

The Canadian Journal of Medicine and Surgery

A JOURNAL PUBLISHED MONTHLY IN THE INTERESTS OF
MEDICINE AND SURGERY

VOL. XVIII. TORONTO, AUGUST, 1905.

NO. 2.

Original Contributions.

SURGERY OF THE STOMACH FROM THE STANDPOINT OF THE CLINICIAN.*

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THERE are many reasons why surgery of the stomach should be more and more interesting to the clinician. Chief among these is the fact that with the increasing clinical experience in this field, it has become possible to perfect the diagnosis of conditions far beyond the degree to which this could be done only a few years ago, when it was possible to actually confirm diagnoses anatomically only in those patients who could be subjected to an autopsy. In the vast majority of cases the diagnosis was made upon theoretical grounds. The patient was treated and improved temporarily; during a subsequent attack some other physician made the same or a different diagnosis, which again could not be proven anatomically, the difficulty arising from the fact that no one could prove or disprove the diagnosis in either case. The moment a case becomes surgical, however, this difficulty is abolished, because the diagnosis can and must be proven to be right or wrong.

There is much ante-mortem pathology in diseases of the stomach, as well as in diseases of all the other intra-abdominal organs, which can be studied properly neither post-mortem nor ante-mortem, unless the organ is exposed to view; and no sooner has this been done in a large series of cases than the diagnosis of the condition becomes much simpler and easier and gains greatly in certainty.

*Read before the Ontario Medical Association, June 6, 7, and 8, 1905.

Gastric Ulcer.—The condition which primarily or secondarily leads to the greatest amount of stomach surgery is the ulcer. The operation may be indicated, 1. Because of the painfulness of the ulcer; 2. In order to control (a) acute or (b) chronic hemorrhage; 3. In order to prevent secondary conditions such as (a) perforation; (b) peritoneal adhesions; (c) pyloric obstruction due to cicatricial contraction; (d) hour-glass stomach; (e) gastric dilation due to obstruction; (f) starvation; and last but not least, (g) implantation of carcinoma in the ulcer.

Diagnosis of Ulcer.—Since the presence of gastric ulcer primarily is the beginning of so many of the surgical conditions, it is important to recognize this lesion early in its development.

The most constant symptom in the presence of this lesion is pain. This is usually located below the tip of the sternum, is increased upon pressure, and upon taking food. The patient can usually tell which food will cause the pain to become severe. If the ulcer is on the posterior surface of the stomach the pain radiates into the back, usually to the left of the median line and up as high as the lower end of the scapula.

Very commonly the pain accompanying the presence of gall-stones is mistaken for the pain due to gastric ulcer, but it is usually not difficult to differentiate between these two, because the former is increased upon pressure at the point between the end of the ninth rib and the umbilicus, a point first located by Mayo Robson, while the latter is increased upon pressure in the median line.

Again, in case of gall-stones the pain in the back extends to the right at about the level of the tenth rib, while in gastric ulcer it is greatest in the median line or to the left of this and higher up.

The stomach contents are usually exceedingly acid in the presence of gastric ulcer, and there is an abundance of free hydrochloric acid present unless the ulcer has become carcinomatous. It should, however, be stated here that the chemical examination of stomach contents must always be looked upon only as of value in corroborating diagnosis, made as a result of a study of the history and physical examination. Robson and Graham have demonstrated this fact conclusively in a large series of carefully studied cases.

The history usually states that the patient has felt distress upon eating for a considerable period of time; that there has been eructation of acid stomach contents; that this is much more severe when certain articles of food have been taken; that the patient is much less uncomfortable when carefully following some diet which experience has taught him to select.

Quite frequently the feces are observed to be black from the presence of partly digested blood from slight gastric hemorrhages.

So many of the patients have, however, received subnitrate of bismuth as a remedy, or some form of iron, that care must be taken not to confound the effect of these remedies upon the color of the stools with that of hemorrhage from a gastric ulcer.

Frequently these hemorrhages have not been observed, but

still the loss of blood has been sufficient to cause a marked anemia, hence this condition must be considered in connection with the other symptoms and the history. In patients who are severely anemic and who are suffering from some form of gastric disturbance, one can usually demonstrate the loss of blood from chronic ulcer by a careful study of the case. Fuetter has demonstrated that by overcoming this anemia by careful dieting, many chronic ulcers will heal, which without especial attention to this feature seemed quite incurable under non-surgical treatment.

With careful internal and especially dietetic treatment, a vast majority of all cases of ulcer of the stomach which have been recognized early, can undoubtedly be healed permanently, if not only the immediate treatment, but also the after treatment is carried out carefully and conscientiously. That this can be actually expected in these cases has been shown in a large number of patients suffering from this condition.

But there are many of these cases which apparently recover only to relapse again and again. Many of these go from one physician to another, each time temporarily improving or recovering.

Robson has found that most cases which ultimately come to operation have been apparently cured a number of times and our observations fully confirm his report.

It is well to bear in mind this element of the history of any given case, because it should have a distinct bearing upon the choice of treatment in the future. Any case in which there has been a number of apparent cures with subsequent recurrence of the ulcer should properly receive surgical instead of medical treatment in the future.

Differential Diagnosis.—The most common condition which is mistaken for gastric ulcer is disease of the gall-bladder, especially gall-stones or sand. Next in order comes chronic appendicitis with acute exacerbation during which the pain is usually referred to the region of the umbilicus. In this case the pain is lower down than in gastric ulcer, and it is increased upon pressure in the region of the appendix near McBurney's point.

Renal Calculus.—Has been mistaken for gastric ulcer. In this case the urinalysis will usually clear up the diagnosis; moreover, the pain is increased upon pressure over the kidney, and radiates downward and inward along the course of the ureter.

Duodenal Ulcer.—It is only the fact that ulcer of the duodenum is not very common, which makes the occurrence of mistaking this condition for gastric ulcer somewhat infrequent. This condition has almost exactly the same symptoms as gastric ulcer, but the point of tenderness upon pressure is over the middle of the right rectus abdominus muscle above a transverse line drawn through the umbilicus.

Volvulus.—In rare cases volvulus of the jejunum may be mistaken for gastric ulcer, but the violent vomiting containing bile soon after intestinal contents, but no blood, makes the differential diagnosis relatively easy.

Neurasthenia.—It is often very difficult to make a differential diagnosis between gastric disturbances due to neurasthenia and those due to chronic ulcer. This is especially true, because not infrequently neurasthenia results from the suffering, anemia, and inanition which is caused by the presence of a chronic ulcer.

It is quite likely that for several years to come, quite a number of patients suffering from neurasthenia due to other causes will be subjected to stomach operations as a result of erroneous diagnosis.

Any other severe intra-abdominal condition like intussusception, ruptured ectopic gestation, ovarian cyst with twisted pedicle, peritoneal adhesions either septic or tuberculous, may be mistaken for gastric ulcer. In a few cases I have seen an interesting condition which gave rise to a mistaken diagnosis of gastric ulcer. In these cases the great omentum had become attached by its free margin to some point in the lower portion of the abdominal cavity, the tubes, ovaries, uterus, bladder, the cecum or the abdominal wall. The tension of the omentum upon the stomach gave rise to symptoms which could not be distinguished from gastric ulcer.

In a number of patients in whom we had made a diagnosis of gastric ulcer with pyloric obstruction and consequent dilatation of the stomach, we found the pylorus unusually open and the duodenum dilated to from 2 to 4 times its normal diameter down to a point below the entrance of the common duct. Upon exposing the jejunum this was found strongly contracted in these cases.

The lymph nodes near the duodenum in these cases were usually enlarged, indicating lesions of the mucous membranes lining the duodenum. In these the pancreas is usually also enlarged, and the gall-bladder is distended with bile together with mucus, sand or gall-stones, and frequently all of these substances are found in the same gall-bladder.

It seems reasonable to suppose that the obstruction at the point of entrance of the common duct into the duodenum or below the point must be primarily physiological in character, due to the irritation caused by the mucus, sand or small stones in the gall-bladder and duct.

The observations of Cannon and Blake which show that there is a physiological mixing process which takes place in the duodenum is extremely interesting in connection with this particular class of cases. Continued attention to these cases is likely to develop facts which will have great interest for the clinician.

Another condition of clinical interest has been observed in a considerable number of cases. It has been found that many cases of gastric ulcer have previously suffered from chronic, recurrent, or catarrhal appendicitis, usually with peritoneal adhesions to the appendix, or the cecum, or both, or with fecal concretions in the appendix; but always with some form of obstruction to the passage of gas. This pathological obstruction has resulted in a physiological obstruction to the passage of gastro-intestinal contents through the pylorus, and this in turn had been the exciting cause of the gastric ulcer.

Clinically one can usually follow a very interesting sequence in cases of gastric ulcer which do not end abruptly by perforation or fatal hemorrhage, or by what is probably less frequent in cases in which the ulcer is at all advanced, by permanent healing.

At this point, however, I believe that it is proper to express the opinion that it seems most likely that a very large number of small ulcers heal so perfectly that it is quite impossible to demonstrate their existence either ante-mortem or post-mortem, and that there are few cases which go beyond this initial stage without healing which will later heal permanently.

Vicious Circle in the Development of Gastric Ulcer.—It is not uncommon to observe the following history in the development of gastric ulcer:

1st. There is severe pain two to four cm. below the ensiform cartilage in the median line. This may be more severe directly after eating, or only after eating certain things, or it may be most severe when the stomach is empty, and may be relieved by taking food, but its location is quite constant and the pain is increased upon pressure at this point. There is at this point no dilatation present.

2nd. In attempting to protect the ulcerated surface against traumatism there is a physiological obstruction of the pyloric sphincter. This obstruction may be increased in two ways: (a) There may be developed an indurated edematous area due to the extension of the ulcer, or (b) as a result of the healing of the ulcer there may be formed a certain degree of cicatricial contraction which in itself will constitute an obstruction.

3rd. In order to overcome this obstruction the remaining portion of the stomach musculature will become hypertrophied.

4th. This is certain to be followed by muscular exhaustion and relaxation, and this will result in gastric dilatation.

5th. No sooner had this occurred, than the pyloric obstruction is still further increased by the fact that the lower margin of the greater curvature is depressed far below the level of the pylorus, and all of the food must not only be forced through the already obstructed pylorus, but it must also be elevated to the level of the latter aperture.

The fact that in the normal stomach every portion is drawn to a higher level than the pylorus, as the organ is forcing its contents into the intestine, has been shown very beautifully by Bettman, and more recently by Cannon.

6th. In the meantime, another condition has arisen which will prevent healing. The obstruction, together with the sacculation, gives rise to the accumulation of residual food in the dilated stomach, which undergoes decomposition in place of digestion. In this manner, all of the fresh food is vitiated by being mixed with the decomposed residual food remnants in the stomach. In this manner, each successive condition makes the previous state of things more grave. In the meantime, two other conditions have

arisen which will serve to prevent the tendency of healing in the ulcer.

7th. Almost immediately after the beginning of a gastric ulcer, a great amount of mucus is secreted, apparently to protect the diseased surface. This, however, causes the food to become coated, and this in turn interferes with gastric digestion. This condition is followed gradually by the secretion of an increased amount of hydrochloric acid, which is undoubtedly the physiological remedy for facilitating the digestion of food covered with mucus. With the increasing acidity of the stomach contents, the chances of healing of the ulcer is greatly reduced, and its extension is practically certain, hence each one of the conditions in turn becomes more and more exaggerated, and conditions go from bad to worse, unless a radical change is established whether by internal treatment, or if this prove ineffective, by surgical operation. I have had an opportunity to verify these clinical observations in a very large number of patients suffering from gastric ulcer, and they are in keeping with observations of most clinicians, who have studied such cases extensively. These facts would indicate the importance of careful treatment at the very beginning of gastric ulcer in order to secure complete healing before any of the secondary conditions have arisen, and also the necessity of eliminating all of the primary causes of the lesion in every individual case after healing has taken place, in order to prevent a possible recurrence.

This is especially important, because each successive attack is more difficult to relieve permanently. The chances for permanent relief are more and more reduced, because each time some lesion will remain, which must lessen the resistance of the tissues, or increase, at least, to a slight extent, the difficulty of emptying the stomach.

It is likely, that with proper after treatment, especially as regards diet and general hygiene, it would be possible to reduce the number of cases of recurrence to a great extent. This would reduce the number of cases, which now properly fall into the domain of the surgeon.

Fuetterer has written most effectively upon this phase of the subject, and I am confident it is worthy of our most serious attention. This is true, primarily, because it would permanently eliminate all of the many serious sequelæ, which are now so common.

All of this would indicate that surgery of the stomach begins where internal and dietetic treatment of disease of this organ fails to give permanent relief. It also indicates that surgery, in order to be of value, must result in local rest and in the drainage of irritating contents of the stomach, in all non-malignant cases, and in the early removal of the growth in malignant cases. It seems reasonable to suppose that the most careful attention to diagnosis of non-malignant cases, and the surgical treatment of that portion of those which cannot be relieved permanently by internal treatment, must result in a vast reduction of the number of malignant cases.

At the present time some form of gastro-enterostomy seems to have given the most satisfactory results. Robson pointed out the fact, most emphatically, that the anastomosis must be located actually, and not only theoretically, at the lowest point in the stomach, in order to be safe and effective, and leave the patient free from regurgitant vomiting.

Theoretically, there seem to be many arguments in favor of a posterior gastro-enterostomy, but practically the results seem equally satisfactory, provided the opening is sufficiently large, and is in fact at the lowest point of the stomach.

A method has not yet been found, which completely satisfies all reasonable demands for performing gastro-enterostomy. I have had the time to look up only those of my cases of stomach surgery, which I have treated in the Augustana Hospital, hence I will speak only of these in this paper. But the methods and the results have been the same in the cases I have treated in other hospitals, hence this is of no material importance. The following table will give a convenient idea of these operations:

	Total.	Recovery.	Died.
1. Incomplete Gastrectomy.....	5	4	1
2. Pylorectomy.....	9	8	1
3. Gastro-enterostomy, Murphy Button—			
Malignant Cases.....	24	16	8
Non-malignant.....	10	9	1
4. Gastro-enterostomy, McGraw Ligature—			
Malignant Cases.....	22	16	6
Non-malignant.....	65	59	6
5. Gastro-enterostomy, other methods.....	12	10	2
6. Perforated Gastric Ulcer.....	10	2	8
7. Gastrectomy.....	4	2	2
8. Exploratory Laparotomy for Carcinoma of Stomach.....	32	24	8
Total.....	193		
9. Ulcer of Stomach, not operated.....	66	60	6
10. Carcinoma of Stomach, not operated.....	49	..	15
Patients returned to their homes unimproved, 34.			

It will be seen from this that most of the operations were performed for the purpose of securing rest for the pyloric end of the stomach, and drainage for its cavity; also that gastro-enterostomy was performed oftener by means of the McGraw ligature than by any other means. This method has been more satisfactory in my hands than any other up to the present time. I still follow the original direction of the author of the method, which I published in the *Journal of the American Medical Association*, June 6th, 1903. It seems likely that all of the methods now in use will be displaced by some new method which will be more nearly ideal than any now in use.

So far nothing has been said concerning the treatment of any of the sequelæ, or the complications of gastric ulcer, because it is to be hoped that these will be eliminated to a great extent in the future, by the cure of the ulcer itself.

Complications.—The most common complications are perforation and hemorrhage.

Sequelæ.—The sequelæ are: (1) Chronic ulcer, (2) stricture of the pylorus, (3) gastric dilatation, (4) hour-glass stomach, (5) peritoneal adhesions, (6) inanition, (7) anemia, (8) neurasthenia resulting from the constant suffering, the malnutrition and the anemia, (9) carcinoma, and (10) jejunal ulcer following gastro-enterostomy.

Perforation.—The diagnosis of perforation is relatively simple. There is a history corresponding to that given for gastric ulcer above. During some exertion, the patient suddenly experiences severe pain in the region of the stomach. This is frequently attributed to the eating of a large meal, and may consequently be mistaken for acute gastritis. The pain becomes diffuse very suddenly. The patient is nauseated, and sometimes vomits blood or bile. The abdominal muscles become rigid, the patient is in a severely shocked condition.

The greatest point of tenderness is in the region in which tenderness existed previously. In many cases the liver dulness is obliterated to a greater or less extent, but it is not safe to place too much weight upon this symptom, because it frequently is present only after the perforation has existed for several hours, and if operation is postponed until this diagnosis can be confirmed by this symptom, the extent of the infection is usually so great that the operation cannot save the patient.

With two exceptions, all of my cases in this class were in this hopeless condition when they were admitted. The important point in connection with these cases is an early diagnosis and an immediate operation. The latter should consist in a free abdominal incision, careful sponging out of stomach contents that have escaped into the peritoneal cavity, closure of the wound in the stomach with Lembert sutures, preferable of silk or Pagenstecher thread. Drainage should always be used.

In cases in which the diagnosis is not made for 24 hours or longer after the perforation has taken place, it is difficult to state which course is the worst to pursue. In my own experience, all of the cases which came under my care in this advanced stage, which were operated, died within a few days, while a few which were not operated, recovered, the opening in the stomach being closed by a plug of omentum. In some of these cases a subphrenic abscess developed, later requiring an operation.

I am confident, however, that these cases were all somewhat less serious from the beginning than those which were operated and died; and it would consequently not be proper to attribute the recovery of the former to non-operative treatment, and the death of the latter to the operation.

It seems proper to advise an immediate operation in all cases of perforated gastric ulcer, in which an early diagnosis is made, and to use one's judgment in each individual case of perforation, in which the diagnosis is not made early.

Gastric Hemorrhage.—A few years ago there was quite a marked tendency toward the immediate operation for gastric hemorrhage. Mayo Robson's experience in this direction was so encouraging, that quite a number of surgeons favored operative treatment for this condition. It seems, however, that this is quite unnecessary, because in almost every case the hemorrhage will cease, and if the patient is carefully treated, her general condition can be greatly improved, so that the risk of the operation itself will be much less than when performed during a hemorrhage.

The treatment should consist in exclusive rectal feeding. It may be well to administer from two to four ounces of castor oil early in the treatment, and then to place nothing whatever in the stomach, until there has been no blood in the evacuations for several days. Feeding by mouth should be begun with great caution, and as soon as the patient's general condition is good, the operation should be performed.

Sequelæ.—In the treatment of the first three in the above list, (1) chronic ulcer, (2) stricture of pylorus, and (3) gastric dilatation, the method must be the same. It must consist of drainage of the stomach cavity by gastro-enterostomy, or in rare cases by Finney's pyloroplasty. The one point of greatest importance which must not be overlooked, is the choice of location for the opening in the stomach at its very lowest point.

Rodman's suggestion, advising the excision of the ulcer-bearing area in these cases, is undoubtedly worthy of consideration. In my own experience the results have been more satisfactory in cases in which I have excised the pylorus in connection with making a gastro-enterostomy, but as this adds another element of danger to the operation, it may be well to continue our observations, before making this a routine treatment in these cases.

In cases in which a pylorotomy is not made at the same time, the gastro-enterostomy opening is likely to become partly or completely obstructed by contraction, and this may be followed by a recurrence of the ulcer. In cases in which a pylorotomy has been made, this has never occurred in my experience.

At the present time the choice of operation must lie between the methods introduced by McGraw, that employed by Mikulicz, Moynihan's method, or the method developed by Robson-Murphy's oblong button; or Connel's suture method can be employed in connection with the methods of Mikulicz or Robson, but it seems likely that the button will continue to lose more and more of its old advocates while it is not likely to gain many new ones. This is true, especially, because with it the size of the opening is virtually limited, and there is a distinct objection in the minds of most surgeons against a non-absorbable foreign body.

The one great point in favor of the button is its ability to punch out an opening, and to leave the union between the stomach and the intestine with the slightest possible amount of connective tissue.

In order to be of any practical value this paper must point out some of the dangers to be avoided in surgery of the stomach.

Unnecessary Traumatism should be Avoided.—There is great danger in unnecessary manipulation, because this increases the shock and the tendency to infection.

In all of these cases much can be done to prevent this by making an ample abdominal incision. Much time is frequently occupied in finding the jejunum, resulting in useless handling of viscera. By simply lifting out the transverse colon, and following its mesentery to a point a little to the left of the median line, one can always find the beginning of the jejunum in a few moments.

In gastrectomy and pylorotomy it is possible to reduce the manipulations to a minimum by simply grasping the four main arteries, and also the greater and lesser omenta between these four points, and then excising the intervening portion, which has been grasped by long-jawed forceps, in order to prevent leakage.

There is danger of necrosis of the stomach, if the gastric artery is injured, and of the transverse colon, if the middle colic artery is grasped in clamping the greater omentum.

In making a posterior gastro-enterostomy, there is danger of contraction of the opening in the mesocolon, unless the edges of this are sutured to the stomach.

There is always danger of angulation of the jejunum at its point of attachment to the stomach.

In all stomach operations it is well to have the patient placed in the sitting or semi-sitting posture, within a few hours after the operation, in order to prevent hypostatic pneumonia, and to facilitate drainage of the stomach by gravitation.

The greatest danger after operation comes from acute gastric dilatation, but this can be remedied readily by introducing the stomach tube. If gastric lavage is employed, it is, however, important not to introduce a sufficient amount of solution to do harm by pressure. Half a pint at a time is quite enough water to introduce. It is a rule with us to make use of gastric lavage, whenever any patient is distressed after an operation upon the stomach.

In three cases in which gastro-enterostomy had been performed for the relief of pyloric obstruction in my series of cases the progress was perfectly normal for 3, 5 and 8 days, when the patient suddenly began to suffer from dyspnea. This continued for 6 to 12 hours, when the patients died. In the first two, an autopsy was not permitted. In the third it demonstrated the fact that the patient had died as the result of acute gastric dilatation.

We had previously had a number of similar experiences less severe in character, in which the dyspnea had subsided at once upon the use of gastric lavage, but it had not occurred to us that the distress was really due to acute gastric dilatation.

One would think it almost impossible for this condition to escape recognition, but the presence of the dressing over the abdomen, and

the fact that the distress is referred to the chest, is almost certain to lead one astray, unless one's attention has been directed especially to the possibility of the occurrence of this condition. We have since observed this acute gastric dilatation to a greater or less degree in a number of cases, and have always been able to obtain prompt relief by the use of the stomach tube. Aside from the gas one always finds decomposing mucus and usually some old blood.

It is well to bear this possible condition constantly in mind in the after treatment of these cases.

Feeding.—These patients should be given one ounce of one of the various predigested foods in three ounces of normal salt solution as a nutritive enema every four hours.

After the third day some of these predigested foods may be diluted in water and given by mouth, but the rectal feeding should be continued.

Later, broths and thin gruels may be given, but milk should not be given until quite late, as it is rather more likely to decompose than these predigested foods.

The patients may be permitted to chew steak, and to swallow the juice within a week after the operation.

**RESECTION OF THE SPLENIC FLEXURE OF THE COLON,
MALIGNANT DISEASE, WITH EXHIBITION
OF PATIENT AND SPECIMEN.***

BY INGERSOLL OLMSTED, M.B., HAMILTON.

THIS patient, Mrs. X—, was seen with Dr. Arnott, of Hamilton, on the 6th of March, 1904. He informed me that she had been taken suddenly ill three days previously with cramps in her abdomen, sickness of the stomach and vomiting. She had not had any movement of the bowels for three days before her attack. Her abdomen became distended, and, in spite of purgatives and high enemas, there was no free evacuation. She had had some fever, and increased frequency of pulse. When I saw her, she was much better, the bowels had moved freely and she said she was nearly well.

Her history, obtained, is as follows: With the exception of one sister, who died of a tumor of the womb, her family history is excellent.

She has had nearly every disease of childhood. She married, had two children, but no miscarriages. During the last 18 years she has been troubled with asthma. The menopause occurred in her 46th year, and was unaccompanied by any particular unpleasantness. She has always worked hard, has been a hearty eater, but was never troubled with any disturbance of the digestive tract till two years ago.

The present illness began quite suddenly in January, 1902. She awoke one morning with crampy pains in the abdomen, nausea and vomiting. The pains were felt especially around the navel and left hypochondriac region. There was some abdominal distension and constipation of the bowels. The bowels acted after a large enema had been given, and fresh blood was seen in the stool.

During the last two years she has had frequent attacks like the one described, which lasted from one or two hours to two and three days. Relief came as soon as the bowels moved, and almost invariably some fresh blood was found in the stools.

Two of these attacks were quite severe, one in Oct., 1903, which lasted about ten days, and another in January, 1904, which lasted two weeks. It was very difficult to get the bowels moved at that time, and she had considerable fever.

Between the attacks she would have about two stools daily, but at no time did she have a large, well-formed motion. When one of her attacks appeared, and enemas were given, small, hard fecal masses about the size of marbles came away. During the attack in January, 1904, Dr. Arnott felt a lump, about the size of a walnut, in the left side of the abdomen, between the last rib

*Read at the Ontario Medical Association, Toronto, June, 1905.

and the ilium. After the attack this lump could not be felt. Her weight had diminished about 30 lbs. during the last two years, and she has been almost free from her asthma.

She is a medium sized woman, fairly well nourished. The lungs are slightly emphysematous, heart sounds normal, arteries somewhat thickened and urine negative.

The abdomen is not distended and no peristaltic waves are visible. The liver has normal dimensions. On palpation, a lump about the size of a small orange is felt in the left flank, just under the edge of the ribs. It possessed very little mobility.

A diagnosis of cancer of the colon was made, and operation advised.

She entered the City hospital and was operated on, on the 12th of March, 1904.

Under ether anesthesia a long oblique incision was made, following the course of the fibres of the external oblique muscle, just to the inner side of the tumor. On opening the abdomen this tumor was found to be in the upper part of the descending colon and attached to the inner part of the transverse colon, the splenic flexure being free. The great omentum was attached to, and covered the inner side of the growth. No glandular involvement could be felt.

The mass, including the distal end of the transverse, splenic flexure and upper end of descending colon, was freed from its attachments, clamped off with Kocher's intestinal clamps and removed. The two divided ends of the bowel were brought together and an end-to-end anastomosis was made by means of sutures over a large Robson bone bobbin. The coats of the proximal portion of the bowel were very much hypertrophied. Three rows of sutures of fine black silk were used in making the anastomosis, and the omentum was also stitched over the junction line. The abdomen was closed without drainage.

There was very little shock following the operation, and convalescence was without incident.

She returned to her home at the end of three weeks, and has gained in health and weight ever since.

Strange to say, her asthma has returned, and now it is the only thing she complains of.

On opening the bowel and cutting through the tumor, the growth is found to almost completely close the lumen of the intestine, only a small opening, which would scarcely allow the passage of the small finger being left through the centre of the growth. The upper surface of the growth is ulcerated, and lying free in the bowel above this is a plum stone. This had evidently acted like a ball valve. The patient says she remembers having swallowed a plum stone the previous fall.

The tumor proved to be a cylindrical celled epithelioma.

Selected Articles.

THE FAMOUS "LONDON" HOSPITAL.

BY LALLY BERNARD.

ON a cold, wet April day, it was not an alluring prospect which greeted us when we emerged from the underground station of the Metropolitan Railway at Whitechapel and caught our first glimpse of the immense facade of the great pile of buildings which cover nearly eight acres of ground, known as the "London Hospital," an enormous institution, where, since the day it was opened, the doors have never been closed for one hour, and where such a thing as a paying patient is unknown. We enter the wide-open gates, passed through an open court-yard, and under the immense porte-cochere, and found ourselves in the main hall of the building, where porters were engaged answering innumerable questions, and groups of young medical students stood chatting by the porter's offices. To the right a receiving room showed rows of benches arranged on the tessellated pavement, and a perfect army of men behind glass partitions was questioning applicants, who were either destined to find a place in the wards of the hospital or to pass on to the gigantic "out-patients' " hall to receive the advice or medicine which they sought. This was a lofty room, tiled to about sixteen feet above the level of the floor, lighted from the roof, warmed with hot water radiators, and admirably ventilated by means of air-ducts and fan. This beautiful hall cost £25,000, and it was built by money sent to Mr. Sydney Holland, the indefatigable chairman of the committee, by one who desired that his name should not be revealed. It was opened by the King and Queen in June, 1904, and when one considers that 13,000 patients pass through the hospital during the year, it is easy to imagine that this great clearing-house of sick and sorry men, women and children is of supreme importance in the working of that enormous institution. It is not so long ago that one heard harrowing tales of the experiences of the "out-patients," who sought relief at the great hospitals, of the hours of waiting, more often than enough in the open—mothers with ailing children, sometimes suffering from some contagious disease, and men who fainted from the strain of standing through those long hours of exhausting suspense, and it is comforting to know that the most wretched mortals from the east end of London find rest, light and warmth awaiting them before

the doctor's verdict is given. To the mind of the writer nothing spoke more forcibly of the excellent organization of the London hospital than the expeditious way in which this great mass of suffering humanity was sorted, according to individual needs. The secretary of the hospital, who took us over the building, said that the work of the receiving officers was one of supreme importance. They were qualified medical men, who are supposed to unite with their professional knowledge qualities which might be expected from a Sherlock Holmes and Bishop of London combined. In the out-patients' hall, sections were marked off by a signboard, bearing notices such as "New women patients," etc. The receiving officers have to use methods not necessarily conducted upon the usual lines common in charitable institutions. But were they to err in classing one genuine case of necessity as "fraud" the newspapers would instantly clamor for an investigation, while, on the other hand, were free medical advice given to a patient who might well be able to pay for it local practitioners would be up in arms. Off the great hall where the out-patients were gathered were offices for the different surgeons and doctors, six of the first named and eight of the latter, who attend daily to the wants of the thousand or fifteen hundred applicants. Those who were given a prescription by the doctor took their bottles to the dispensary, where they received a shilling's worth of medicine for a few halfpence. In the great cellars of the hospital is the machinery, which turns out pills and cough lozenges by the ton, and here are also the supplies for the dispensary and the enormous supplies which are necessary for the operating theatres and the surgical wards, etc. The requirements of the hospital necessitate 3,500,000 pills and tabloids per annum. During 1903 six tons of cotton wool, 130 miles of bandages and 90 miles of lint were used, while the total length of the material expended in surgical stitches and ligatures amounted to between 29 and 30 miles. So one can easily imagine that in the effort to reduce the expenditure per bed, wholesome supplies of every kind are necessary. During the past few years the hospital has been to all intents and purposes rebuilt, and the work is still in progress, while iron buildings for temporary use are at present full of beds. Two storeys have been built on to the main wings and a splendidly equipped suite of five operating theatres, with rooms for the administering of anaesthetics adjoining, and sterilizing chambers have been added, and the whole building has been coupled up with an internal telephone exchange; the staircases have been refashioned and two immense lifts built in addition to the three or four formerly in existence.

The hospital has room for 800 patients—on the morning of the day of our visit there were 740 patients in the wards—a staff of 700 men and women administer to the wants of these, the most wretched class to be found in London, for out of the 13,000 admitted in one year nearly two-thirds came from within a two-mile radius of the hospital. And this is the centre of "Darkest

London." Now, what of the men and women who minister to the needs of these suffering mortals? One might spend many days in that great hospital and never come in direct contact with the whole 700, but when one passes through wards without number, through operating theatres where the attendants are busily engaged in arranging for an operation just about to take place, or cleaning the theatre just after the operation has taken place, through the sterilizing rooms, the kitchens and the endless departments which constitute this great hospital, one cannot help receiving a general impression of the "human machinery" which keeps this great work moving, and this impression, I am bound to say, was a satisfactory one. The selection and supervision of people who are to hold in their hands what is really the power almost of life and death require a peculiar penetration and instinctive genius. The man who is at work in the sterilizing room, preparing the marine sponges which are soon to be put into a sealed flask containing a strong antiseptic, and will only be removed by the surgeon who breaks the seal; this man by carelessness or callousness may defeat the skilful surgery of the most famous doctors in Europe to-day. No matter what the sum spent on costly operating chambers, on the latest machinery, on all the thousand and one scientific apparatus, the fidelity and intelligence of the human species are required if good results are to be obtained.

"Ninety-eight per cent. of our surgical cases heal by first intention," is the statement of Mr. Morris, the secretary, and that means that these poor bread-winners whom fate takes into the hospital are discharged sound and well in nineteen days instead of two or three months, as in days gone by. It is very wonderful, for it means that seven hundred people, exclusive of the medical staff, are united in one common bond fighting against disease and death.

Second in interest to the writer were the kitchen arrangements, and for this reason we were taken almost directly from the receiving room and the out-patients' department in a giant elevator—one of several, large enough to carry a bed—to the top of the building, where the new kitchens are situated. Surely a triumph of sanitary ingenuity is this department, and an impossible theatre for wilful waste. Here are men in snowy-white overalls, busily engaged in cleansing the giant roasting ovens; tessellated floors again, shining tiles and light and air everywhere. Never an odor of greasy tins or stale food; electricity, steam and gas, all pressed into the service, to insure the maximum of results with the minimum of labor and expense. Everything spick and span, the kitchen might be converted into an operating theatre without danger to the patient, so perfect is the standard of "surgical cleanliness" observable. All the supplies for the larder and store rooms are brought to the chef from an outside lift, which has no connection with the other portion of the hospital. Everything is carved for the patients in this kitchen. Skilfully devised tin boxes, with

separate drawers lined with enamel, stand on hot water tables; each box bears the name of its particular ward, and the contents are arranged according to the diet chart sent up by each nurse for every individual patient, and carried out according to the doctor's orders in the first place. At meal times immense trucks are lined up on one side of the kitchen, in charge of the special ward porters; at a given signal they are wheeled into the elevators, and in three minutes are deposited in the ante-room off each ward, where hot plates are in readiness, and in less than five minutes each patient has his meal placed before him. Yet, strange to say, in spite of this almost military precision, there is nothing of "barrack-like" atmosphere in the wards. We were fortunate enough to be taken through the majority of the wards after visiting hours, when the patients who were well enough, were gathered about the great open, tiled fireplaces in the centre of the wards, which are bright with flowers and plants. The "Teale" slow combustion grates give out an immense heat, and no other form of heating is necessary.

"The item for scrubbing and cleaning this hospital alone is over six hundred pounds a year," the committee grumble. "But one cannot have it done for less," said one of the officials. "This includes the nightly cleaning of the receiving rooms and the out-patients' hall. It means that boiling water has to be provided; that electric light has to be kept going, and, as the hospital has never been closed day or night since it was opened, you can imagine what the task of cleaning means." Yes, one could imagine it. Soft soap, mops and cloths, the official mentioned with an absolute confidence in the prescription for old-fashioned cleanliness, but in the numberless operating theatres, tiled, tessellated, with no corners, but curves everywhere, there is a piece of hose attached to a brilliantly polished bit of brass piping, and when these rooms are cleansed the steam is turned on. Later an electric fan is put in motion, and the steam sucked out through an open duct, which is, I believe, protected from the outer air by a layer of cotton wool, which acts as a filter, and is frequently changed. One could listen for hours to the precautions taken to render everything that is used in the operating theatres antiseptic, so that wounds will heal by "first intention," and the fascination of such recitals lies in the precision with which the human mind must cover the ground of "all important trifles." There was the sterilizing room, with the enormous steam sterilizer at work, where trays of white enamel, which held the instruments used in the last of the thirty-eight operations performed that day, were boiling in seething tanks of water, and would continue to be boiled for an hour to come.

"Boiling water comes first, steam second, and only the articles which will not stand boiling are steamed," we were told. Up to the beautiful room, full of daylight, which came through open windows, as well as the brilliant Finsen burners, where a score of patients—mostly women—were being treated by the nurses

for the dreadful disease known as lupus, which eats away the human face and body. Here was the light presented by Queen Alexandra when Princess of Wales, and painted above the apparatus presented by her were her own words: "Nothing like perseverance." The nurses, who were seated treating their patients, all looked as if the work on which they were engaged had no suggestion of terror or fatigue for them. They chatted away with their patients, who during the course of treatment feel no discomfort. But the nurses are only allowed to spend three months at a time in this department, for all these "light" cures appear to exhaust the vitality of those who administer them. The reason of this has not as yet been ascertained, but it is the same with the men who manipulate the X-rays. The cures made by the Finsen light treatment are extraordinary. We were shown those terrible photographs of "before and after," the "after" in more than one case meaning the patient leaving the hospital with a new nose so skilfully adjusted that without spectacles one could not detect the artificial feature. One man had come all the way from the West Indies, and a single treatment had sufficed to cure the disease, which had been taken in an early stage. As a rule there are two women to every man patient admitted to this department. In one corner of the room a healthy-looking young girl was having a birth mark known as "port wine" stain gradually removed from her face, and the sister in charge told me that they had been most successful in removing moles and excrescences from the human face by means of the light. On into the room where the man in charge of the X-rays had just adjusted under the light a young lad, whose ankle was to be photographed, with a view to seeing if there was a fracture or severe sprain hidden by the fearfully swollen flesh and tissue.

Then a peep into the "high frequency" chamber, all in darkness save for the flashes of violet light, where a patient was being treated for some nervous disease. There was no time to see the Training School for Nurses, which is one of "the" features of the London, or the great laundry, where 25,000 "pieces" are tured out each week. We pass through the children's ward. Alas! many of these small mites were mentally as well as physically afflicted. Atoms of suffering humanity, attended by splendid healthy young women, and piteous sights, raised that so often suppressed note of interrogation in one's mind: "Why? Ah, why is it permitted?" Only a few days before the hospital had lost one of its most brilliant young house surgeons, who had bent over a wretched, deformed, imbecile "runt" of a child, brought to the hospital suffering from diphtheria. The child coughed in his face. In two days, in spite of all that could be done, the young doctor and the child both lay dead in the mortuary chapel.

One has a good chance to study the question of the alien population of the East End at the London Hospital. Here are two Hebrew wards, where the patients have a separate kitchen pro-

vided, and their food cooked by a Hebrew according to the rights of their religion. A separate set of dishes and utensils are kept for use during the feast of the Passover, and a tiny roll of parchment is fastened to the lintel of the door in the ward. Not many Hebrew women are to be found among the nurses; they are said to be too excitable and emotional as a general rule to stand the work.

Now for a visit to the famous bacteriologist, Dr. Bulloch, a pupil of Koch's. We found the young Scotch doctor in his sanctum, where he has a veritable miniature "zoo" of bottled microbes. One must, however, according to Dr. Bulloch's latest theory in regard to the tubercule bacilli, no longer talk of the deadly microbe. Their deadliness consists in the "refuse" which they produce. Since the day of Koch's famous discovery of the tubercule bacillus there has been a new discovery. The white corpucles which are supposed to consume the tubercule bacilli will not perform their particular function unless these microbes are coated with what is called "Opsonins," a word derived from the Greek term, which means "to make tasty." Opsonin is the matter found in the fluid of a healthy person, and if the bacilli gain access to the system of a person in good condition the white corpucles devour the palatable opsonin-enveloped bacilli, but where the weakling absorbs the tubercule bacillus there is not enough "sauce" to make it a palatable morsel for the white corpucle. So the present theory which Dr. Bulloch advances is the introduction of a lymph, which directly and almost instantly increases the accumulation of "opsonin" in the blood, and he believes that the open-air treatment is the necessary adjunct to perfect this "cure." We listened with great interest to Dr. Bulloch explaining how he had tested the blood of a girl suffering from lupus, and had found that her blood contained the necessary amount of opsonin, but that it was not circulating properly through the affected parts. Poulticing was tried, and by this means circulation of healthy blood re-established, and a marvellous cure was the result. All this was intensely interesting, and it was hard to tear ourselves away from the doctor's room, where we listened to the account of the wonderful effects of antitoxin in cases of diphtheria, and how it rendered people immune from the danger of catching the dread disease, when administered as a preventive of the mysterious germ which causes the dread "lockjaw" or tetanus, and the work of the bacteriologist in battling with it, but we had to go, for the shadows of evening were creeping into the greyness of the rainy day. Just as we approached the great entrance hall a police ambulance was wheeled up, and the shrunken figure of a man whose head was swathed in bandages was carried into a private receiving room, where accidents were set apart. We waited for the fraction of time which was necessary to let this sad little cortege pass. "What was it?" we asked the stalwart policeman preparing to take the ambulance back to its station. "Tried to cut 'is throat," was the laconic

answer. Would the great hospital insure more than the healing of the "open wound" for that poor shrunken body which encased an immortal soul and human heart? was the question which would obtrude itself as the train carried us through the darkness away from that institution which presents all that is best in human endeavor in this great grey world called London.—*Toronto Globe.*

SUNDOWN JOURNALISM.*

BY T. D. CROTHERS, M.D., HARTFORD, CONN.,

Editor Journal of Inebriety.

INSTITUTIONS organized to give medical lectures and instruction only in the evening are called "sundown colleges." The supposition is that a number of young men who are busily occupied during the day with other work are unable to take up medical studies until after sundown, or in the evening. It is claimed that limited means and urgent duties prevent them from studying medicine at any other time; hence this teaching is secondary, and is a form of by-product instruction, after the stress and strains of the day.

I have used this term to describe some of the peculiarities and eccentricities which appear in journals and journalistic work—the simplest explanation of which is sundown work, or work done when the brain and body are debilitated and below par from the strains and labors of the day. Scientific work in medical journals or elsewhere is rarely demanded under stress and strain, or should be consigned to sundown periods, when the brain is debilitated from other duties and is less clear and vigorous. Critical readers of medical journals are frequently surprised at the wide variation in the quality, style and tone of the work presented. The editorials differ widely and the point of view often changes, and the thought is sometimes harsh, discordant, or vague and confused. Credulity and scepticism alternate so rapidly as to confuse the reader. While the editor is known to be a man of excellent judgment and careful in his conclusions, the editorial work fails to confirm this estimate of his ability. The inference is that this is the work of other authors, and my plea last year before this Association to have all editorial matter signed, was to enable the reader to clear up this mystery. While journals, like individuals, have frailties, and editors have distinct personalities, the reader is distressed when these peculiarities change rapidly, and become confused and hysterical, and move on unusual zigzag lines. The real pleasure to the reader of a journal

*Read before the Medical Editors' Association at Atlantic City, June 6, 1904.

is to know and respect the author's consistency, good judgment and uniform impressions of the changing conceptions of science. When he fails in this, evidently some clouds have come into the horizon and broken up the usual order of events—one explanation of which would be sundown journalism—work done under unfavorable conditions, forced work, in which tobacco, coffee, tea, whiskey, morphine are appealed to for help. Editorial comments on matters of which we know the author's familiarity, which fall so far below the usual levels of good sense and clearness of expression, must be attributed to this source.

During the past year, many of the contributed articles on consumption have brought out distinct ear-marks and foot-prints of sundown thinking and working. Evidently some of these papers were written by persons suffering from this disease, with its peculiar delusions, and mental twists, largely influenced by the time of writing and the form of drugs used. Other papers on appendicitis have a markedly sundown movement, with a confused exhaustive tone. Such writers are working at night, suffering from fatigue, strain and exhaustion, following the operations and other work which they have performed.

Most of the great weeklies, and some of the monthly journals, contain many marked examples of sundown contributions, noted in the jarry, exclamatory style from the effects of alcohol, or the softer notes and the assertive confidence in which conclusions are stated under the influence of morphine. The cocaine influence in these contributions is more pronounced than that of any other drug, particularly in the endless repetitions and explanations involved, and movement in a dreamy, hazy mass of words.

The query is often made why all this mass of journalistic work coming from the press every week and month should be so ephemeral and valueless. The evident explanation of some of it is sundown writing, stimulated by drugs, and efforts to work the body and brain at a time when rest is required.

The same errors appear in books. Often a clear, vigorous medical teacher, whose work in the class-room is stimulating, will write a book that utterly fails to sustain his reputation. The impression in the class-room as a teacher is broken up by the halting, obscure, non-stimulating, expressionless work in the volume. Reviewers are disappointed in the text-books of eminent practitioners and teachers, that fail to present the best thought and conclusions, and practically are nothing but involved literary patch-work, lacking in form, shape and vigor. The critic is conscious that the author has given only a weak production of what he could have done; hence his praise is formal and mechanical. One of the popular text-books on the market is notoriously a midnight work, stimulated by opium and cocaine; another text-book

with a large sale has drug writing and drug work on every page, and the so-called brilliant passages are followed by vague statements so marked that the exact drug used can almost be pointed out.

Frequently some eminent physician in active practice will deliver an address as president or orator for some occasion, and the expectations of his friends will be greatly disappointed. The vigorous, clear-headed man when seen in print appears as a vague, sophomoric thinker, confused in range of thought, jarring in style and seldom rising to the time and occasion. Often the effort to be strictly scientific appears most prominent by following other authors and restating their conclusions from different points of view, dove-tailed with his own opinions, and all covered with an air of mystery and technical words.

Lectures, essays and pamphlets which conclude with enormous bibliography, convey the impression and expectancy of an exhaustive effort; yet, when critically examined, the sundown flavor and general feebleness of work is apparent. German literature is very often marred by these posing effects of bibliography following commonplace writing on well-known subjects, mixed up with excessive technicalities and sentences so involved that the author's meaning is never clear.

Editors are always troubled with contributions from influential, active medical men, whose writings are mere by-products and feeble sundown efforts. Their standing in the community and reputation often makes it difficult to refuse such work, and yet the editor knows that it is mere stuff and fustian, and often without the merit of style and culture. The only objection that can be offered is that the columns are crowded and his stock of supplies exceeds the demand for a long time to come, and this is literally true of this class of work. I have come in contact with many medical men, noted as voluminous writers, who are, or have been, disabled from the use of spirits and drugs. They usually suffer from insomnia, and take to writing midnight articles that reflect accurately their exact mental condition. Some of these writers, after varied experience as journal contributors, become book authors. It is needless to add that the paranoic brain, influenced by beer, alcohol and drugs, appears more or less prominently in all their work. Foreign medical literature, both in journals and books, often exhibits the same marked traits, the same banquet twist, the same wine and beer coloring, and the same midnight work often unmistakably. While the range of thought is less versatile and vigorous, it always excels in stupid conservatism and technical minutiae.

To all careful observers, the examples of this kind of work apparent in general literature will be surprising. Magazines and

articles and books present many illustrations of midnight work done under the influence of alcohol, morphine and cocaine. A book having a large sale, and admired by many persons, was written by one using cocaine. The plots, the mystical style and the range of thought and other indications are conclusive. It is surprising to note how exactly the writer, both in scientific and general literature, unconsciously and exactly describes his mental health and condition in his writings.

As editors and writers, we may not always be able to make wise discriminations of the contributions offered, or determine the real value of scientific writing, but personally we can avoid sundown work and midnight thinking, and thus cultivate sharper eyes and clearer brains in detecting the movement and direction of scientific progress. An article recently published by a very clever critic and medical man claims that much of the literature of to-day can be aptly characterized as the direct products of coffee, beer, wine, spirits and compounds of opium and cocaine. There can be no doubt this is true to some extent. We all realize that no one can think or write clearly on any subject with a weary brain, or one forced into service by drugs. It is difficult to understand how a medical man can expect, after the labors and duties of the day, to retire to his office at night and do any good, scientific, literary work. Medicine and literature in any form or direction to be successful requires the clearest thought and the best energies under the most favorable circumstances.

Journals, editors and authors can never bring out forced sundown products and become successful workers. Journals die of neglect and dementia, simply because they are the products of fatigue and forced, unnatural efforts. Editors become marasmic and disappear, because their best energies and efforts have been diverted in other directions, and their literary work is only by-products. Authors pose for a little time and then are forgotten, because they had no message and no thought to communicate. What they said was thought after sundown in an atmosphere of tobacco, coffee, spirits and drugs. In all this there was mental and physical starvation, acute mental poverty, with consequent confusion of thought and purpose. I repeat what I have said before—that these obvious conditions explain much of the failures in journalism and literary and scientific efforts by medical men. The surgeon, the neurologist and the active practitioner in any department of medicine can never write lectures, learned essays, or clear editorials after sundown. Such work must be done in the morning, under the very best conditions and favorable circumstances for clear thinking and exact writing. Dictating to a stenographer after dark, when the duties of the day are ended, carries with it a distinct impression which critical readers do

not fail to discover. Sundown books, sundown authors and sundown journals ought to disappear, and will do so in the near future. When journals appear to meet a real demand, and editors understand the conscious and unconscious claims of scientific medicine, and authors feel that they have a real message and group of facts to communicate, then the mediocrity of medical and particular journalistic literature will pass away.

MECHANICAL RESTRAINT AND SECLUSION OF THE INSANE.

DR. CHARLES W. PAGE, Superintendent of the Danvers Hospital of Massachusetts, U.S.A., read an article on this subject at the Conference of the State Board of Insanity in Boston, at their meeting in May last. The article is published in full in the *Boston Medical and Surgical Journal* of Dec. 1st, 1904, and reviews the whole subject from the time when Pinel did away with restraint in the Bicetre, at the time of the French Revolution, to the present day.

He explains the work done by Wm. Tuke, at York Retreat, and Dr. John Conolly, at Hanwell, in this respect, and quotes the following from this last writer: "After five years' experience, I have no hesitation in recording my opinion that with a well-constituted governing body, animated by philanthropy, directed by intelligence, and acting by means of proper officers, there is no asylum in the world, in which all mechanical restraint may not be abolished, not only with safety, but with incalculable advantage."

We here quote Dr. Page in part:

"At Danvers mechanical restraint was abolished about four years earlier in the women's than in the men's wards, not because women patients are less difficult to manage, but for the reasons that an arbitrary position on this question was not assumed by the superintendent at first, and because the assistant physicians and supervisors in the women's department were especially responsive to suggestions in this direction. Eventually, when non-restraint had permeated the whole hospital, and when the chief assistant, who had been gradually convinced of the feasibility of non-restraint against his pre-conceived but honest convictions, remarked in answer to some statement of fact, which was made one day, 'Oh, it's a comparatively easy matter to avoid mechanical restraint now because we don't have the cases that require it as we formerly did,' then and there, the superintendent took occasion to point out that he had discovered exactly what every man

brought into intimate association with non-restraint had discovered, namely, that non-restraint once established in an institution, conditions which formerly suggested its use rarely if ever occur; that, as institution after institution had been placed on the non-restraint basis, there had been a continuous, successive rediscovery of the same altered internal conditions, from the days of Conolly to the present time, a period of some fifty years. Such being the fact, it must be admitted that this less fractious, less turbulent condition of the insane in the wards of the hospitals was always the outcome of non-restraint and never the forerunner.

"This discloses the real solution of the controversy. Where restraint is permitted, the general spirit of the management breathes coercion, antagonism, enforced submission. When non-restraint is the undeviating rule, tact, persuasion and sympathy soften and mellow every act towards the inmates. The employment of mechanical restraint gives the attendants a wrong sense of their personal power over patients, such a physical advantage that they instinctively incline to self-assertion; to issue peremptory commands; to use ill-considered, irritating speech; to give curt answers; to make threats; in short, to attempt to intimidate all but the most quiet patients. 'Do this, or so, or you will be sent back to the wards, you will be secluded, or you will be put in a strait-jacket,' is the natural style of speech adopted by attendants when threats and penalties are at their command. Having thus threatened a penalty, the average uninstructed attendant concludes that proper hospital discipline demands its infliction unless the excited, frightened patient meekly capitulates, a result one could hardly expect with a sane person, much less with a deranged, apprehensive lunatic. Even well-meaning attendants naturally fall into such errors unless carefully drilled and faithfully watched. Fresh recruits are constantly entering the nursing service, and only by individual work with them can the highest ideals of a qualified nurse be instilled into their minds.

.....

"Perhaps I speak with assurance, but I worked out this problem at Danvers, where mechanical restraint was abolished deliberately. As has been stated, its use was discontinued in the female wards four or five years before it was wholly given up in the male department.

.....

"The beneficial effects thus ensuing, when considered in the aggregate, are of such magnitude, I am resolved that the non-restraint rule shall not be broken except as a last resort, as a

life-saving measure. Since that time, I have been responsible for the custody and treatment of more than six thousand insane persons, not one of whom was restrained with mechanical appliances by my orders or without my knowledge.

“ The argument against mechanical restraint applies in large measure to seclusion of the insane. While seclusion is, in some degree, less demoralizing in its effects or its influence upon the nursing staff of an institution, only in rare and exceptional cases can its employment be remedial or beneficial. If, as Conolly said, ‘ Restraint is Neglect,’ it is doubly true that seclusion is neglect. If used, it should never be prolonged. As a rule, thirty minutes’ seclusion is worth, as a corrective measure, more than twenty-four hours of the same treatment. Next to execution, solitary confinement is the severest doom that legal tribunals can pronounce upon hardened criminals. Solitary confinement is universally considered to be painfully trying to a sane mind. How can it be improving to a deranged man, shut away from associations with human beings, incapable of comprehending the logic of his position, consumed by delusions or burning with revengeful indignation towards the authors of his imaginary wrongs ?

“ Can all the insane be managed without restraint or seclusion ? Conolly always said, ‘ Yes,’ to that question. When, after consulting with him, superintendents of other institutions remarked that they would return home and try non-restraint in their asylums, he would coolly reply, ‘ You will succeed if you are in earnest.’ Some Continental hospital officials were well-nigh exasperated by Conolly’s calm, significant, qualified prediction, ‘ You will succeed if you are in earnest.’ He had been in earnest. In order to attain his ends at Hanwell, he had devoted a surprising amount of personal attention to each trying, difficult patient, visiting such both by day and night, watching the conduct of attendants towards such cases with unceasing vigilance.”

Dr. Page measures the capacity of a nurse, or a superintendent as Conolly did. If a superintendent or a nurse on a fair, earnest trial finds that he or she is not able to manage the insane patient without resort to mechanical restraint, it demonstrates beyond doubt or cavil the incompetency of each, and such a nurse should be at once dismissed and a superintendent should recognize his incompetency. The governing board should put a man in his place who could do so and he seek a field where he could fill the duties of his place.

It will be remembered that Dr. Henry Maudsley married the daughter of Dr. Conolly and came under the influence of this splendid man as to the management of the insane, which will

explain why he has been such a staunch adherent of the doctrine and gospel of love in the management of the insane which was at the bottom and was the corner stone of Wm. Tuke and John Conolly's success in turning the current in English asylums at the end of the eighteenth and of the nineteenth century into the courses Dr. Page defines and illuminates.

Dr. Page continues:

"I formerly permitted the use of restraining apparatus upon patients, endeavoring to limit its use to rare and exceptional cases. While working under this policy, I not only found it difficult to decide upon cases, and to convince the nurses that restraint was seldom necessary, but every exception in favor of mechanical restraint seemed to weaken the courage and resolution of the nurses, as well as to diminish my influence and control over them. Then, too, as long as nurses understood that straps and jackets could be employed as final measures, they not only relinquished mild efforts too quickly, but were inclined to assume a dictatorial, aggressive manner towards patients upon slight occasions; and this spirit of coercion as evinced by the nurse in his or her attitude towards the patient was, according to my observation, the starting point of the trouble with refractory patients in the great majority of cases.

"Now that mechanical restraint is discarded, the nurses understand that they will be regarded as incompetent unless they can manage the patients in their charge without resort to violent measures, seclusion and restraint. Intelligent nurses do not complain of such restrictions. They appear ambitious to demonstrate that a trained nurse can manage the insane without the fetters and instruments which are relied upon in such cases by the unprofessional keeper. Certainly, the non-restraint rule has advanced a kindly, humane spirit in our wards as no other measures could have done. Nurses have no temptation nor power to control patients by threats of punishment. Under such conditions, whatever native tact, art and persuasive powers the nurse may possess are rapidly developed; and, as a result, more sympathetic, friendly relations are early established between nurse and patient, and the common annoyances and irritations formerly experienced by both parties are largely avoided."

He concludes as follows:

"Nurses who possess self-poise, capacity for tact, and power to rapidly conceive expedients will naturally succeed. I have seen slender, light-weight girls manage the hardest wards quite as well as those of large stature. As an aid towards the development of such nurses at Danvers, each ward is supplied with special report slips to be used according to directions printed on each slip, viz.: 'When a patient escapes; attempts to escape;

receives an injury, accidentally or otherwise; has to be handled with force, or is secluded; the attendant engaged in the affair, or the one in charge of the patient at the time, must send a written report to the medical officer in charge of the ward in which the patient belongs, who will countersign the same and forward it to the office of the superintendent.' At a convenient time, the patients thus reported are visited by the superintendent with the slip in hand, when such personal investigation and instructions as may seem necessary can be given.

"Being in earnest is the solution of the non-restraint question. The ruling authority over and above the nursing staff must be in earnest; and this signifies clear insight as to the evil and its remedy; certainly as to what can be done with the iron by virtue of patience, sympathy and tact; with determination, watchfulness, faith and enthusiasm."

SURGICAL CORRECTION OF HAIR LIP AND CLEFT PALATE.

THE *Journal of the American Medical Association*, March 18th, 1905, contains an article by G. V. I. Brown, A.B., L.D.S., M.D., C.M., entitled "A System for the Surgical Correction of Hair Lip and Cleft Palate," in which the author describes a method of treatment, accompanied by illustrations and the histories of a large number of successfully treated cases. In his conclusions he says:

"It is too often taken for granted that more or less sloughing and pus formation must follow extensive mouth operations, and that surgical asepsis is impossible. In a sense, this must be admitted to be true, owing to natural anatomic obstacles to complete sterilization and the constant exposure to infection from so many sources, but notwithstanding all this, most gratifying results can be secured, and so nearly a true primary union obtained as to make its essential benefit the same even with extensive wound surfaces. With the periosteum stripped from the palate surfaces; incisions reducing circulation to the farthest safe limit; nasal secretions above in contact with raw surfaces; mouth secretions below, mixed, as often occurs, with gastric regurgitations, and vomited matter; only a comparatively thin veil of tissue bridging the space of the palatal separation of the bones, and at the velum, exposed to destructive influences at every movement of the tongue, or act of swallowing, it goes without saying that only the most rigid adherence to antiseptic surgical care could be effective.

“ Strong solutions of poisonous, or tissue destructive, germicidal agents are necessarily precluded in the mouth. Dilution in the oral fluids renders otherwise effective solutions of practically no benefit. The histologic character of the nasal, oral and pharyngeal mucous membrane surfaces renders sterilization extremely difficult, and it has been conclusively proven, that animal fats, dead mucous cells and other surface coatings resist even powerful drugs to such an extent as to protect underlying bacteria, while germs on the immediate surface are destroyed. Mechanical cleansing, therefore, is a first necessity, and next to this, frequent use of non-toxic, or mild solutions of otherwise injurious germicidal agents. Preparatory preparation of the field of operation consists in scrubbing membranous, dental and other surfaces, removal or antiseptic care of teeth or roots, and at least temporary stopping of carious tooth cavities. My post-operative sheet anchor is dioxogen,* which gives mechanical cleansing, in setting free the dead mucous cells and destroying the resistant nature of the intervening secretions, while at the same time it gives an immediate and powerful effect on bacteria in destroying their vital properties.”

A NEW ANESTHETIC.

To go to sleep quietly before a surgical operation, to slumber peacefully after it, and to waken up as if from natural sleep with no recollection of what has happened, and with health and appetite unimpaired—all this seems an unrealizable ideal in anesthesia; yet we are assured that French physicians have found a new anesthetic that accomplishes all these results. Up to this time it can not be said that any substance in use has quite realized the surgeon's ideal. Chloroform and ether are the most common, but with chloroform there are occasional accidents which do not appear altogether preventable, even with the recent devices that enable the physician to administer it mingled with air in any desired proportion. As to ether, its well-known after-effects are most disagreeable. Some recent attempts to utilize the anesthetic qualities of other chemical substances, culminating in the discovery just mentioned, are described in *Cosmos* (Paris, May 27) by a contributor. He says:

“ Other liquids, such as the bromid and chlorid of ethyl, or their mixture in certain proportions, produce rapid anesthesia with

* I use Dioxogen because in my experience it has proved the most uniformly free from acid of any of the preparations of H₂O₂, commonly sold as such, and because an imbure or a strongly acid solution must necessarily be absolutely prohibited when hourly treatments of the mouths of patients, many of whom are infants, is prescribed.

a minimum of danger, but their effect is fleeting, lasting scarcely one or two minutes, and it can generally be utilized only for very short operations—the opening of abscesses, the extraction of teeth, the removal of adenoid growths.

“Cocain and its recent substitute, stovain, produce local anesthesia that is very useful for small operations in a limited region. By injection of either of these substances into the spinal marrow we may produce insensibility of the whole lower part of the body, which with a sufficient dose may be extended over the whole body. But in spite of the progress of antiseptic manipulation . . . some cases of death and others of paralysis have followed the use of this method.”

The writer reminds us that the awakening from the effects of all these anesthetics is more or less disagreeable. The Parisian hospitals, however, are experimenting with a substance that is said not to possess this inconvenience. This agent, which is named “scopolamin,” is an alkaloid extracted from a plant (*Scopolia japonica*) of the nightshade family (*Solanaceae*), sometimes known as “Japanese belladonna.” This has been familiar to physicians for many years as a sedative and it has even been used as an anesthetic since 1900, but the most successful methods date only from December last. The substance is now used mixed with morphine, and three hypodermic injections are required, each of which throws the patient into a deeper sleep until he is quite insensible. A peculiarity is that the muscles do not become flaccid, and that the patient may be awakened as from normal sleep. Says the writer:

“It is very important to note that no matter how deep the sleep may be, if the patient be shaken or spoken to loudly and insistently, or if a noise is made near him, he will awake precisely like a man in a natural sleep. But if he is pricked or pinched he shows not the slightest sensitiveness. This complete anesthesia, with persistence of the intellectual functions, is particularly striking with scopolamin, which seems to act exclusively on the sensitive fibres.

“After the operation, the patient is placed in his bed, where he continues to sleep as calmly as before it; the breathing is very quiet, and not the least complaint is heard, though sometimes there is a good deal of perspiration.

“The duration of the sleep varies slightly with different subjects: it averages four or five hours after the operation (or nine to ten hours in all).

“The awakening takes place exactly as in ordinary sleep. The patient opens his eyes, and his face expresses astonishment at finding himself in bed. He tries to get his ideas together . . . and asks questions of those about him, wanting to know whether the

operation has yet taken place; generally he calls for a drink and then goes to sleep again for several hours. Sometimes he stays awake and wants something to eat. Several have refused to believe that they have been operated upon.

"On the morrow, the patient eats in his customary manner and follows with appetite the regimen demanded by the operation that he has undergone.

"Finally, and this is an important point—none of those operated upon remember anything of the operation or of its pain, even when they have appeared sensitive during its progress; and this fact is the most striking because some patients have appeared to be completely awake through the operation, speaking and complaining as if they had received no anesthetic.

"Some surgeons, after the first injections of scopolamin, administer chloroform. The effects are nearly the same, and in this case the scopolamin has the advantage of saving the patient from apprehension of the operation and of the chloroform . . . ; but this addition is unnecessary, and scopolamin alone appears to furnish a prolonged anesthesia without the inconveniences of chloroform."—Translation made for *The Literary Digest*.



Medico-Legal



TRAUMATIC HYSTERIA.

A MOST interesting case has just been concluded in the High Court of Justice, before Judge Chute, at the Spring Assizes—namely, *Lewis v. Toronto Street Railway*. The plaintiff, who was a healthy young negro girl, aged 23, had attained some success as an artist, and is well educated, sued for \$25,000 damages for injuries received while traveling as a passenger on the railway worked by the defendants.

The accident happened on June 6th, 1904. Miss Lewis was in an open electric car, about the fourth seat from the front; the car was at the time traveling at a fair rate of speed when a phenomenon occurred described as an explosion, accompanied by flames and sparks, which arose about her and flew up into her face. Overcome either by fright or shock, she fell or jumped off the car, and was picked up shortly after by a policeman, to whom she was able to speak intelligibly. After being taken home she became unconscious, and remained in that condition for four or five days, when she recovered consciousness, but was found to be paralyzed, suffering very severe pain in the head and back, with marked photophobia, the eyelids being kept tightly closed. The left side was anesthetic and completely paralysed, the right partly so. Her mother, who attended her, stated that her hair and lips were burned and that she was bruised severely on the left side, but there was no evidence to support this statement. She remained in this condition for ten months, the only change of importance being a slight reduction in the amount of the paralysis, and some change in its exact location, and the occurrence of at least two severe convulsive seizures within two months of the accident.

Mr. I. H. Cameron was appointed to examine the patient for the court, and several medical experts were called, including Drs. Meyers, Powell, Caven, Reeve, Wishart, and Cassidy, who was the attending physician throughout the greater part of the illness. There was practically no disagreement among the experts as to the nature of the trouble, which was diagnosed as traumatic hysteria, though there was some difference as to the probability of ultimate recovery, the probable time that would still elapse before recovery, and the possibility of recurrence. No evidence was adduced to prove the existence at any time of any injury having an anatomical

basis, but the court admitted the construction of the word "injury" to include not only shock, but fright. The experts for the defence when pressed to set a time for probable recovery, claimed that it should not exceed one year from the cessation of litigation, as the authorities were agreed that the existence of legal proceedings had a tendency to prolong the condition.

The cause of the phenomenon was shown by electrical experts to have been in all probability the formation of an arc or circuit by the approach of a wire to the wheel caused by the jolting of the car, and the argument of negligence was based upon the condition of the apparatus that would allow such an occurrence.

The judge called attention to the rule that damages were not recoverable for merely mental injuries, but held that there was no contributory negligence on the part of the plaintiff, even if she had jumped off from fright. The verdict of the jury was for \$10,000.

The case is extremely interesting, as it is the first in which the condition for which damages are claimed was admitted to be a pure hysteria, and in which no physical injury was proven as the exciting cause apart from fright and shock; while, from a medical point of view, the history of the case and its ultimate result will be of value as affording a test of the probable duration of other similar cases.—*B. M. J.*, June 17, 1905. W. A. Y.

School Hygiene.

EPIDEMIC SYNCOPE.

CLOWNE, a small coal mining town in Derbyshire, was unknown to fame (medically speaking) until May 17th of this year. It is true that the teachers of the elementary school report that they had noticed "something objectionable" about the air of the girls' class-room since last summer holidays, and that solitary cases of fainting have occurred. But in the week following May 17th, 46 cases of fainting occurred in this class-room. An escape of gas was noticed in the lobby, and this matter was at once set right, but the cases of syncope occurred quite as frequently afterwards. Accompanying symptoms were chills and rigidity, and the patients were, afterwards, in a weak condition, and were assisted or carried home. The fainting fit lasted from 15 to 30 minutes. The school was twice closed for a short period, but, on classes being resumed, fainting again occurred among the girls. The infants in an adjoining class-room were not affected. The county council authorities were notified, and Dr. Barwise, the county medical officer, went to Clowne and made a careful investigation. The floor was taken up and the gas pipes examined, the drains were examined, and tests were made for carbon di-oxide and carbon non-oxide but all with negative results. Dr. Barwise ordered that the chimneys should be swept and fires lighted and, on discovering that all the open fire-places in the school had been carefully stopped up, he ordered that these should at once be opened again, and, further, that a class of boys should be placed in the offending class-room. This was done, and the boys have, at last reports, retained consciousness.

Dr. Barwise thinks it certain that the attacks are due either to (1) poisoning by carbon non-oxide, or (2) a nervous origin. It should be added that the "oldest inhabitants" do not agree with the doctor. They have another theory, based on practical experience in mining accidents. It is known that a "fault" runs through Clowne, and that the "fault" passes under the school. The recent earthquake was distinctly felt in Clowne and, therefore, the old miners think that the girls were, perhaps, poisoned by "after-damp" set free by the disturbance consequent on the earthquake.

If this is correct, it may explain the immunity of the boys, inasmuch as the supply of "after-damp" is probably exhausted.

Physical Education.—It is proposed to form in Great Britain a National League for Physical Education, and the movement in this direction, which was inaugurated on July 20th, 1903, at a dinner given at the Athenaeum Club, for the purpose of discussing the question, has been already so generally approved of by institutions and societies, and by men and women distinguished in science, education, law, medicine, and public affairs, as well as members of both houses of Parliament, athletes and others, that there can be no doubt of its success, and indeed of its necessity. Lieutenant-Colonel Wellor, of the Twentieth Century League, 28 Victoria Street, London, S.W., is the secretary *pro-tem*. Among those who are to speak at a preliminary meeting to be held at the Mansion House are, the Lord Chief Justice of England, the Bishop of Ripon, Sir William Broadbent, Sir James Crichton Browne, Mrs. Bramwell Booth, Alderman and Sheriff Strong, and Mr. J. Crompton Rickett, M.P. The League owes much to the enthusiasm and self-denying labors of Sir Lauder Brunton, who does the most of the work, but, like "Bobs," "does not advertise."

"Temperance" Text-Books.—When next we have a book of lessons on "Intemperance" considered in Ontario, prithee let us have a teacher and a doctor collaborate. Teachers, as a rule, are very temperate, and so are a good many doctors. The things that are taught to young children sometimes under the name of "Temperance," would almost make the angels weep.

Children Gain Weight Periodically.—Some curious experiments have been made at one of the royal philanthropic institutions in Copenhagen. For some years back the 70 boys and girls in the place have been carefully weighed every day in groups of 15 and under. Thereby it is proved that the children gain weight mostly in autumn and in the early part of December. From that time to the end of April there is scarcely any increase in weight. More remarkable still, there is a diminution till the end of summer.

Diseases Dangerous to the Public Health.—The Michigan State Board of Health in compliance with Act 60,146, Laws of 1895, sends to each school superintendent and teacher in Michigan every little while, bulletins prepared for use in schools, giving special lessons on health subjects. The above is the title of one of these bulletins, of which the 15th edition (243,000) has recently been issued. This is a good plan. These bulletins constitute the text-book on the subject, and the teacher is required to use them. But they are at once sensible and interesting, and we think the teachers, probably, are only too glad to use them.

Free Feeding.—Now that all England has decided that starving school-children must somehow be fed, Miss Marion Elliston makes a good suggestion to prevent pauperisation. This is briefly as follows: She proposes to attach a "school restaurant" to each of the two hundred school kitchens already established by the London County Council, for the instruction of school children in cookery for working-people. In these school restaurants the children could obtain a breakfast for 1-2d. or 1d., and a dinner for 1d. or 2d. To the head-teacher tickets could be given for the use of those children who needed such assistance, to be used at his or her discretion.

Hygiene and Physiology in Schools.—One of the practical questions recently discussed in England in regard to School Hygiene has been the dearth of teachers properly trained in school Hygiene (a very broad and deep subject nowadays). Dr. Heron, in an article on this subject, suggests that physicians should visit the school regularly to give this instruction, and that the teacher should not be expected to give it, as it needs special professional knowledge and training. He would offer this post first to the school physician, then to the local health officer, and failing these, to a physician in active practice. There is much to be said on both sides of this question. The teacher is over-worked and under-paid, and, moreover, does not as yet, either in the Normal Schools of Ontario or anywhere else, receive the necessary training. But after all, in many ways, the teacher is the best one to do this work. We are glad to see that the Ontario Medical Association, the Ontario Educational Association, and the Provincial Board of Health are studying out this problem. The community looks to them for advice.

H. MACM.

The Canadian Journal of Medicine and Surgery

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Advertisements to insure insertion in the issue of any month, should be sent not later than the tenth of the preceding month. London, Eng. Representative, W. Hamilton Mill, 8 Boulevard Street, E. C. Agents for Germany Saarbach's News Exchange, Mainz, Germany.

VOL. XVIII.

TORONTO, AUGUST, 1905.

NO. 2.

Editorials.

RACE SUICIDE IN ONTARIO.

SOOTHING criticisms about race suicide have been heard at church synods for some years back, and condemnatory observations about a falling birth-rate have appeared in successive reports of the Registrar-General of Ontario. These criticisms and regrets are well-meant; but the people do not take them seriously to heart. So little attention is paid to them that, if tested by their results,

one might say that a good many of the married people of Ontario "have ears and hear not." It seems quite useless for moralists, statisticians and publicists to politely suggest to the married woman of Ontario to-day, that she ought to imitate her mother or grandmother in raising a fine family of ten or twelve children. Moralists, statisticians and publicists of sixty years ago had little to do with the social and economic conditions which held a married woman down to the laws of her reproductive nature, causing her to bring forth as many children as she was able to bear. The general opinion of her own sex at that time favored such additions to the birth-rate. Large families were common in Ontario; families of one or two, after a married life of ten years and over, were exceptional. Sixty years ago, dwellings, even in towns and cities, were small; housekeeping simple and rude; the men and women possibly of sterner stuff than their successors of the present generation. Domestic help, abundant and good of its kind, could be got at low rates; monthly nursing was obtainable at easy terms. To-day, domestic service and obstetric nursing cannot be got at low rates, while the rate of wages earned by tradesmen, clerks, etc., though higher than it used to be, does not bear the proper ratio to the wages demanded by domestic servants and monthly nurses.

No sensible man objects because women have won the right to practice medicine, law, architecture, or any other profession; but he objects when domestic servants and nurses ask for wages so high as to make them prohibitory, unless to the wealthy. Besides, domestic service is costly, because it is no longer abundant. In cities, the mass of working girls—shop girls, factory girls, etc.—look with disdain at a girl who works in a kitchen, even though she should dress well when out-of-doors, and though she can earn better wages than they do themselves. Out of democratic conceit, or because some of their sex have entered professional life, girls find something degrading in domestic service, and they shun it. This is the case, even when the family is of exiguous proportions; but should the reply to her first question, "How many in the family?" be "Eight or ten," Jane abruptly closes the interview. Then, again, many landlords refuse to let their vacant houses to people blessed with large families. But, in this city at any rate, no matter whether the family be large or small,

rents, particularly the rents of small house property, have more than doubled in the last ten years. Thus a seven-roomed house, that used to rent at \$12 a month, is now rented at \$25, and, if vacated, could be let for \$30. There are other reasons why children are unwelcome—poverty, inability to clothe and nourish them properly, love of amusements, etc.—but the list is long enough. Any presumably sane woman, the wife of a tradesman, clerk, or struggling shopkeeper, who adds to the difficulties of her lot in life, by increasing the population, is regarded by her female friends as silly, a fit subject for pitying regards.

It need not be wondered at, therefore, that married women—good women, too—practice what their better natures revolt at, and that they sometimes take risks to health and life, of the most desperate kind, rather than bear children. Husbands, no doubt, have something to answer for in the adjustment of the reproductive question; but, in most instances, they are swayed by the opinions of their wives, who, in the last analysis, respond to the unwritten social and economic ideas of their own sex. Moralists may deplore, statisticians may regret, and publicists fuss over the race suicide observed in this part of Canada; but the married women, the strictest of logicians in matters pertaining to the family, have settled the birth-rate of Ontario and it is going to be small.

J. J. C.

STOVAINE, A NEW LOCAL ANESTHETIC.

THE hydrochloride of a benzoyl derivative, called hydrochloride of *dimethylaminobenzoylpentanol*, or more simply, using Ladenburg's nomenclature, the hydrochloride of amylenes $\alpha\beta$, is known in commerce as "Stovaine" and enters the therapeutic field under the same name. It was first extracted from the group of amino-alcohols by a French chemist, M. Fourneau. It was presented to the Academy of Medicine, Paris, by M. Billon, March 15, 1904, and subsequently, May 15, 1904, to the Academy of Science by MM. Launoy and Billon. When studying the new drug, M. Billon made a test of its toxicity, as compared with that of cocaine. Using a one per cent. solution of stovaine, he gave five intravenous injections of it to a rabbit, which weighed two kilo-

grams, 450 grams, the entire amount injected representing 25 cubic centimetres of the solution. The rabbit exhibited some symptoms of nervous shock, and had a slight tetanic convulsion. On the other hand, injections of 8 to 10 cubic centimetres of a one per cent. solution of cocaine killed a rabbit of the same weight.

Since that time, laboratory studies and chemical experiments have been sufficiently multiplied to enable students to form accurate opinions of the action of the new anesthetic.

Stovaine crystallizes in brilliant scales, which bear a strong likeness to hydrochloride of cocaine. It melts at 175 deg. C. It is very soluble in water. Like other alkaloids, it is precipitated from watery solutions by a solution of mercuric chloride and the solution of potassium-mercuric iodide. It is precipitated by weak alkalies. It is decomposed by sulphuric acid, setting free benzoic acid. It gives a precipitate in presence of alkaline phosphates, It is soluble in methyl alcohol, as well as in ether. Absolute alcohol only dissolves 1-5th part of its own weight of the drug. It is very slightly soluble in acetone. It shows a slight acid reaction in the presence of litmus paper, but is neutral to helianthin. Its watery solutions are sterilizable by heat. Prolonged boiling for an hour does not change it. It is much more stable than cocaine.

In his recently published thesis, "Les Injections Analgésiantes Loco Dolenti dans les Névralgies Périphériques," Dr. de Maillasson, Paris, states that stovaine has several advantages over cocaine.

"In the first place, it exercises a real action in relieving the pains of inflamed tissues, whereas cocaine has scarcely any effect in such cases. To anesthetize inflamed tissues with cocaine, it is necessary to employ very toxic solutions of that drug (1:40). The weak toxicity of stovaine has been recognized by many authors, particularly by Billon and Fourneau, who have demonstrated that the fatal dose of stovaine is 0.20 per kilogram of the weight of an animal, while the fatal dose of cocaine is 0.05, according to Livon, or 0.075 according to Pouchet. Stovaine rarely kills the guinea-pig; dogs and cats, which have received injections of it, have convulsions, the drug acting as a poison to the nervous system. In operating on the human subject, Reclus has employed, without accident, 20 centigrams of stovaine, and Chaput, 22.5 centigrams. Its toxicity is the same, no matter what route is

used for introducing it into the system. Although less toxic than cocaine, stovaine possesses the same anesthetic power as the former, according to Reclus, Huchard, Chaput, and de Laperonne."

It apparently does not contract the nasal mucosa to so great an extent as do similar solutions of cocaine. If it is desired to open the nasal passages widely, as for examining purposes, this characteristic may prove a disadvantage; on the other hand, it may prove an advantage, as in the snaring of redundant tissue, by not causing the nasal mucosa to shrink too much, and, therefore, enabling the operator to remove it more easily. The secondary swelling of the nasal mucosa following the use of stovaine is less than that occurring after cocainization. In some patients cocaine causes considerable constriction in the pharynx, with a constant desire to hawk and remove a supposed foreign body. Stovaine produces much less of this distressing symptom. After the local anesthetic effects of stovaine have disappeared, there are no secondary headaches or feeling of lassitude.

M. de Laperonne, Paris, who has employed it in ophthalmic practice, finds that it contrasts favorably with cocaine, being less toxic in its effects than that drug. It can be used for ophthalmic operations, either as an instillation (4 per cent. in normal saline), or as a subconjunctival injection. On the whole, it is inferior as an instillation to cocaine; on the other hand, as a subconjunctival injection, it surpasses cocaine in its effect. By combining stovaine and cocaine in the proportion of two to one, a mixture for instilling purposes is obtained which does not irritate the cornea, nor cause alteration in the vessels or tension (*vide Presse Medicale*, April 13, 1904).

Professor Reclus says: "Stovaine and also cocaine seem to me to be properly used in the removal of circumscribed cutaneous and subcutaneous tumors, in operations for lupus, lipomata, fibromata, canceroids, in amputations of fingers or toes, in operations for ingrowing toe-nails, whitlows, abscesses, gastrotomies, artificial anus, hernia, umbilical, inguinal or crural (strangulated or not strangulated) hemorrhoids, anal dilatations, hydroceles, varicoceles, castrations, laparotomies for non-adherent ovarian cysts, tubercular peritonitis, empyemas, with or without costal resection. In my hospital service, two-thirds of the surgical operations are

done with stovaine." (*Vide* La Stovaine, Dr. René, Piedallu, de l'Université de Paris.) Professor Reclus uses solutions of 0.75-100 and 0.50-100 which can be injected up to 40 c.c. without inconvenience. The technique is the same as that adopted in producing local anesthesia by cocaine.

Professor Tuffier has employed it frequently in producing spinal anesthesia. He begins his operation two minutes after the hypodermic needle has been withdrawn from the spinal canal. Stovaine employed in this manner produces analgesia as high up as the umbilicus, and, consequently, is suitable for operations on the perineum, iliac fossæ and the lower extremities. Solutions of one per cent. of stovaine have been injected into the gums in dental cases; two centigrams, that is to say, 2 c.c. of this solution, suffice for the extraction of a tooth.

In general medicine, Huchard has used it in proximity to the painful areas in cases of neuralgia, and also in epidural injections. He considers that it renders important services in intercostal neuralgia, lumbago, and sciatica. Huchard uses a one per cent. solution and injects 2 to 3 cubic centimetres, subcutaneously or deeply, and only 2 centigrams in epidural injections, at intervals of two or three days. So far stovaine is on trial; but, from the experiments made with it, it is likely to become a formidable rival to cocaine.

J. J. C.

THE NEW HOSPITAL AND ITS RELATION TO THE PROFESSION.

PROGRESS—the word of the hour! In its name we congratulate the city of Toronto, the University, and the entire medical profession of the new General Hospital, the building of which is now an assured fact. Many a discussion has taken place, and many an idle word has been spoken for and against the scheme in its infancy, as it hovered between a dream and a wide-awake reality. Now, the decision of the city council in granting two hundred thousand dollars toward the project we deem final, and the new hospital, as it takes its place in our midst, will represent all that is modern, and will, we understand, have on its gates "Open Sesame" to all reputable medical men (not as a privilege, but as a right), to follow their patients into private, semi-private, and other wards where they pay for the cost of their main-

tenance. This arrangement is not only just but is one to favor unity and a keener loyalty to one another among members of our profession, uniting them by a common interest. Of course it goes without saying that only the regular staff of the hospital will attend to the medical and surgical needs of "free" patients. The great, new institution will be a boon to the medical faculty of Toronto University for clinical purposes. Although this point is a very necessary and important one, it should also be remembered that the purpose of the hospital is to extend aid to the afflicted, and not to be simply a university institution. All that remains now to be done is for more of our wealthy men to come forward, Cawthra Mulock like, and render generous aid. To those interested in the smaller institutions, may we say, perhaps the day is not far distant when the few individual hospitals will make suitable arrangements to become *parts* of the central one, and so share in the benefits and facilitate the work and place all buildings on an equally modern scale. Perhaps this suggestion sounds Utopian. We think not, because, as Valdimar said to little Elsie, "To-morrow will bring another day"—and we doctors are accustomed to live on such threads as hope is woven of. The amalgamation would certainly prove advantageous to all. To gain the desired end, however, a few of the "chatty" men in the profession would need to hush the music of their melodious (?) voices, and do a little quiet thinking, and come to the conclusion that in unity lies strength, dignity and prosperity. Then, perchance, the new central hospital might add several auxiliaries in different parts of the city, that would Phœnix-like arise out of the ashes of some much-needed bonfires, and the united hospital, with its well equipped branches, tower, a monument to the judgment and common sense of the medical profession, as a body, and in the lives of the people be ever a legacy of the twentieth century to Toronto the good.

W. A. Y.

EDITORIAL NOTES.

The Vital Statistics of Ontario for 1903.—The report of the Registrar-General of Ontario for 1903 shows that the marriages registered for that year numbered 19,830, corresponding to a rate of 9.0 per 1,000 of the total estimated population, 2,198,692. "The increase of 1,842 over the preceding year," the report says, "is most marked, for, in 1902, the increase was only 37 over 1901." The marriage rate is regarded as satisfactory. There were registered during the same year, 48,742 births, including still-births, 25,071 being male, and 23,671 female, the rate being 22.1 per 1,000 of living persons. This rate is lower than that of any European country, with the exception of France, in which in 1900 it was 21.9. In comparison with adjoining states and provinces, it is found, from the latest returns, that in the year 1902 the birth-rate was as follows:—Quebec, 34.05; Rhode Island, 25.09; Connecticut, 22.5; Vermont, 21.9; New Hampshire (1902), 20.04; New Hampshire (1903), 19.68. The deaths for 1903 numbered 29,664, including still-births, a rate of 13.4 per 1,000. This was a little larger than in 1902, but is satisfactory, particularly when compared with adjoining states and provinces for 1902. In that year Quebec had a death-rate of 18.2 per 1,000, and the nearest approach to that of Ontario was Connecticut, with a rate of 15.2 per 1,000. These reports thus show for Ontario, in 1903, a marriage rate of 9.0 per 1,000; a birth-rate, including still-births, of 22.1, and a death-rate, including still-births, of 13.4 per 1,000, the former and the latter being officially regarded as satisfactory, and the birth-rate as unsatisfactory.

Residential Properties and Eye-sores.—The depreciation in value of a residential property owing to the construction of an eye-sore in its neighborhood, sometimes calls for rather animated comment. Relying on appearances, gentlemen have built handsome residences on the best residential streets in this city, and have found out, after a few years, that undesirable neighbors had become impressed with the advantages of sites on the same street, equally with themselves. In the case of physicians, this fact is especially noticeable. The Toronto physician keeps his office in his dwelling, which is situated on a thoroughfare, or in the vicinity of

one. The vicinity of a thoroughfare may be free from the invasion of trade and commerce; not so the thoroughfare. Hence, the physician who buys a house on a thoroughfare, while estimating its present value to himself, should look ahead and endeavor to estimate its value or utility to some other man, after ten or fifteen years. Toronto is a growing city and must continue to enlarge, as the chief trade and manufacturing centre of Ontario and the North-West provinces. Houses, well suited for dwellings ten years ago, have been changed into shops and factories, and what has been, and is, will be. What cannot be cured must be endured; but it does hurt one's feelings, and one's pockets also, to have an eye-sore erected altogether too close to the walls of a pretty house, where one had hoped to escape the blighting influence of a residential blemish for many years. Recently a municipal by-law providing for the creation of a residential district in this city was passed. This district is bounded by the north side of College street, the south side of Bloor street west, the west side of Yonge street, within 200 feet of the rear of the lots abutting on that street, and the east side of Spadina Ave., within 120 feet. The values of properties situated within the above-mentioned limits will be enhanced; but the principal object sought by the promoters, many of whom are physicians, is to exert an inhibitory influence on the growth and development of the eye-sore nuisance in the new residential district.

Nearly Bled to Death.—Death from arterial hemorrhage is peculiarly shocking to the surgeon, and most surgeons think that the means of promoting it should be placed within the reach of every pupil in the public schools. In this city, last June, a young man narrowly escaped bleeding to death. His arm was cut off just above the elbow by a belt on a flywheel in a machine shop. With the blood spurting from the maimed arm, the young man staggered away from the machine. The other men in the shop did not know how to check the flow of blood, and therefore telephoned for the ambulance. The driver of the ambulance drove his horse at a gallop to the scene of the accident. By tying a handkerchief around the stump and twisting it by means of a stick, he arrested the hemorrhage. The injured man's arm was subsequently dressed at the Emergency Hospital. Many intelligent but hypersensitive persons of the male sex faint at the sight of

blood, and even if they knew how to check a hemorrhage, would be speedily unfit to do it. However, a Spanish windlass, the device improvised by the driver of the Toronto ambulance, is so easily applied, and so effective, that every pupil of the public schools should be taught how to make one.

Drug Treatment for Inebriety.—J. S. Bolton, M.D., Nottingham, England, reports in the *British Medical Journal*, June 10, 1905, that early in Aug., 1904, he began to treat a case of chronic inebriety by hypodermic injections of strychnine and atropine. The treatment was administered twice a day at the doctor's office. The patient, a tailor's cutter by trade, was 45 years of age. He had been a total abstainer till he was 20, then a moderate drinker for ten years, at which time he began to drink whiskey, continuing the practice until he could not give it up. He had tried many times to give up drinking, but the effort had always ended in failure. Finding his organs free from organic disease, Dr. Bolton commenced treatment by injecting into the biceps muscle of his left arm a watery solution containing 1.60 gr. of strychnine hydrochloride and 1.30 gr. of atropine sulphate. He also gave him a mixture containing red cinchona bark, to take every four hours. The patient was told to take as little alcohol as possible, and his wife was instructed to give special attention to his diet, feeding him on eggs and milk, soup, cocoa, etc., until he had an appetite for solid food. Treatment was continued twice a day for forty days; after which he came once a day; then every second day till October 13th, 1904, when he was told that he need not come again for treatment, but only to report himself, unless the craving returned, in which case he was to come at once. Dr. Bolton says: "I saw him just before Christmas (1904). He was keeping right, but said he did not like to be too confident till the festive season was over. He, however, passed through it satisfactorily. I hear of him now every few weeks, and he is keeping straight. It is quite evident that, under favorable conditions, some of these cases can be successfully treated as out-patients by the family doctor, if he has sufficient time and patience to give to them."

Hepatic Congestion a Factor in Seasickness.—Persons who eat too much, sleep too long and take little exercise, have congestion of the liver, and, if attacked by seasickness, are apt to suffer

from prolonged and distressing symptoms of nausea. A distinguished clergyman, a noted preacher, had been sent to Europe by his admiring congregation, in order to enable him to get rid of an obstinate dyspepsia. During a month's stay abroad, he gave his brain a rest, ate heartily, slept a good deal and, as usual, took but little exercise. Shortly after the return trip to America was begun, seasickness seized him and held him for a week. Yet, he confessed, while walking the deck, as the ship was nearing port, that his health was then better than it had been for many years. In reference to the *modus operandi* of cure, he added, naively: "If any physician had given me a course of treatment half as severe as that ordered for me by Neptune, I would not have tolerated it." There was so much philosophy in this remark, that we thought then, and have often thought since, that physicians should try the "Neptune" method of treating the dyspepsias of patients who suffer from congestion of the liver. As the prevention of seasickness is better than its cure, it may be well to remark, that an emetic, followed by a cholagogue cathartic, taken before sailing, was successful in preventing attacks of seasickness both in going to Europe and returning, in a gentleman who, when no medicine had been taken, had previously suffered from seasickness, even when crossing from Toronto to Niagara-on-the-Lake.

Retirement of Dr. Reynolds from the Commissionership of Health of Chicago.—In retiring, after ten years' service, from the position of Commissioner of Health of Chicago, Dr. Reynolds shows that the health conditions of Chicago have vastly improved during his administration. "Its death rate during 1893 was 212 in every ten thousand of its population, of all ages. In 1904 the rate was 136 in every ten thousand. Improvement in general healthfulness, 36 per cent. In 1893 there were 8,125 infants out of 32,954 living under one year of age—a rate of 246 per thousand. Last year, out of 40,578 living under one year, there died 5,125—a rate of 124 per thousand. Reduction of infant mortality—50 per cent. In 1893, out of a child population of 121,564 living between one and five years of age, there were 4,328 deaths—a rate of 35 per thousand. In 1904, out of 162,315 children living at this age-period, there were 2,027 deaths—a rate of 13 per thousand. Saving of child life, 64 per cent. In 1893 the aggregate ages of the 27,083 individuals, who died during that

year amounted to 617,492 years, or an average of 22.8 years each. In 1904 the aggregate ages of the 26,313 decedents footed up 855,107 years, an average of 32.5 years each. Increased duration of life during the last twelve years, 42.5 per cent., or an increased "expectation of life" of nine years and nine months for every man, woman and child living in Chicago. Referring to the causes and influences operating for the decreasing death rate of Chicago, Dr. Reynolds puts *first* the educational work of the department, through the bulletins, circulars and leaflets, popularized by the daily press and eagerly taken up by the Woman's Club and kindred organizations. The Chicago people have thus learned the importance of an improved milk supply in the saving of children's lives between one and five years, the "milk feeding" period. The *antitoxin treatment of diphtheria* has been promoted. The restriction and prevention of consumption has been taught. The practice of vaccination has been completely revolutionized in Chicago, and the Chicago people are now a vaccinated population. Adults have learned to know the relation between impure water and typhoid fever. Mothers have been taught the hygiene of the young. Dr. Reynolds pays a tribute to the medical profession of Chicago: "In ten years the attitude of the profession to the department has undergone a remarkable change, and it is to-day one of the most efficient factors in the prevention of disease and the promotion of longevity." Dr. Reynolds deserves to be complimented on his administration of the sanitary service of Chicago, and Chicago may be felicitated on her good fortune in having enjoyed for ten years the services of so honest and capable an official.

J. J. C.

PERSONALS.

DRS. G. S. RYERSON and E. E. KING returned from England last month.

DR. CHAS. O'REILLY is building a residence on the north side of College Street.

WILSON—To Dr. and Mrs. F. W. E. Wilson, Niagara Falls, on July 11, a son.

CONGRATULATIONS to Dr. W. H. Pepler on a welcome addition to his little family last month.

THE engagement of Dr. D. King Smith, of Jarvis St., to Miss Myles, of Queen's Park, is announced. Dr. Smith is at present studying in London but will return this month.

DR. JOS. GRAHAM, son of the late Dr. J. E. Graham, and who is occupying Dr. G. A. Peters' house at present, is building a house on the south side of College Street, next door to Dr. Garratt.

DR. JOHN MCCOLLUM, brother of Dr. W. J. McCollum, has been appointed by the Ontario Government on the list of city coroners. The new appointee, who is probably the youngest of Toronto's coroners, was formerly on the house staffs of the General and St. Michael's Hospitals.

SINCE the other forms of text for this issue went to press, we understand that, as a result of Dr. Meyers' deputation to Premier Whitney, it has been arranged that this autumn, sometime, suitable arrangements will be made at Toronto General Hospital whereby a special department will be set aside for the treatment of cases of incipient insanity.

DR. H. P. H. GALLOWAY, who for some years has been actively associated with Dr. B. E. McKenzie, in the Toronto Orthopedic Hospital, Bloor St. E., left on the 29th ult. for Winnipeg, Man. Dr. Galloway will take up practice there, and expects to open an orthopedic hospital in the course of next year, as a branch of the parent institution in this city. We wish him every possible success.

PROF. A. B. MCCALLUM, of the University of Toronto, left on June 30th on a lengthy trip. He is a member of the British Association, which meets in August in Cape Town for three days, and in Johannesburg the following week for four days. Excursions have been arranged to the more important points in South and Central Africa, especially those that were storm centres during the war. Prof. McCallum will return by the Red Sea route.

Obituary

DEATH OF DR. THOS. G. JOHNSTON, M.P., WEST LAMBTON.

THE entire profession were shocked to read in the morning newspapers of July 4th, that Dr. T. G. Johnston, M.P. for West Lambton, had succumbed to but a few days' illness. Dr. Johnston died at Ottawa at 12.22 a.m. that day. It was over four weeks prior to that that he was attacked with erysipelas in the face. This gradually spread, and settled in the bowels, developing into a virulent form of blood-poisoning. Dr. Johnston maintained a gallant fight against the disease, and until the last hopes of his recovery were cherished. His devoted wife and daughters, and eldest son, Kenneth, were at his bedside when he passed away. Deceased received the best medical aid that Ottawa could afford. Dr. McKinnon was in constant attendance, and when the patient's condition grew serious, Sir James Grant, Dr. R. W. Powell, Dr. Carsens, and Dr. Courtney were called in consultation. The late Dr. Johnston was beloved by everybody in the House of Commons. He was a quiet, amiable man, who was staunch in his political beliefs, but was never known to utter a word calculated to wound. His death is unfeignedly mourned by members and employees of the House alike.

Members of the House recall the circumstances under which the late Dr. Johnston received the reported death of his son Kenneth. He kept his great grief in check, and all he said was: "He died a glorious death."

The late Dr. Johnston was the son of T. W. Johnston, M.D., who came to Canada in 1832 from the north of Ireland, and settled on a farm in Moore Township, Lambton County. The father adopted medicine as a profession and studied at Louisiana Medical College, graduating as a physician after four years in that institution. He began his practice in Sarnia, where the son was born. August 4th, 1849. Dr. Johnston, sr., was in his latter years, Registrar of Lambton County. His wife was Grace, daughter of Thomas Sutherland, Edinburgh, Scotland. The son received his education at the public and grammar schools, Sarnia, and at McGill University. He entered the medical department of the latter institution in 1867, and graduated M.D. four years later. He succeeded to his father's medical practice in Sarnia, and carried it on

successfully. He assisted in the establishment of a general hospital in that town. The late Dr. Johnston was an active participant in public affairs. During two terms, 1896 and 1897, he was Mayor of Sarnia, and was for four years a member of the School Board. He also served in the Municipal Council several years. In politics the late Dr. Johnston was an ardent Reformer and a staunch supporter of Sir Wilfrid Laurier. When a vacancy in the representation of West Lambton occurred, owing to the elevation of the late Judge Lister to the Bench, Dr. Johnston was the unanimous choice of the Liberals of that constituency, and on December 14th, 1898, he defeated the Conservative candidate, Mr. John Farrall. He was re-elected at the general elections of 1900 and 1904, when he was opposed by Mr. W. J. Hanna and Mr. James Clancy, respectively.

The late Dr. Johnston always took an active interest in militia affairs, and served as member of the Lambton provisional battalion during the Fenian Raid of 1866-'67, receiving a medal for this service. He was a member of the Church of England, was identified with the Masonic body, R.A.M., Knights Templar of St. Simon of Cyrene, Scottish rite, and Consistory at London, and also belonged to the I. O. F. He was married in 1873 to Miss Frances, daughter of the late George Brown, of Goderich. Two sons, Kenneth and Godfrey, and three daughters, were the issue of the marriage. Kenneth served in South Africa with the first Canadian Contingent. He emerged alive from the campaign, although after Paardeberg it was reported that he had fallen in battle.

Perhaps the best proof of the esteem in which our confrere was held, is an abstract from one of the afternoon papers of July 4th: "The news that Dr. Thomas G. Johnston, M.P. for West Lambton, died at Ottawa this morning will cause a great shock to all who knew him. He was pre-eminently an example of the personal equation in politics. He held his constituency against all comers, as much through his own boundless popularity as through the principles and record of the party he had espoused.

"Dr. Johnston had the gift of attracting friendship. He did it without effort. There was something about him that appealed to the most generous and manly instincts of those he met. Without protestations of any sort, he gave the impression—which was the true one—that he was a man who loved all mankind. He exhaled that atmosphere of quiet, abiding benevolence toward the world, which makes the world kind in its turn. Those who came within the radius of this strong, amiable nature, surrendered to its spell at once. The effect of this charming personality was to make friends more affectionate, while it deprived political foes of their bitterness.

“ A pronounced Liberal in his views, Dr. Johnston was equally esteemed on both sides of the House. In his own party he was the confidant of many secrets. No 16 brought his cares to him and the doctor prescribed. The prescription generally took the form of a brave smile, cheery word, a shrewd tip on the political weather, and a slap on the back that was particularly heartening. The doctor was one of those calm, confident natures that are built to lean upon, and he never sent the tired and heavy-laden away by reminding him that he had troubles of his own. In his readiness to take on the worries of other people and to put courage into the dispirited, he resembled James Sutherland, who, indeed, had the same quiet air of reserve force, and the same deep-seated inexhaustible geniality of temperament. Such men are a great treasure to any party. They win converts by their own amiability, without opening their mouths to do it. No malice in their hearts toward a living soul, no one has a grudge against them. Their political friends are spurred to unusual efforts by the virtues of their candidate. Their political enemies fight half-heartedly because they are really ashamed to dispute anything with such good fellows.”

Death of Nisbett Collier Kitchen.—At his home in South Dumfries, on Sunday, June 18th, 1905, Nisbett Collier Kitchen, aged 68 years. The late Mr. Kitchen was a brother of Dr. E. E. Kitchen, of St. George.

News of the Month.

A NURSES' RESIDENCE FOR THE HOSPITAL FOR SICK CHILDREN.

A RESIDENCE for the nurses at the Hospital for Sick Children, to cost \$75,000, is to be erected by Mr. J. Ross Robertson. A permit for the erection of the building was issued to Mr. Robertson, and work will commence almost immediately.

The building to be erected is a gift to the hospital and as a memorial of Maria Louisa Gillbee, the first wife, and Helen Goldwin, the only daughter of Mr. Robertson. The site for the residence is on the grounds of the hospital, south of the main building, and near Hayter Street. It will front north, looking into the hospital grounds, and will extend from Elizabeth Street to Laplante Avenue, a distance of 150 feet. It will be constructed of red brick, in colonial style, and will have about eighty rooms for nurses, domestics, and officials of the hospital.

The new nurses' home will contain on the ground floor a large lecture hall, reception room, library and writing rooms, and will be large enough for sixty nurses, with a general kitchen and a diet kitchen for the instruction of the nurses. It will also contain a large demonstration room, so that nurses may receive in the residence the necessary instructions before entering the wards.

The diet kitchen will be under the supervision of an expert in domestic science, so that every nurse will have a full knowledge of cooking before her course is finished.

The second, third and fourth floors will be for the lodging of the nurses in light and airy bedrooms, with sitting rooms on each floor, baths, lavatories and special study rooms. The fifth floor will be for the domestics and the centre part will have a gymnasium, in which the nurses will have manual and athletic exercises. In the centre of the building will be a roof garden, so that nurses off duty in the summer evenings can get a breath of fresh air.

The building will be ventilated on the most approved principle. The plans have been adopted after a thorough inspection of all the homes in the United States, and the best expert advice from superintendents of homes, such as Miss Nutting, of Johns Hopkins, Baltimore, Md., Miss Drown of the City Hospital, Boston, and Miss Brent, Lady Superintendent of the hospital on College Street.

It is expected that the building will be completed in a year, and be ready for occupation on the 1st of October, 1906. Some years ago Mr. Robertson presented the hospital with the Lakeside Home for Little Children on the Island, which was erected at a cost of \$25,000, making his total gifts to the hospital \$100,000. In twenty-five years the Lakeside Home has cared for nearly 10,000 sick children, and the mother hospital on College Street, 60,000.

CANADIAN MEDICAL ASSOCIATION.

THE following is the preliminary programme of the annual meeting of the Canadian Medical Association, to be held in Halifax, N.S., August 22nd to 25th, 1905:

President's Address.—Dr. John Stewart, Halifax.

Address in Surgery.—Mr. Francis M. Caird, Edinburgh, Scotland.

Address in Medicine.—Dr. D. A. Campbell, Halifax.

Address in Gynecology.—Dr. Howard A. Kelly, Baltimore.

Address in Ophthalmology.—Dr. J. W. Stirling, Montreal.

Discussion.—Renal and Ureteral Surgery. Introduced by Dr. A. Primrose, Toronto.

Two Cases of Retro-Ocular Neuritis—Dr. Geo. H. Burnham, Toronto.

Paper, Title to be Announced.—Dr. H. A. Bruce, Toronto.

The Symptoms, Diagnosis, Prognosis and Treatment of Neoplasms Affecting the Central Nervous System.—Dr. D. A. Shirres, Montreal.

Chorea, with an Analysis of 130 Cases.—Dr. Robert King, Halifax.

Rare Forms of Aneurysm—Dr. Maude E. Abbott, Montreal.

The Buried Suture.—Dr. J. M. Elder, Montreal.

Dentigerous Cysts, or the Removal of the Inferior Dental Nerve for Tic.—Dr. M. C. Smith, Lynn, Mass.

Combination Operation for the Radical Cure of Inguinal Hernia.—Dr. F. N. G. Starr, Toronto.

Two Case Reports:

(1) A Case of Chylo-Thorax;

(2) Further Notes on a Case of Myelogenous Leukemia, with Disappearance of the Splenomegaly and Myelocytes.—Dr. D. G. J. Campbell, Halifax.

Physical and Clinical Researches of Radium.—Dr. Myron Metzenbaum, Cleveland, Ohio.

Prostatectomy.—Dr. E. W. Cushing, Boston, Mass.

The Surgery of the Stomach in Non-Malignant Conditions.—Dr. Geo. E. Armstrong, Montreal.

Dislocations (with Lantern Demonstration).—Dr. J. Alex. Hutchison, Montreal.

The Fever of Late Syphilis.—Dr. Arthur Birt, Berwick, N.S.

Postural Albuminuria of Children—Dr. W. H. Eager, Halifax.

The Prodromata of Insanity.—Dr. W. H. Hattie, Halifax.

The Treatment of Smallpox without Pitting.—Dr. Archibald Leitch, St. Thomas, Ont.

Tracheotomy as a Remedy in Severe Whooping Cough.—Dr. A. B. Atherton, Fredericton, N.B.

Recent Fracture of the Clavicle, with Operative Treatment.—Dr. J. W. T. Patton, Truro, N.S.

In addition to the foregoing, several have promised papers, but have not yet decided upon the title of same.

WORK ON NEW CONVOCATION HALL FOR TORONTO UNIVERSITY COMMENCED.

THE stakes were driven on the 13th ult. to mark the site of the new Convocation Hall on the university grounds, on the southwest corner of the campus, and the contractor will begin the excavations for the foundations at once. This part of the work is included in the masonry contract, which has been let to Mr. Robert Robertson, Scollard Street. The other contracts have all been decided upon, the chief being: Plastering, W. J. Hynes; iron work, Dominion Bridge Company; carpentering, A. B. Coleman; painting, J. McCausland & Son, Limited; plumbing, Bennett & Wright Company. The building is to be finished so that the next convocation may be held there.

Mr. Pearson, of Darling & Pearson, the architects in charge, discussed the site, which he thinks will not encroach materially upon the campus.

“I have worked and worried and schemed so that the campus would not be injured, and the plans have been laid so that the view of the main building from College Street will not be obscured. The building has been pulled round a bit to show the treatment of the facade from the main building. The Physics building will be set back from the Chemical building, and the Convocation Hall from the Physics building, so that anyone standing on College Street will be able to see the whole front of the university. We have allowed 75 feet between the Convocation Hall and the Physics building, and 66 feet between it and the Chemical building, so as not to impede the light. There will be a 50 or 60 foot drive in front of the hall.

"We have considered the trees, and intend to dig a trench and drag those worth preserving across the roadway and set them between the campus and the drive."

Mr. Pearson believes there is no site for the hall but that chosen, and holds this view after much consideration. The hall is modelled after the Sorbonne in Paris, one of the best buildings acoustically in the world. Within it will be about 70 feet in height from the floor of the auditorium to the lantern in the roof. Two tiers of galleries will be reached by fireproof stairs, and the whole of the ground floor will be fireproof, while the exits will empty the building of its 2,000 occupants in two and one-half minutes. A twenty-foot loge will run all round the hall, and a cloak room is provided opposite the entrance.

MEDICAL EXAMINERS APPOINTED.

THE Council of the Ontario College of Physicians and Surgeons adjourned on the 8th ult. to meet again in Toronto next year. The business before the Council at its closing session was the receiving of the report of the Complaints Committee. The examiners were upheld in their decision in each instance. Upon the suggestion of Hon. Dr. Sullivan, a committee was appointed to wait on the Government, with a view to establishing a Bureau of Health. The Government will also be asked to assist in the establishment of sanatoria for the treatment of consumptives. Drs. Macdonald, Moorehouse and Campbell were appointed the Executive Committee for next year.

These official examiners were appointed: Anatomy descriptive, Dr. T. W. C. McKay, of Oshawa; theory and practice of medicine, Dr. George Hodge, of London; clinical medicine, Dr. H. R. Duff, of Kingston; midwifery, operative and other than operative and respiral diseases, Dr. J. R. McCabe, of Strathroy; physiology and histology, Dr. R. D. Rudolf, of Toronto; surgery, operative and other than operative, Dr. W. T. Parke, of Woodstock; clinical surgery, Dr. J. S. McCullough, of Alliston; medical and surgical anatomy, Dr. T. H. Middleboro, of Owen Sound; chemistry, theoretical and practical, and toxicology, Dr. A. R. Pyne, of Toronto; materia medica and pharmacology, Dr. James S. Sprague, of Stirling; medical jurisprudence and sanitary science, Dr. D. J. Sinclair, of Woodstock; diseases of women, Dr. R. E. Webster, of Ottawa; diseases of children, Dr. James Newell, of Watford; pathology, therapeutics and bacteriology, Dr. Isaac Wood, of Kingston; homeopathic examiner, Dr. W. A. McFall, of Peterboro'.

ITEMS OF INTEREST.

Additional Successful Candidates.—The following are additional successful candidates of the College of Physicians and Surgeons of Ontario: Primary—A. W. McPherson, Peterboro'; G. R. Reid, Kingston. Intermediate—V. W. Stewart, Toronto; A. W. Keene, Essex. Final—J. H. Bennett, Oshweken; C. W. Clark, Picton.

New Coroners.—The following appointments, not hitherto mentioned, are announced in the current *Gazette*: Charles Norval Laurie, M.D., Port Arthur, Associate Coroner for the District of Thunder Bay; James Anderson, M.D., Hamilton, Associate Coroner for the County of Wentworth; William Hamilton Merritt, M.D., St. Catharines, Associate Coroner for the County of Lincoln.

Dr. Macdonald, President of the Ontario College of Physicians and Surgeons.—At the annual meeting of the Council of the College of Physicians and Surgeons of Ontario last month, the following officers were elected for the ensuing year: Dr. A. A. Macdonald, Toronto, President; Dr. W. H. Moorehouse, of London, Vice-President; Dr. R. A. Pyne, Registrar; Dr. E. Wilberforce Aikins, Treasurer; Dr. J. C. Patton, Auditor.

New House Surgeons for the Toronto General Hospital.—At a special meeting of the Board of Trustees of the General Hospital, held July 11th, Mr. J. W. Flavelle presiding, the house surgeons for 1905-6 were appointed, their names being Drs. Fred Brodie, Alfred McNally, W. A. Burr, T. Alexander Davies, Allan Kinghorn, E. C. Burson and A. G. McPhedran. The externe physicians have not yet been appointed. Dr. J. W. Rowntree, who has been filling the position (as a temporary expedient) of medical superintendent, resigned his duties two weeks ago. Dr. J. N. E. Brown, who till recently practiced in the Yukon, and filled a responsible Government position in Dawson City, was appointed successor to Dr. Charles O'Reilly on the 21st ult. We wish Medical Superintendent Dr. Brown every possible success in his new sphere of work.

Addition to St. Michael's Hospital.—Funds are being raised for the erection of a new \$50,000 wing to St. Michael's Hospital. The building is to be located across Victoria Lane, from the main hospital. The work would be commenced immediately, but that the hospital authorities are in hope of obtaining from the city that portion of the lane adjoining the hospital. A direct communication from the old building to the new is desired on each floor, and for this reason they wish either the lane or the right to erect bridges over it from one part of the building to the other. The present buildings will accommodate 50 surgical and 180 medi-

cal patients, but two-thirds of the medical patients are in the old north wing, formerly a church, and but poorly ventilated or protected from fire. When the new wing is built the northern part will be occupied by the attendants, who now board on Victoria Street.

Deputation of Medical Profession Wait on Premier.—In pursuance of the views set forth by Dr. Campbell Meyers at the recent meeting of the Ontario Medical Association, to the effect that there should be some accommodation in the city hospitals for poor people with insane tendencies, a large deputation, consisting of more than 50 doctors and some members of the medical faculty of Toronto University, waited on the Premier recently. They made a plea for legislation of some kind, the doctors of the city being all in favor of some better provision being made for the indigent insane. Dr. Meyers' idea is that there should be some better way of handling those in the incipient stages of insanity. As it is at present, the patient is immediately hurried off to an asylum or allowed to roam around until he does some harm or is so far gone that he must be placed under restraint. For the rich man there is the sanitarium, where he may be treated while the disease is young. For the poor man there's only the mad-house. It is to be earnestly hoped that Premier Whitney will at once take steps to remedy this state of affairs, and Dr. Meyers is to be congratulated upon bringing this very important subject to the front.

Visit of British Medical Association to Toronto in Prospect.—

At a meeting of representative medical men of Toronto, held at the Medical Library, Queen's Park, on July 13th, a resolution was passed, on the motion of Dr. R. A. Reeve, seconded by Dr. Grasett, inviting the members of the British Medical Association to visit Toronto next year as the guests of the medical men of the city. Dr. A. J. Johnson presided over the meeting, and the object of the gathering was explained by Dr. Reeve. The subject had arisen previously at meetings of the Canadian Medical Association and the Ontario Medical Association, and it was again mentioned at the meeting of the latter body held in June. At the meeting the whole question was thoroughly discussed, and in addition to the resolution already referred to, others asking for the co-operation of other medical associations were also passed. The meeting, of which Dr. Thistle acted as Secretary, was adjourned until a reply is received from the British Association. The invitation, we are glad to say, goes from the profession as a body, and not from any sect or teaching body, and we feel sure that, in case of an acceptance, the British Medical Association will receive a most hearty reception in Toronto.

Correspondence.

The Editor cannot hold himself responsible for any views expressed in this Department.

CANADIAN MEDICAL AUTHORS.

To the Editor of THE CANADIAN JOURNAL OF MEDICINE AND SURGERY :

DEAR SIR,—In your June number, A.B., in reviewing Dr. Adam Wright's "Text-Book of Obstetrics," says: "With the exception of a few small handbooks on various subjects, this is the first work of importance written and published by a Canadian." Our businessmen, in recent years, have manifested a most commendable spirit in labeling their goods, "Made in Canada." Only a short time ago, another Canadian, Dr. Price Brown—a citizen of Toronto, too—wrote and published a "Text-Book on Diseases of the Nose and Throat," a work of such scientific and literary excellence as to give its author very high rank amongst medical writers. Why should we not emulate our manufacturers, and not, as some of us do, scarcely try to conceal a sneer at any degree, book or author, not of the Mother Country? Canadians are not wanting in loyalty to Britain, but they owe it to their own self-respect to recognize Canadian merit and scholarship. It is true we have not as yet a very long or large list of native authors, but, instead of completely ignoring those we have, would it not be more patriotic and just to be governed by the advice of the old Latin maxim, "Non numero sed pondere æstimanda sunt," when speaking of the medical authors "Made in Canada"?

S O'Hara Avenue.

J. HUNTER, M.D.

FIFTEENTH INTERNATIONAL MEDICAL CONGRESS.

To the Editor of THE CANADIAN JOURNAL OF MEDICINE AND SURGERY :

DEAR SIR,—Anticipating that a large number of American physicians will attend the Fifteenth International Medical Conference to be held in Lisbon, Portugal, April 19 to 26, '06, the undersigned has completed arrangements for the chartering of a first-class vessel, upon which the American delegation may sail as one party. In this way better accommodations can be secured at a more reasonable price, the social features of the trip will be enhanced, and each individual surrounded by those who are personally congenial.

Additional security, and consequently added pleasure will be obtained as the party will be in charge of a traveling conductor who is thoroughly conversant with the language and the customs of the countries to be visited en route.

As there will doubtless be some diversion as to the choice of the routes, depending on individual inclination and previous opportunities for foreign travel, a number of returning routes have been selected, the itineraries of which, although separate from the journey proper have been arranged so that the principal points may be visited together. Those who desire may include a Mediterranean excursion. Madrid, Corunna, Vigo, Aport, the Escorial, Toledo, Seville and Cordova may be visited, as well as an opportunity to return leisurely through Italy, France and Great Britain.

Hotel reservations for the party have also been arranged for in the best hostelrys of Lisbon, and in addition a number of "floating hotels" will be anchored in the Tagus during the entire session of the congress, thus enabling visitors, who desire, to enjoy all the comforts of a superb hotel system on the water.

Round trip rates from New York will run from \$275 up, according to the tour selected, including all expenses.

Itineraries of the various tours are being prepared, and will soon be ready for distribution. It is important that all who contemplate taking this trip should register at once, so that no disappointment in hotel reservation may be experienced. The final arrangements will, as heretofore, be in the hands of the well-known conductors, Thos. Cook & Sons, which insures perfect and complete service for the trip, and relieving the passenger from all annoying details incident to the voyage. Those delegates who attended the last Congress in Madrid, sailing from New York on the "Princess Irene," will remember the excellent service afforded them.

Dr. John H. Musser, Philadelphia, is chairman of the National American Committee, and Dr. Ramon Guiteras, 75 West 53th Street, New York City, is the secretary, to whom all applications for membership and communications in regard to the presentation of papers, should be addressed.

Further information, reservations, and copies of itinerary may be obtained by addressing the last-named undersigned:

Lewis S. McMurtry, M.D., Louisville.

Nicholas Senn, M.D., Chicago.

J. D. Griffith, M.D., Kansas City, Mo.

W. F. Southard, M.D., San Francisco.

Frank P. Norbury, M.D., Jacksonville, Ill.

W. T. Corlett, M.D., Cleveland, O.

C. H. Hughes, M.D., St. Louis, Mo.

R. T. Morris, M.D., New York City.

A. Vander Veer, M.D., Albany, N.Y.

Jos. M. Mathews, M.D., Louisville.

J. B. Murphy, M.D., Chicago.

Jas. E. Moore, M.D., Minneapolis, Minn.

Chas. Wood Fassett, Krug Park Place, St. Joseph, Mo.

The Physician's Library.

BOOK REVIEWS.

The Doctor's Recreation Series. The Inn of Rest: divers episodes in hospital life, relative to the doctor, the nurse the patient. Edited by SHELDON E. AMES. New York, Akron (Ohio), Chicago: The Saalfield Publishing Co. 1905.

This is another volume of the Doctor's Recreation Series, about which we have taken occasion to speak several times already. It may be said to be a worthy companion of the preceding volumes, and contains many sketches that are instructive, amusing and restful. The illustrations are four in number. The one occupying the frontispiece is entitled "Before the Operation," and is excellent; a second, of Laennec, on page 82, must be, of course, from an old engraving and is a little disappointing; the third, showing "Penel at La Salpetriere," and the last "Pare," are particularly good.

There are seventeen chapters by different authors, one of the best being that by Walt Whitman, entitled "Hospital Scenes and Persons." Anna H. Drury contributes about twenty or more pages on "Nurse and Doctor," and A. B. Ward a chapter on "The Invalid's World,"—both being most enjoyable.

Clinical Treatises on the Pathology and Therapy of Disorders of Metabolism and Nutrition. By Prof. CARL VON NOORDEN, Physician-in-Chief to the City Hospital, Frankfort a. M. Authorized American edition, translated under the direction of Boardman Reed, M.D., Professor of Diseases of the Gastro-Intestinal Tract, Hygiene, and Climatology, Department of Medicine, Temple College; Physician to the Samaritan Hospital, Philadelphia, etc. Part VI., Drink Restriction (Thirst Cures), particularly in Obesity. By Professor CARL VON NOORDEN and Dr. HUGO SALOMON. New York: E. B. Treat & Co. 1905.

For many years past we have been in the habit of thinking that the majority of people drink too little water. This little book brings strongly before us the fact that in a great many instances at least, the opposite condition certainly exists. It is pointed out that this is due to the fact that the drinking of large

quantities of hot water and the douching out of the large intestines has been overdone. Not only is this the case, but it is shown that both the medical men and the public have forgotten that every mouthful of water that is taken into the stomach imposes an added amount of effort on the heart and kidneys particularly, before it is got rid of. Many victims of dilated heart, dilated stomach, and of Bright's disease, practically have been encouraged to drink themselves to death.

Professor von Noorden makes a very strong effort to point this out in this book, and everyone that reads it must feel that it is quite time that the possibility of water-logging a patient should be taken into consideration.

A. J. J.

Modern Clinical Medicine. Infectious Diseases. Edited by J. C. WILSON, A.M., M.D., Professor of Medicine, Jefferson Medical College; Physician-in-Chief to the German Hospital, Philadelphia; Physician to the Jefferson and Pennsylvania Hospitals, etc. An authorized translation from *Die Deutsche Klinik*, under the general editorial supervision of Julius L. Salinger, M.D., with two colored plates and sixty illustrations in the text. New York and London: D. Appleton & Co. 1905.

It seems to us to have been a most praiseworthy move on the part of D. Appleton & Co. to give the profession on this side of the Atlantic the advantage of being able to procure an English translation of *Die Deutsche Klinik*, a work which represents the combined labors of the foremost medical men in the Fatherland. *Die Deutsche Klinik* undoubtedly stands as the most recent collaboration of scientific medicine in Germany, a country that has been for years in the vanguard of not only bacteriology, but has done so much to advance, especially, laboratory research. The English edition of this splendid work will be welcomed on our shores, the arrangement being most convenient, and the work, in its entirety, well suited for every-day reference.

Malformations of the Genital Organs of Woman. By C. H. DEBIERRE, Professor of Anatomy in the Medical Faculty at Lille. With eighty-five illustrations. Translated by J. HENRY C. SIMES, M.D., Emeritus Professor of Genito-Urinary and Venereal Diseases in the Philadelphia Polyclinic. Pp. 182. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut Street. 1905.

This little monograph is of value because it certainly accomplishes what the translator claims in filling "a void in English medical literature." The title of the work indicates its scope, and the author has presented his subject in a manner which is at once

interesting and instructive. No extended review is necessary, except such as is required to commend it to those readers who are interested in the subject. That the treatise is written in a true scientific spirit may perhaps best be indicated by quoting the last paragraph in the book, which reads thus: "Our general conclusion from the study of the anomalies of the genital organs of woman is that in nature nothing is unusual, and our ignorance alone gives power to the fetich gods and manatous of all times and of all countries."

A. P.

Enlargement of the Prostate. Its history, anatomy, etiology, pathology, clinical causes, symptoms, diagnosis, prognosis, treatment, technique of operations, and after-treatment. By JOHN B. DEEVER, M.D., Surgeon-in-Chief to the German Hospital, Philadelphia, assisted by ASTLEY PASTON COOPER ASHURST, M.D., Surgeon to the Out-Patient Department of the Episcopal Hospital; Assistant Surgeon to the Orthopedic Hospital, and to the Dispensary of the German Hospital. Illustrated with 108 full-page plates and a colored frontispiece. Philadelphia: P. Blakiston's Son & Co., 1012 Walnut St. 1905.

Though so far we have but had time to make a somewhat careless perusal of this, the most recent work from the pen of the well-known John B. Deaver, we think it will not be long before the volume is in the hands of most active surgeons.

It is only during the last year or two that the prostate gland has been receiving any notice, as up till quite recently such a thing as surgical interference with that organ was considered almost out of the question. For this reason, therefore, if for no other, Dr. Deaver's volume will be received with more or less alacrity, the author having had considerable experience along this line of work. The book may be said to cover not only the author's views, but those of other surgeons as well, and is, therefore, by no means biased or one-sided. It covers pretty well all the literature dealing with diseases of this gland, and is freely illustrated. The volume, as a piece of book-making, could hardly be excelled.

W. A. Y.

Report of the Commission for the Study and Treatment of "Anemia" in Porto Rico. Authorized by Act of the Legislative Assembly. Approved Feb. 16th, 1904. Respectfully submitted to Hon. Beekman Winthrop, Governor of Porto Rico, Dec. 1st, 1904.

As intimated in the title, this is the report of the commission appointed about a year and a half ago by the Government of Porto

Rico, for the study and treatment of anemia, so very prevalent throughout that island. The pamphlet is well worth sending for, and a copy can be procured by any physician sending his card to the M. J. Breitenbach Co., 53 Warren Street, New York City. "Tropical Anemia" is accountable for a very large percentage of the death rate in Porto Rico, and it was a very wise step on the part of the Governor to have a scientific investigation made into the causation of the disease, which, for many years, has been carrying off such a large number of the inhabitants. The pamphlet gives quite a number of clinical histories in detail, including the previous history of the patients, the treatment adopted, and results. It is interesting and instructive to find that Gude's Peptomangan proved itself to be curative in a large number of cases. This is worth remembering, as by proving effective in so severe a type of the disease in question, it seems to be a preparation worthy of more general recommendation by physicians. It is seldom that one hears of any proprietary preparation receiving such a proof of its efficiency. It is noticeable that the first twenty-four pages of the pamphlet are taken verbatim from the official report issued by the government.

Acute Contagious Diseases. By WILLIAM M. WELCH, M.D.,

Diagnostician to the Bureau of Health and Consulting Physician to the Philadelphia Municipal Hospital for Contagious and Infectious Diseases; for thirty-three years Physician-in-Charge of the Municipal Hospital; Fellow of the College of Physicians of Philadelphia; and by JAY F. SCHAMBERG, A.B., M.D., Professor of Dermatology and all Infectious and Eruptive Diseases, Philadelphia Polyclinic and College for Graduates in Medicine; Assistant Diagnostician to the Bureau of Health, and Consulting Physician to the Municipal Hospital for Contagious and Infectious Diseases; Fellow of the College of Physicians of Philadelphia; Member of the American Dermatological Association. Illustrated with 109 engravings and 61 full-page plates. Philadelphia and New York: Lea Brothers & Company. 1905.

The writers of this book have succeeded in their endeavor to present a practical treatise on acute contagious diseases. The diseases, however, that are dealt with, constitute a rather small group, and are those that they have most frequently come in contact with in the Municipal Hospital of Philadelphia. The book, therefore, though large, does not include, by any means, what we are in the habit of considering all the infectious diseases, although it does contain, perhaps, the most important.

A large amount of space has been devoted to the subject of smallpox, and particularly to its diagnosis. This is a very strong

feature in this book, and one that is of very great value to the student and practitioner. Smallpox is a disease which many practitioners and students do not often come in contact with, and the writers have made a thorough study of nine thousand cases of this disease, and illustrated their article with many photographs of patients who have been under their care.

Chickenpox, scarlet fever, measles, rubella, typhus, and diphtheria are all described in a most thorough manner, and, I think, may be considered absolutely up-to-date.

The book is one of undoubted value to the practitioner and possibly also to the student; certainly to the student who is coming into contact with the infectious diseases described. To the average student, however, the descriptions are so elaborate, and the distinctions are so minute, that it might be found somewhat difficult to master all the detail.

A. J. J.

Sandy. By ALICE HEGAN RICE. Toronto: William Briggs, Publisher.

A bright story of an Irish lad, a young Patrick in very truth, with his head full of poetry, a temperament as variable as the wind, and with a smile like a sunbeam. He lands in America and makes a career for himself, so the reader follows him with interest, and many a laugh, where'er his changeful lot is cast, until the book closes over on a happy wedding day.

W. A. Y.

A Reference Handbook for Nurses. By AMANDA K. BECK, of Chicago. 32mc volume of 150 pages. Philadelphia and London: W. B. Saunders & Company. J. A. Carveth & Co., Limited, 434 Yonge Street, Toronto. 1905. Bound in flexible Morocco, \$1.25 net.

This little book contains information upon every question that comes to a nurse in her daily work, and embraces all the information that she requires to carry out any directions given by the physician; it includes also instructions for all emergencies that may arise before or between visits of the physician. It is of immense value to student nurses because it contains all the material they are expected to commit to memory from notes. Physicians, too, will find the book of value, because it contains exact details as to solutions, foods, dosage, poultices, applications, etc. There are also articles on bacteriology, massage, medical electricity, obstetrics, care of infants, and such like information. The mechanical get-up of the book is both convenient and attractive. It is of a size to fit the pocket, and is neatly bound in flexible Morocco.

W. J. W.

Saunders' Pocket Medical Formulary. By V. J. M. POWELL, M.D., author of "Essentials of Diseases of Children"; Member of Philadelphia Pathological Society. Containing 1831 formulas from the best known authorities. With an Appendix containing Posological Table, Formulas and Doses for Hypodermic Medication, Poisons and their Antidotes, Diameters of the Female Pelvis and Fetal Head, Obstetrical Table, Diet-list, Materials and Drugs used in Antiseptic Surgery, Treatment of Asphyxia from Drowning, Surgical Remembrancer, Tables of Incompatibles, Eruptive Fevers, etc., etc. Seventh Edition Revised. In flexible morocco, with side index, wallet and fl.p. Philadelphia and London: W. B. Saunders & Co. 1905. Canadian Agents, J. A. Carver & Co., Limited, 434 Yonge St., Toronto. \$1.75 net.

When a work has reached its seventh edition there can be no doubt of its practical usefulness. And it is not at all surprising to us that Saunders' Pocket Medical Formulary should have attained such popularity, for we know of no similar work containing so much useful, practical, and accurate information in so small a compass. In this new seventh edition there have been added over 460 new and valuable formulas, selected from the works and private practices of the best authorities. The editor has shown rare discretion in the elimination of many obsolete formulas, inserting in their place newer and better ones, embodying a large number of approved new remedies. In its new edition this Formulary is thoroughly representative of the most recent therapeutic methods, and its convenient size and mechanical get-up make it the most desirable work of its kind on the market.

Mucous Membranes, Normal and Abnormal. Including Mucin and Malignancy. By WM. STUART-LOW, F.R.C.S., Assistant Surgeon Central London Throat Hospital, Hon. Sec. British Laryngological Association, Fellow London Laryngological Society. London: Bailliere, Tindall and Cox, 8 Henrietta Street, Covent Garden. 1905.

Systematic investigation in this department of physiology and medicine has been much neglected, and yet what a large percentage of the ailments we meet with arise therefrom.

The author warns us against over-use of the douch, spray and other means employed for washing away that important natural protective, viz., mucin.

Light is thrown on the connection of syphilis and cancer, and the association of syphilis and cancer with hypomyxia. The reader will find many other interesting problems discussed, and a study of this important subject will richly repay the practitioner in his daily medical practice.

W. H. P.

Maternitas. A book concerning the care of the prospective mother and her child. By CHARLES E. PADDOCK, M.D., Professor of Obstetrics, Chicago Post-graduate Medical School; Assistant Clinical Professor of Obstetrics, Rush Medical College. Chicago: Cloyd J. Had & Co., 40 Dearborn St.

This manual, while thoroughly scientific in its teaching, tells its story simply and fully, omitting nothing of importance.

The methods taught can be very easily understood and carried out by mother and nurse.

It should appeal strongly to both prospective mother and nurse, as its advice is based on good common-sense principles, but does not encroach on the domain of the medical attendant, being mainly a preparation to impress on the mother the necessity for co-operation with her physician. A careful perusal will be enjoyed by all practitioners of obstetrics.

W. H. P.

Progressive Medicine. A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by HOBART AMORY HARE, M.D., assisted by H. R. M. LANDIS, M.D. June 1, 1905. Philadelphia and New York: Lea Brothers & Co. \$6.00 per annum.

The present volume is quite up to the usual high standard of excellence maintained by this journal. It contains review articles on hernia, surgery of the abdomen, exclusive of hernia, gynecology, diseases of the blood, diathetic and metabolic diseases, diseases of the spleen, thyroid gland, and lymphatic system, and ophthalmology.

A paper by H. J. Stiles, of Edinburgh, on the operative treatment of hernia in infants and young children, is very thoroughly reviewed. Stiles does not advocate the use of the truss with children, or even with very young infants, but prefers operative treatment in almost all cases. The writer is more conservative, and agrees with Dr. Ganno and others, who think that a very large percentage of children under three years of age may be completely cured of hernia by means of the truss. Many varieties of operations for hernia are discussed.

Operations on the stomach for various diseased conditions are now being discussed by journals and medical societies generally. Recent articles describing these are very thoroughly reviewed.

In the section dealing with gynecology, considerable space is given to cancer and myoma uteri. The short review of the literature dealing with the ravages of gonorrhoea in women is opportune, and the opinions expressed by the writer are conservative.

There is not a single dull article in the whole volume.

A. E.

We are in receipt of the 26th edition, Catalogue of Batteries and Electro-Therapeutical Specialties, as published by the McIntosh Battery and Optical Co., of Chicago, Ill. It is a very complete list indeed, and goes to show that this firm are determined to occupy only the vanguard in the manufacture of this line of goods.

Merck's 1905 Manual. (Third edition.) The third edition of Merck's excellent Manual of Materia Medica has just recently come to hand. A year or so ago we took occasion to pronounce upon the second edition of this booklet, and we said then that it was quite a valuable guide to the newer pharmaceutical preparations, and worth procuring. The third edition is considerably larger. It has been thoroughly revised and almost entirely rewritten. It might be called a handy reference manual for the physician for pocket use.

Cunningham's Anatomy. Messrs. William Wood & Company are pleased to announce a forthcoming new edition of Cunningham's Text-Book of Anatomy. During the two years of this book's existence, it has sprung into universal favor and is now the standard text-book in a majority of the prominent medical schools of this country. Cunningham's Anatomy is the most recent text-book on the subject, and from opinions given by the leading teachers in America, is undoubtedly the best work now in the field. That this fact is realized is shown by the strenuous efforts which are being put forth by publishers of competing books, not only in revising their text-books, but in the revision, striving, so far as possible, to imitate the arrangement and style of Cunningham. Cunningham is unique, in that it is a text-book of anatomy written by anatomists. The illustrations are new and original, having been drawn and engraved especially for the book. Their execution is beautiful, and, being genuine hand engravings upon wood, they possess the artistic charms and graphic quality that no mechanical process can give. Many of them are in colors, in some cases five or six paintings having been employed. In the second edition a large number of colored illustrations have been added, and new drawings showing the insertions of the muscles. The section on the nervous system has been practically redone and many new figures have been prepared for it. The entire work evidences careful revision, amplification and the correction of many typographical and other errors, which crept into the first edition. An index of seventy-three double-column pages makes the vast contents of the book readily accessible. There is good reason to believe that within a very short time the sale of this book will exceed the combined sale of all other text-books on anatomy.