.) had intubated two cases, death resulting in both; this was before antitoxin was introduced. Intubation, to give good results, should be done early.

Dr. G. M. Campbell said the results of intubation were very pleasing. He also preferred large doses of antitoxin, 3000 units, repeating in three hours.

Dr. Murphy suggested the Trendelenburg position in feeding intubation cases.

Dr. L. M. Murray asked if there was any limit to age for intubation.

Dr. Mader inquired if there were any permanent ill results to vocal cords after intubation.

Dr. Chisholm, in reply, said he had not noticed any permanent ill effects to vocal cords, though such might occur from the use of a tube. Patient could be fed by a catheter through the nose. He blamed one case of pneumonia to an error in feeding. Did not think there was

any age limit to the use of antitoxin. Before the days of antitoxin results were not good.

Dr. Mader reported a case of chicken-pox, which had been seen by Drs. Doyle, Ross and Trenaman. The rash was fairly typical on the body, but some of the lesions on the forehead were distinctly papular and somewhat "shotty." Patient was a young man who had not been vaccinated since infancy. Rash quickly disappeared.

Feb. 12th, 1902. Meeting held at Halifax Medical College.

Dr. A. Halliday presented the following pathological specimens which he described in detail:

1. Pericarditis, with photographs of the heart covered by fibrinous exudate, and also the specimen itself—"pine apple" heart. He also showed a bacterial culture of an organism from the heart and lungs of this case.

Dr. G. M. Campbell described the specimen as it occurred at post-mortem; it was now much altered in appearance.

Dr. C. D. Murray spoke of the clinical history of the case which had been made under his care at the Victoria General Hospital.

2. Valvular disease following rheumatism in a young girl, with some hypertrophy of heart and deposits on valves. The deposits on auricular wall and aorta were of small size. Infarcts were present in spleen and kidneys. Hemiplegia had occurred from embolism to the brain. The causation of infarcts was then explained by Dr. Halliday.

Dr. Murray mentioned some points in the clinical history of the case, the remarkably high temperature, 106°, and the slow respiration which occurred coincidentally with the hemiplegia.

3. Tumor removed from leg which had existed for some years and then started to grow. A microscopic specimen appeared like epithelioma.

4 and 5. Miliary tuberculosis of lung, spleen and liver.

6. Atheroma of liver and aorta.

7. Brain with adherent membranes. Pachymeningitis hæmorrhagica.

8. *Acarus farinae*, found in cheesy particles, passed by a child which was fed on milk and flour.

Dr. G. M. Campbell then exhibited the following specimens:

1. Small granular kidney with moderately hypertrophied heart and granular contracted liver; microscopic sections also shown. The case was that of a woman who died from uræmic convulsions.

2. Liver of a man aged 48. Abdomen had been tapped several times during the preceding two weeks. There was hypertrophic cirrhosis, liver weighing nine pounds.

Dr. Murray gave the clinical history of the case.

3. Ulcer of stomach, adhesions to liver and diaphragm, and pleural cavity filled with watery pus.

MEDICAL COUNCIL OF NEW BRUNSWICK.

ANNUAL MEETING OF THE COUNCIL OF PHYSICIANS AND SURGEONS.

The annual meeting of the Council of Physicians for New Brunswick was held at the Queen Hotel last evening. Those present were Drs. Thomas Walker, P. R. Inches, G. A. Addy, Jas. Christie, of St. John; Drs. C. T. Purdy and Smith of Moncton, and Dr. J. W. Bridges of Fredericton. After the usual routine business had been transacted the following officers were elected for the ensuing year:

Dr. C. T. Purdy, Moncton, President

Dr. Thomas Walker, St. John, Treasurer.

Dr. Stuart Skinner, St. John, Registrar.

Examiners—Drs. Jas. Christie, P. R. Inches, G. A. Addy, J. W. Bridges, Stuart Skinner, and Thomas D. Walker.

Drs. H. S. Bridges and G. U. Hay were appointed examiners on preliminary work.—*Fredericton Herald*, Mar. 20th.

Personals.

Dr. J. Reynolds, for the past two years house surgeon at the Victoria General Hospital, has settled at Sydney Mines.

Dr. Robbins, also a former house surgeon of the Victoria General Hospital, has taken Dr. Love's place at Bridgeville, Dr. Love having gone to Sydney Mines.

Dr. John F. Black's many friends will be pleased to read his interesting letter, published on another page.

Dr. G. E. DeWitt, of Wolfville, has lately returned from visiting some of the large hospitals in the United States. Some of his experiences are published in this issue.

Book Reviews.

THE ALIENIST AND NEUROLOGIST, for April.—This admirable journal contains the following original articles: "Outlines of Psychiatry in Clinical Lectures," by Prof. Wernicke; "Gall's Special Organology," by P. J. Moebius, M. D.; "Puberty and Genius," by Cesare Lombroso, M. D.; "Juvenile Female Delinquents," by Eugene S. Talbot, M. D.; "A Question of Figures," by E. O. Spitzka, M. D. Besides the usual Editorials, Selections, Book Notices, Reviews, Publisher's Notices, etc. \$5.00 per annum. Address subscriptions to Henry L. Hughes, Manager and Publisher, 3857 Olive Street, St. Louis, Mo.

THE INTERNATIONAL MEDICAL ANNUAL, 1902.—A year book of Treatment and Practitioner's Index. New York; E. B. Treat & Co., 241-243 West 23rd Street. Price \$3.00.

The International Medical Annual is now in its twentieth year. It is probably safe to say that it enjoys a greater popularity than any other year book published. This is by reason of the very practical character of the articles which it contains. All the literature of the preceding year is reviewed by the large staff of editors, and what is of real merit and practical value is epitomized in a very readable manner. The Annual is so well known that it scarcely requires recommendation, for no one who has subscribed to it one year would think of missing a subsequent issue. It is quite sufficient to say that the issue of 1902 is, if possible, even more valuable than its predecessors.

Books of the Month.

ATLAS AND EPITOME OF OPERATIVE SURGERY.—By Otto Zuckerhandl, of Vienna. Edited by J. Chalmers DaCosta, M. D., of Philadelphia. Second edition, thoroughly revised and enlarged. With 40 colored plates, 278 text illustrations and 410 pages of text. Price, cloth, \$3.50 net.

ATLAS AND EPITOME OF OTOLOGY.—By Gustav Bruhl, M. D., of Berlin, with the collaboration by A. Politzer, M. D., of Vienna. Edited with additions by S MacCuen Smith, of Philadelphia. With 244 colored figures on 39 lithographic plates, 99 text illustrations and 292 pages of text. Price, cloth, \$3.00 net.

Notes.

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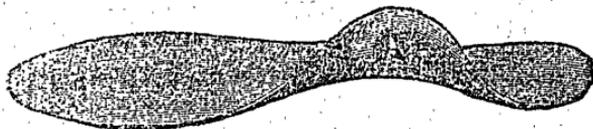
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