

DOMINION MEDICAL MONTHLY

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No. 1

Original Articles

THE DISEASED TONSIL AND ITS EFFECT UPON THE GENERAL SYSTEM.*

By W. P. CAVEN, M.D., TORONTO.

In the first place, I would like to draw attention to the influence that chronic enlargement of the tonsillar tissues, and in this I include the adenoid tissue in the vault of the pharynx, may have on both the mental and bodily development of children.

This is a subject of special interest to the general practitioner, as it is he who first has an opportunity of coming in contact with the conditions; and upon his thoroughly understanding these conditions and their proper treatment may depend the future mental and physical development of the child.

Hypertrophy of the tonsillar tissues is occasionally congenital, or the enlargement may follow diphtheria or the eruptive fevers. It may be part of the general hyperplasia of the lymphatic glands and lymph tissues (spleen, thymus, etc.) throughout the body, met with in the condition of lymphatism or Status Lymphaticus, a condition of special interest owing to the frequency of occurrence of sudden death from some apparently trivial cause. We are all familiar with the great risks of anesthetics here, either local or general, cases of sudden death in this condition have also been reported immediately after injection of antitoxin for diphtheria, and patients, the subjects of lymphatism, also seem to incur special risk of sudden death while bathing.

Pretauf believes that the subjects of this hyperplasia have

*Read at Canadian Medical Association, Toronto, June, 1910.

lowered power of resistance, and are specially liable to paralysis of the heart.

The immediate effect of tonsillar hypertrophy is, of course, mouth breathing, and this indirectly leads up to well-marked chest deformities and to a characteristic facial expression. The child becomes dull, stupid looking, answers slowly; lips become thick and altogether may present the picture of one both mentally and physically stunted.

It is interesting here to note that Hutchinson has suggested that the embryological relationship of tonsillar tissue with the pituitary body may account for the interference with development.

Dupuytren, in 1828, drew attention to the chest deformities associated with enlarged tonsils, and it is now well recognized by physicians that the Pigeon Breast, the Barrel Chest and the Funnel Breast are largely induced by naso-pharyngeal obstructions.

In the Pigeon Breast, the sternum is bulged forward and Harrison's groove (diaphragm attachment), deeply marked. In a mouth breather, one can see the lateral regions retracted during inspirations by the diaphragm.

The Barrel Chest is brought about by the recurring attacks of asthma and consequent emphysema, due to the chronic naso-pharyngeal irritation and obstruction.

In the Funnel Breast there is a deep depression at the lower sternum, and there seems every reason to believe that obstruction to the breathing, due to adenoids, is a main factor in its production.

In mouth breathers, we also recognize a nasal quality in the voice, and stuttering is undoubtedly associated with it in some cases, the hearing is often impaired, and I think physicians will bear me out in saying that their little patients have often ceased complaining of headaches and facial muscle spasms by clearing away the obstructions to breathing.

The physician also is often consulted in regard to a fetid breath, which is found to be due to cheesy deposits in the tonsillar crypts.

A consideration of all these facts makes one think Catlin was not so far astray when he said, "Shut your mouth and save your life."

It is interesting here to note the results of attending to the cases of enlarged tonsils in the school children of New York City.

"Mayer" says that some of the children after operation showed an improvement of 100% over their former ability to work and in behavior, from the simple removal of hypertrophied tonsils. Within six months, 76 out of 81 operated on at one time had been promoted and were doing well in the advanced grades.

In the second place, I am going to say a few words about the constitutional affections entering the system by way of the tonsil and produced by tonsillar disease. I would here draw your attention to the fact that the enlarged visible tonsil is not the most dangerous. True it is the cause of obstructions; but it is the small diseased tonsil, buried deeply between the pillars of the palate which has no drainage and whose secretions are retained, that is the source of infection, the lymphatics from which distribute the poison.

What part does the tonsil play as a portal of entrance for tuberculosis? I think that all the evidence goes to show that we can regard the tonsil as one of the important portals of entrance. In lymphatic tuberculosis, we usually find that the victim has been a sufferer from catarrh of the mucous membranes and diseased tonsils, in consequence of which the local resistance is lowered, and the bacilli to which all are exposed are enabled to grow and are taken up by the lymphatics and passed into the glands. We see the same process in tuberculous mesenteric glands associated with catarrh of the bowel, and the tuberculous adenitis of the bronchial glands as a result of whooping cough and measles.

A case in point I quote from Marcelli: "On the right side of the throat of a young girl, there was found a chain of glands, among which there was an especially large one in front of the sterno-cleido-mastoid muscle. Pectoral organs healthy; no T. B's. in sputum. Right tonsil hypertrophied; small pieces of the tonsil were removed, and on microscopic examination were found to contain sparse but unmistakable tuberculous bacilli under the epithelial layer, especially of the crypts and also in the parenchyma (*Arch. Ital. di Laringol, Marcelli*)."

As Hudson-Maknen puts it, "We have all seen tuberculous glands of the neck appear and reappear in spite of repeated operations, until the focus of infection, viz., a diseased faucial tonsil has been found and removed, and I have no hesitation in saying that if these diseased faucial tonsils were found (I say found, because as a rule they are submerged) and removed at the proper time, tuberculous and otherwise infected glands of the neck would soon be in a great measure a thing of the past, and many cases of apical and other regional tuberculosis of the lungs would undoubtedly be nipped in the bud."

For a long time clinicians have noted the fact that acute articular rheumatism often follows an attack of tonsillar angina. Are the diseased tonsils a port of entrance for the virus? This is a

question which is at the present time arousing great interest, and it is certainly one of the utmost importance. Its answer involves the etiology of rheumatic fever.

The discovery of a specific pathological agent in acute articular rheumatism has as yet not been definitely decided.

Many organisms have been described: a special bacillus by Achalmé, forms of streptococci, Wassermann's diplococcus, called the micrococcus rheumaticus, and which has been isolated from the throat and joints and exudates in cases of rheumatic fever, and which Poynton and others have injected into rabbits, producing endocarditis and arthritis.

Cole, on the other hand, produced these same results with strains of streptococci. Clinically acute rheumatism presents many of the features of a septic infection, the character of the fever, mode of involvement of the joints, tendency to relapse, the sweats, the anemia, the leucocytosis and liability to endocarditis and involvement of the serous membranes.

The benign character of the joint inflammation in acute rheumatism, no pus formation, suggests that the organism producing the disease is an attenuated streptococcus. I think that the consensus of opinion at the present time is that the disease is due to a bacterial affection, even though its absolute proof is not yet at hand.

In view of these pathological findings and the clinical characters above enumerated, are we not justified in saying that diseased tonsils are a port of entrance of the bacteria, not the only port, but one of the ports.

The removal of the diseased tissues and clearing up the pharyngeal cavity, with the cessation of the rheumatism, would be the proof of the pudding.

I lately have had under notice a young lady of twenty-three years of age, who rarely went two or three months free from tonsillar affection and attacks of subacute rheumatism. This had been going on for years. About one year ago her tonsils were enucleated, they were somewhat of the submerged type, and a few drops of pus were squeezed from them. Since this clearing out she has been absolutely free of her rheumatic symptoms.

Another case of extreme interest which I have lately seen was that of a man of forty-six years of age, who had suffered a great deal from subacute rheumatism, and under my observation had had two previous attacks of quinsy, both of which were of long duration. This winter he again had a suppurative tonsillitis, the suppuration also being peritonsillar, and the organism found

being the streptococcus. The abscess was lanced and pus discharged freely, a day or two later erythema nodosum appeared on the legs and several of these nodes suppurated and large abscesses formed.

This streptococcus infection by way of the tonsil produced rheumatic manifestations, and yet the virus could not be called attenuated, in view of the pyemic manifestations. I had never before seen suppuration take place in erythema nodosum, nor had I ever seen general abscess formation from quinsy.

I have only spoken of these two systemic diseases, tuberculosis and rheumatism, but many others have been attributed to tonsillar infection, e.g., measles, scarlet fever, whooping cough, endocarditis, myocarditis, pericarditis, nephritis, appendicitis, chorea and pleurisy.

THE DISORDER OF MEDICAL CHARITY.*

BY LAURISTON E. SHAW, M.D. (LOND.), F.R.C.P. (LOND),
Physician to and Lecturer on Medicine at Guy's Hospital, London,
England.

Introducing his subject, Dr. Shaw prefaced his remarks by saying that he was not going to deal with internal medical charity, which he defined as the charity one member of the profession might extend to another or to his brethren as a whole, that charity that might be the outcome of medical men getting together in society work and association. Personal intercourse promotes brotherly feelings.

Collective internal medical charity he defined as the arrangements made by medical men themselves to deal with themselves those cases where sickness or early death throws members or their dependents upon the charity of the community at large. In this respect the profession of medicine should be self-supporting. To do it requires an organization where contributions could be collected from all members of the profession proportionate to their means. But such a provident system should be reserved for those who had previously shown prudence, regard for others and respect for the profession itself. Some such scheme seems a necessity to uphold the dignity of the profession.

External medical charity Dr. Shaw divides into individual and collective classes. The address principally deals with collective external charity, after a word was said about individual external charity. Of the latter everyone is cognizant. All over the world there are numerous evidences of this, and upon this the profession has often felicitated itself. And this has not always been confined to the bald, mere act of medical charity—it has been extended in such full measure as individual means will allow. If a physician in the practice of his calling dispenses his medical charity and goes further and puts his hand in his pocket and helps to a morsel of bread, that is a matter of each man's individual conscience and

*Digest of address delivered before the Stratford Division of the British Medical Association and published in *The Lancet*, Dec. 24th, 1910.

compassion. In this the medical man is as liable to do harm to charitable enterprise, just as the lay dispenser of charity. If in his own particular field the medical man restricts his charity to that field it may be a safe practice; but often other cases are brought to his notice beyond his own immediate environment. Then he is quite likely to get a "Kingdom comer," until death do them part. He who brings to the doctor this class of patient is a vicarious philanthropist; and medical men very often complacently comply. Dr. Shaw cites a good instance where a medical friend told him it was his custom when approached in this manner to send a small donation to the would-be philanthropist that it might be used to secure for the patient paid medical advice, observing that where the medical man was paid for his trouble the patient would benefit better thereby—(some wiseacres will deny this). Then the medical man is generally neither too flush with money nor too flush with generosity of this character to contribute to the fee of another practitioner. Promiscuous private charity, like promiscuous public charity, is fruitful in causing failure of suitable provident schemes whereby the really poor, whom we have ever with us, may be benefited.

Collective external medical charity is of greater moment to the medical profession, because as the volume increases the greater the harm. This sadly needs reform. Towards that reform there must be concerted action. It is widespread and apparent and needs no special commission to enquire into its extent and its whereabouts.

That the mere excess of the volume of medical charity is a splendid tribute to the qualities of heart of those responsible for it there is no gainsaying. In this our heads are controlled by our hearts; and in the face of individual suffering there is no help for it. But it is just because of this that in our cooler and saner moments we should give consideration to the ultimate results of our actions. The administration of medical charity, however, should be made more orderly, but to do this it is necessary to recognize the limitations of a civilized community. The impulsive philanthropist must be educated to take a wider view and be led to consider possibilities of prevention rather than cure of disease.

But is the imperative call of suffering and impending death the sole cause of the excessive supply of medical charity? Not by any means. Medical charity is cheap, and more of it can be purchased for a given sum compared with other charities. This is fully exemplified in the endowing of a bed in a charitable institution which will carry with it for all time both physician's and

surgeon's attention, as well as that of house surgeon and physician, sisters, nurses, attendants, laboratory workers, etc. When a bed is so endowed does not the philanthropist lay out his money to good advantage? The question is not why is such cheap charity so largely bought, but why is it so cheap to buy? Why can every philanthropist who thinks of building a hospital or founding a dispensary be confident that he can secure unlimited medical service free of cost?

Is it because the members of the medical profession possess a spirit of self-sacrifice and devotion to the cause of suffering humanity even greater and above that of their fellow-citizens? The orators at functions of medical men and others repeatedly assert this, and no medical man ever takes it upon himself to deny it. All sit with composure and gulp the compliment. This is not enough; some more satisfactory explanation must be found. The motives which lead medical men to give their services so freely to charitable institutions are "experience, advertisement, and honor." Here is something to gain which may be set over against the injustice of medical charities being run at the expense of the medical men who work them. Thus is afforded to a small section of the profession experience, advertisement and honor—the chief cause of the cheapness of medical charity. Thus is created a small, privileged class of the profession, and it is for the profession as a whole and the public to determine how it is really for the general advantage. Anything like a ring or corner in medical experience cannot be for the common good. In the public interest arrangements should certainly be made for the privileged class freely to share their experience with their less favored brethren by securing constant co-operation between the staffs of hospitals and the practitioners engaged in private practice amongst the neighboring population.

In commercial life advertisement is ultimately paid for by the consumer. In medical life—advertisement by charitable medical practice—the first cost is borne not by the advertiser but by his less prosperous colleagues, to whose possible patients he gives free service. In this way is vicariously paid by the general practitioner large amounts for the consultant's advertisement. It is probable that in the long run the public pays the profession as a whole for the advertisement. The general public and the main body of the profession are justified in looking askance at an arrangement which is largely responsible for the flood of medical charity.

Then there is the failure of medical charity to restrict its bene-

fits to the proper recipients, a difficult matter in itself. There is so much of it and its operations lack co-ordination. The selection, too, of its beneficiaries is unsatisfactory.

The writer then turns his attention to possible remedies. Some advocate ending rather than mending. Some suggest, as others have done before, an organization at public cost to orderly and efficiently effect all that medical charity now does, and then collective medical charity will gradually disappear. The State system of charity schools for elementary education is cited as a precedent for this. Government is tending to pass from the hands of the classes, who have hitherto exploited medical charity, into the hands of the masses, who have received the benefits therefrom; and the latter are quite cognizant of the motto, "It is more blessed to give than to receive."

But there seem to be two outstanding features of any proposed arrangement or organization which would meet with general acceptance: No interference with any State scheme for dealing with the treatment of the immediate poor; the recognition of the splendid results of the past arising from the partnership of medical charity, medical education and medical research. A continuance of this association must be fostered. The established custom of referring a patient to a specialist or calling in a consultant is universal, and here is the role for medical charity. Whilst it provides the help corresponding to the consultant or second practitioner, the latter should refuse in any case to deal at first hand with patients, but freely offering assistance to those who, in the usual way of private practice, by some provident system, or through the State, have secured the services of a medical attendant to deal with ordinary ailments, and are found by him to require and to be unable to pay for further assistance.

If, in following out these essential features, what opportunities would medical charities have for medical education and medical research? Some such arrangement as this would provide for "experience," which would be always shared with the general practitioner; for "advertisement" more valuable to himself and less costly to his unprivileged professional colleagues; for "honor" unalloyed by any feeling that he was dealing shabbily with his less fortunate brethren. The trivialities of out-patient practice would thus be relegated to general practitioners, who would receive proper remuneration for their work; but the student would thereby receive less opportunity for instruction therein, as most medical schools do not put much stress on the teaching of trivialities, which, however,

could be gotten in a provident dispensary or similar institution. The out-patient section of the hospital would then fulfil its true function of the "poor man's consultant."

But the great force, which Dr. Shaw feels confident, will in the end direct medical charity into this defined but effective field of activity, is the public spirit of the medical men responsible for the work. Men who possess the extraordinary advantages conferred on them by hospital appointments will not much longer tolerate the continuance of a system which bring them "experience, advertisement and honor," at such a heavy cost to their less fortunate colleagues, which hopelessly blocks the way to numerous urgently needed reforms in the medical treatment of the sick poor.

Medicine

GRAHAM CHAMBERS, R. J. DWYER, GOLDWIN HOWLAND,
GEO. W. ROSS, WM. D. YOUNG.

Enteroptosis In Children. BY WILLIAM J. BUTLER, CHICAGO.
Journal A. M. A., December 31.

The "habitus enteroptoticus" is described as a condition which is regarded as a congenital and hereditary anomaly by those who have specially written on the subject. While this condition is more frequently seen in females it is often seen in males. The individuals are slender, of frail bony structure, thin musculature, and have little adipose tissue. The chest is long and narrow with small upper and lower apertures. Occasionally it is broad but shallow. The lower ribs are more or less vertical in direction and the epigastric angle is narrow. A floating tenth rib is rare. The abdomen is usually flat, with occasionally slight bulging below the umbilicus, while sometimes the lower part of the abdomen may be very prominent. He takes up and describes the body form in infants and says that in the first months of life of a healthy breast-fed infant we rarely see any suggestion of the enteroptotic habit. On the other hand in frail infants, suffering from various diseases of malnutrition, we often see many of its characteristics. If it could be found that the habitus enteroptoticus had its origin in periods of malnutrition it would be an important matter for the etiology, but this has not been established. He has examined from 300 to 400 children, the majority of them healthy, and gives the results. Fully 50 per cent. of all children have a movable tenth rib. In late childhood, however, at the approach of puberty, fully one-third of the females and about one-sixth of the males exhibit the characteristic habitus enteroptoticus. While no one sign can be depended on in children, he is convinced from his observation that evidences of the enteroptotic habit are observable throughout childhood, but in "a more pronounced form in a late childhood, approaching and in the period of puberty. In the first days of life palpable kidneys and liver are not to be regarded as signs of enteroptosis, as these findings are common at this period of life. Beyond the first year and up to late childhood palpable kidneys and dis-

placed stomachs are exceptional, although signs of this habitus are evident in some of the children examined. On the other hand, coinciding with the development of the adult type of this habitus, with the approach and in the period of puberty, the displacement of the abdominal viscera become less exceptional; in fact, the actual ptoses, I believe, are practically first seen at this time."

Hematemesis. SIR DYCE DUCKWORTH (*The Lancet*, Oct. 29, 1910).

Abstract in *Medical Times*.

Sir Dyce remarks that many observers hold the view that in many patients there is no true ulceration present, but a series of small fissures, or chaps, from which blood oozes freely. With regard to a fatal issue in all cases by hemorrhage, he says that this is happily not a common occurrence. Whatever the lesion, the treatment of the patient is the same, and it consists in absolute rest, recumbency with head low, and morphine given hypodermically. Nothing whatever is to be given by the mouth, not even ice water or pieces of ice. Saline solution, in half-pint quantities, should be given by bowel, and nutrient enemata consisting of from eight to ten ounces of peptonized milk, with yolk of egg and grape sugar, repeated three or four times each day for three days. The mouth should be cleansed with borax, thymol and warm water several times a day. The next grave matter which it is well to bear in mind is the liability of perforation, with alarming symptoms of pain and collapse, calling for immediate surgical action. Milk and lime water and cream are the safest for the first feeding by mouth. An ice bag may be kept on the epigastrium as long as bleeding remains active. As to medical treatment, subnitrate of bismuth and calcined magnesia are the best agents, twenty grains of each after a few days when the bleeding is stopped. The stools should be watched for melena. Calcium lactate and adrenalin have both been suggested, but the author believes that we may dispense with any of these drugs if we carry out the physiological principles. Gastroenterostomy should be performed in cases where ulceration is found near the pyloric orifice on opening the stomach, for this condition may lead to dilatation and other difficulties. Hematemesis depending on advanced cirrhosis of the liver is always a serious and often a terminal symptom in such subjects. The bleeding is sometimes enormous, and should be treated along the same lines. Patients suffering from gastric hemorrhage are always likely to do best in hospitals, for here they have skilled watching.

Skin Inunction. BY LAWRENCE F. FLICK. *Monthly Cyclopedia.*

Abstract in *Cleveland Med. Jour.*

Dr. Flick considers skin inunction as a therapeutic measure. The skin has the power of absorption, not as one of its chief functions, but secondarily and for protective purposes. The disease in which medication by skin inunction has received most general recognition is syphilis, but for 20 years he has used the inunction method in the treatment of tuberculosis and his experience with it has been most satisfactory. He has applied iodine in this way: he first used iodoform dissolved in cod liver oil and olive oil by inunction and the result seemed better than any he had obtained by any other medication given in any way. Incipient cases of tuberculosis seemed to recover in a relatively short time, so short indeed that one got the impression that recovery depended on the inunctions. The one serious objection, however, was the odor, and a few years later when cresoliodide was put upon the market he found it a very satisfactory substitute for iodoform in effect, with the advantage of freedom from odor. He has since then used it in inunction as a routine treatment in all cases of tuberculosis, and like iodoform it gives striking results. While difficult to demonstrate that these results are due to the iodine, he is convinced, after a long experience with iodine inunction in tuberculosis, that it is a valuable method of treatment. Other forms of iodine than cresoliodide and iodoform can be used for inunction. Iodized oil which is much cheaper than solution of cresoliodide gives satisfaction, but does not seem to him to be as useful as the latter. Most iodine compounds are soluble in cod liver oil and olive oil in the proportion of about one dram to two and one-half ounces. In essential oils, such as oil of anise, oil of gaultheria and the like, they are soluble in the proportion of one dram to two ounces. They have about the same solubility in hydrous wool-fat. In prescribing preparations of this kind an effort should be made as far as possible to make them agreeable and pleasant to the sense of smell. He uses oil of anise and oil of gaultheria in his prescriptions, and thinks it possible that these may have a medicinal influence. In recent years he has extended his inunction treatment with marked benefit to the pharynx in those cases in which there is a chronic granular pharyngitis. In tuberculosis this unhealthy condition of the lymphatic tissue of the pharynx and postnasal space, apparently due to a mixed infection of some character, occurs quite often. It is a great source of annoyance to the patient and appears to be an impediment to recovery. It is a troublesome condition which does not readily

yield to treatment. He has found inunction of these parts, especially around the tonsils, with a saturated solution of cresol-iodide in equal parts of oil of anise and oil of gaultheria the most effective treatment. He applies it on a little cotton, rubbing it in vigorously.

Ophthalmology

D. N. MACLENNAN, W. H. LOWRY.

The Fitting of Glasses by the General Practitioner. By EMERSON W. AYERS. *Medical Times*, Dec., 1910.

The author says, in relation to the relief of eye-strain: "No one thinks of applying to a mechanic for the relief of a club foot; and why should the application of lenses to a defective eye be turned over to a mechanic, who has no notion whatever of the structure and operation of the eye, in either health or disease? A large number of the people in the rural districts find the visit to an oculist, who resides in the city, an utter impossibility. They cannot afford either the time or the expense of a trip to the city, the smallest part of which is often the fee of the oculist. This class of people need the assistance to be derived from glasses just as much as those better favored, either in means or environment. They look in vain to the medical man of their acquaintance for help, and they will purchase glasses from whomsoever offers them for sale. The jeweler has seen what looks to him a legitimate commercial opportunity, which he has not been slow to improve. This has turned a profitable part of the legitimate practice of medicine into other channels. The doctor misses what is rightfully his, and the visual organs of the people are being tinkered by pretenders, to the great damage of the vision of the victims.

The people must and will have glasses, and not being able to procure them from legitimate sources, they get them where they can. Let this be made emphatic. If the medical profession fails in any particular to supply what is needed by the public, that thing will be procured by the public from some other source, to the shame and disgrace of the doctor.

I see but one remedy. That is for the general practitioner to qualify himself for the correction of errors of refraction. He can serve the people in his locality, in this department of practice, as well as in others. When he finds a case of serious disease, requiring operation, or skilled treatment, he can refer it to a man who has had experience in that line. The time has gone by when a general

practitioner can claim any standing or credit among his people by denying all knowledge of the eye. He is expected to know.

W. H. L.

An Ophthalmological Phase of the Dangers of Consanguineous Marriages. By POSEY and SAUTER. *Ophthalmic Record*, Sept., 1909.

Statistics show that at least four per cent. of the blind and deaf, and seven per cent. of all idiots are the children of consanguineous parentage, and that these defects are transmitted through many generations. In view of these facts the authors emphatically condemn the marriage of cousins.

W. H. L.

Symptoms of Intoxication After the Use of Atropine in Children's Eyes. By ELSNER. *Review, Archives of Ophthalmology*, Sept., 1910.

The author observed toxic symptoms after instillation of a one-half per cent. solution of atropine into the eyes of several children, and traced them to the hyoscyamine, which was mixed with the drug. Care should be taken to use only atropine that is free from the more poisonous hyoscyamine.

W. H. L.

A Note on Alypin. By R. H. ELLIOTT. *Ophthalmoscope*, 1909.

Major Elliott, working at Madras, gave alypin a trial upon a day when nineteen extractions were to be performed. A two per cent. solution was given, five instillations being used, at intervals of five minutes. Alypin proved most unsatisfactory, the patients felt severe pain, and there was unusual hemorrhage. The drug dilated the pupil, but not so much as cocaine. For pterygial operations, alypin seemed more suitable, complete anesthesia being maintained, but hemorrhage was more troublesome than with cocaine. Adrenalin was used with each drug. The author sees no reason to use alypin instead of cocaine.

W. H. L.

Gynecology

F. W. MARLOW, W. B. HENDRY.

Backache. By DR. EDWARD REYNOLDS and DR. ROBERT W. LOVETT, of Boston. *Journal of the American Medical Association.*

The paper is the outcome of an experimental study of certain phases of chronic backache. To appreciate its full value it would need to be carefully studied in its entirety.

The term "static backache" is introduced, and evidently wisely so, to indicate a large class, for which no other explanation can be given than that they persist as the result of muscular and ligamentous strain in the dorsal region, owing to abnormal attitudes of body or other static defects.

It is pointed out that such defects may arise de novo, or may be the result of attitudes assumed in the presence of various visceral diseases, affecting especially the abdomen or pelvis. Relief of such conditions by appropriate means will often cause the backache to disappear, though at times it will be necessary to give attention to the correction of the abnormal static condition.

In the main, the conditions described have the effect of displacing the centre of gravity of the body forward, and such displacement results in a more or less continuous effort on the part of the dorsal muscles to maintain equilibrium.

As the result of numerous experiments, the authors have arrived at what appears on careful study to be a simple and satisfactory method of locating the centre of gravity of the body and of making tracings of various attitudes as they exist, or as affected by various procedures. Their findings show a close correspondence to the results of clinical observations.

As to the location of the centre of gravity, they find that in the erect position of the body it lies in front of the ankle, knee, sacroiliac and most of the vertebral joints. Its exact relation to the hip joint has not been accurately determined on account of the difficulty of exactly locating the acetabulum in the living individual. From experiments on the cadaver, they conclude that the centre of gravity is anterior to the hip joints, and so in the erect position the trunk is held extended on the legs by the combined and continued

action of the posterior musculature, the chief factors being the hamstrings, the glutei and the erector spinæ muscles. Any condition displacing the centre of gravity forwards would necessarily increase the strain on those muscles.

The authors concluded that under such exaggerated conditions the displacement backwards of the centre of gravity would bring about relief. Corsets of various kinds were experimented with, and it was found that various kinds produced different effects. "Neutral" corsets had practically no effect. "Bad" corsets had the effect of displacing the centre of gravity backwards, but as the hips were carried much further back than the shoulders, the result was detrimental. "Good" corsets displaced the centre of gravity backwards, by carrying the shoulders and hips back to an equal degree, thereby giving tracings resembling the normal, and in cases where properly fitted and adjusted were effective in the relief of backache.

The features of "bad" and "good" corsets are described in the paper. As the paper is practically limited to a discussion of the effect of corsets on the centre of gravity, other means of affecting the position of that centre are not discussed, except for a brief reference to the effect of high heeled shoes, which, by tilting the whole body backwards by their action on the ankle joints, not infrequently give relief to backache.

There can be no doubt that backache as a symptom should receive much more careful investigation from the profession than it ordinarily does.—Ed.

F. W. M.

Genito-Urinary Surgery

T. B. RICHARDSON, W. WARNER JONES.

When to Operate For Enlarged Prostate, With a Review of Six Hundred Cases of Total Enucleation of That Organ.

By P. JOHNSTON FREYER, M.D., of London, England. *Journal of Dermatology and Genito-Urinary Diseases.*

In the September issue of the above mentioned Journal an article with the above title appears from the pen of the eminent surgeon, Johnston Freyer, in which he reviews his results, during the past eight years, after total Enucleation of the Prostate. He first proceeds to answer the question, "At what period in the history of this disease is it advisable to have recourse to surgical operative interference?" but before so doing he proceeds to take into account the following considerations: (1) The specific symptoms dependent on the prostatic enlargement from which at the time the patient is suffering. (2) The nature, size and general conformation of the prostatic growth.

Patients suffering from prostatic symptoms will be found when they apply for surgical relief to come under one or other of the following types:

(1) Patients suffering the usual symptoms of prostatic enlargement in the earlier stages of the malady, in whom on examination not more than an ounce or two of residual urine is found on introducing a catheter.

(2) Those who have probably suffered from prostatic symptoms for several years, in whom we detect a quantity of residual urine varying from three to ten ounces, or even more, but who have never employed a catheter for the purpose of emptying the bladder.

(3) Patients suffering from over-distension of the bladder, with extreme frequency of micturition, possibly continuous dribbling of urine, particularly at night time when asleep, but who have never been relieved by a catheter.

(4) Those cases in which the conditions described in paragraph three have culminated recently in complete retention of urine, and in whom great difficulty is experienced in introducing a catheter.

(5) Patients who from time to time have had retention of urine, which was relieved by the catheter, but who have not employed this instrument as a routine practice to empty the bladder daily.

(6) Patients who for weeks, months, or even years, have employed the catheter daily, once, twice or oftener for emptying the bladder, but who still retain the power of passing a certain quantity of urine naturally.

(7) Those entirely dependent on the catheter for emptying the bladder. In the advanced stages of the disease patients of this type rarely escape from recurrent attacks of one or more of the following complications, viz., cystitis, pyelitis, hemorrhage, vesical calculus, recurrent attacks of fever with rigors, and difficulty in introducing the catheter.

In the first of these types it will, as a rule, be unnecessary and inadvisable to attempt the removal of the prostate: because in the first place the symptoms will probably not be sufficiently irksome to warrant such an operation, and, secondly, the enlargement of the organ will not have sufficiently advanced to render it prominent in the bladder, or to define adequately the lines of cleavage between the true capsule and the enveloping sheath. But in one and all of the other types the removal of the prostate should be entertained and advocated if, on examination, it presents those characteristics—to be presently described—that render its enucleation entire in its capsule practicable, there being no condition of the general health of the patient to negative an operation of this magnitude.

Freyer says: "I cannot too strongly urge early removal of the prostate when there is decided enlargement of this organ, giving rise to urgent symptoms necessitating the employment of the catheter, before grave complications supervene. When undertaken whilst the patient's general health is sound and the kidneys are unaffected there is practically no danger attaching to the operation in experienced hands. But when once complications set in, and particularly when the kidneys become diseased, whether through backward pressure of the urine on these organs or from extension upward of inflammation from the bladder, the operation must necessarily be attended by considerable risk.

Another grave danger attached to postponement of operation is this, that recent experience has demonstrated beyond doubt that the adenomatosly enlarged prostate, which is, of course, a benign growth, has a tendency to assume a cancerous type under the irritating influence of the catheter and complications incidental to catheter life."

In order to ascertain whether the prostate is capable of being enucleated entire in its capsule, the patient, if capable of passing

any urine naturally, is directed to empty his bladder as far as possible, and is then placed on a couch in the recumbent position. The bladder is then emptied of its residual urine by means of a catheter. The forefinger of one hand, previously lubricated, is slowly introduced into the rectum, and when the sphincter ani is thoroughly relaxed, a survey of the rectal aspect of the prostate is made. If the organ is found to be decidedly enlarged, presenting a well marked tumor in the rectum, more or less rounded in shape, bilobed laterally, with a well marked furrow in the median line, smooth on the surface, soft or somewhat dense to the touch, and (most important of all) movable, you know that you have to deal with the ordinary adenomatous enlargement of the gland of advanced life. If, in addition, from its prominence in the rectum you estimate the tumor to be at least of the size of a Tangerine orange, the case may be regarded as in all probability one in which the prostate is capable of being enucleated entire.

Freyer next suggests a bimanual examination of the prostate. By placing the fingers of the other hand on the hypogastrium and pressing them well down behind the pubic arch, directing the patient to relax the muscles, and at the same time making circular pressure with the finger in the rectum, if the prostate is decidedly enlarged it will be felt between the fingers of the two hands and can be slightly moved upwards and downwards or from side to side, like a chronically enlarged uterus, but to a less extent. In thin subjects this method of examination is easily accomplished, but is less satisfactory in stout subjects. Where the prostate can be readily made out by this method one may at once pronounce the case to be one in which the organ can be enucleated entire in its capsule, no matter what magnitude it may have attained. Prostates weighing from two to six ounces are those most easily and rapidly enucleated.

Contrasting the characteristics of the adenomatically enlarged prostate with those of cancer of that organ he makes the following observations. In cancer there are:

- a. Intense hardness.
- b. Outline irregular and median groove obliterated.
- c. The organ presents a nodular surface.
- d. The prostate will be immovably fixed in the pelvis, owing to the invasion by the growth of adjacent tissues.
- e. Invasion of glands—enlargement—of the inguinal group (in advanced stages), and the presence of small, hard, sago-like grains, felt per rectum, covering the surface of the growth beneath the rectal mucous membrane (in earlier stages).

f. Rapid development of prostatic symptoms, and typical cancerous cachexia.

In the entire series of 600 cases there were 37 deaths, in periods ranging from 6 hours to 37 days after the operation, or a mortality of 6.15 per cent. The causes of death were: Uremic symptoms due to chronic kidney disease, 16; heart failure, 6; septicemia, 2; shock, 3; exhaustion (kidneys much diseased), 1; mania, 2; malignant disease of liver, 2; heat stroke, 1; pneumonia, 1; acute bronchitis, 1; pulmonary embolism, 1; cerebral hemorrhage with paralysis, 1.

Though all these deaths are accepted in connection with the operation, in not more than half the number can the fatal result be attributed thereto, the remaining deaths being due to disease incident to old age and unconnected with the operation. In 108 cases vesical calculi were removed at the same time.

In the successful cases there was complete restoration of bladder control, no relapse of the symptoms, and no diminution in the sexual power after the operation.

T. B. R.

Anesthetics

SAMUEL JOHNSTON, M.A., M.D.

Concerning General Rachianesthesia. PROFESSOR THOMAS JONNESCO, Bucharest. *American Journal of Surgery.*

In reply to an editorial in *The American Journal of Surgery*, January, 1910, entitled "Jonnesco's Contribution to Spinal Anesthesia," Professor Jonnesco calls attention in the February number of the same journal to some points he wants emphasized.

He says that his method should not be confused with lumbar rachianesthesia, conceived by Corning and popularized by Bier. He claims his method to be new and distinctive, because he has generalized spinal anesthesia, adapting it to *all operations, on any part of the body.*

He secures the anesthesia by piercing the spinal column at all levels and by adding strychnine to the anesthetic—stovaine, novocaine, tropococaine, etc., and emphatically denies Corning's right to be called the inventor, as the difference in the two methods will not allow comparison. He objects to the editorial being written with reference to only four cases injected at Mount Sinai Hospital, New York, while nothing is said of twenty-three cases demonstrated in various cities of the United States.

Of these four cases, one patient operated on for tumor of the breast experienced pain, and that, therefore, the anesthetic was not complete. He claims that this patient did not feel pain, for he made no resistance either with upper or lower limbs, the upper being paralyzed, he claims, proving anesthesia.

(Query.—Does paralysis of the motor nerves mean also complete paralysis of the sensory?)

He attributes this complaint of pain to the mental impression made upon the patient. He also performed two superior spinal tappings without result, which he says very rarely happens. If it had been his own clinic he would have tried it again, but he did not do it in these cases, as he did not deem it right to prolong a demonstration that was conclusive from three others. The method, to be successful, must be practised regularly to learn the technique and to acquire the skill in manipulation and ability to employ proper doses, according to patient's age and constitution.

He claims that by this method the respiratory nerves are not involved, although all the other nerves of that spinal region are paralyzed, and this is due, he thinks, to the influence of the strychnine.

The injection of stovaine alone in the superior dorsal region stops respiration, even with small doses.

His theory is that, the mixture containing strychnine when injected, the strychnine has a selective power, acting first on the respiratory and cardiac nerves, as well as upon the centres.

These nerves being stimulated by the strychnine, are no longer influenced by the stovaine or other anesthetic.

Recent Progress In Anesthesia. By JAMES TAYLOR GWATHMEY. *The Medical Record.*

After defining what he considered "recent progress," Dr. Gwathmey goes on to say that the basis of his work is founded on the theory of narcosis, formulated by Professor Hans Meyer, of the University of Vienna, which he quotes as follows:

"The narcotizing substances enter into a loose physicochemical combination with the vitally important lépoids of the cell, perhaps with the lecithin, and in so doing change their relationship to the other cell constituents, through which an inhibition of the entire cell mechanism results, and the narcosis immediately disappears as soon as the loose, reversible, combination dependent on the solution tension breaks up. Further, substances chemically absolutely indifferent, as the volatile saturated hydrocarbons, can act as narcotics."

In experimenting on animals he found, as a result, that oxygen increases the value of all anesthetics as regards life, without decreasing their anesthetic effect.

Again, he found that it took just twice as long to kill with the warm anesthetic as with the cold. Warm chloroform and oxygen are safer than ether and air, although the safety of all anesthetics is proportionately increased by the addition of oxygen and by warming. Heat is also indicated to assist in more rapid recovery after the anesthetic and to prevent nausea and vomiting.

Electrical Sleep:—Electrical anesthesia has not been practical for clinical use, but it may be employed, by means of the Leduc apparatus, in the laboratory instead of chloroform and ether. The sequestration method of Dawborn is described. According to this method, the patient is thoroughly anesthetised, after which the thighs are corded, thus cutting off this amount of blood from the brain. The patient is placed in a sitting posture, and only a very small amount of the anesthetic need be given from time to time. In fifteen minutes from the commencement of the anesthesia, the cords are gradually loosened. This method is used in operations on

the head and neck, but is contraindicated in patients with a weak heart.

Dr. Gwathmey speaks of Anesthetic Shock, which he maintains occurs in fifty per cent. of surgical cases, either before they reach the table, during the induction period of the administration, or afterwards from an overdose of the anesthetic.

In the first two instances the psychic element predominates to such an extent that patients have died from fright even before any anesthetic is given.

This serves to show that patients need preliminary treatment, both mental and medical, to eliminate this psychic element.

Medication should consist of morphine alone, morphine and hyoscine, morphine and chloretone, or an enema of one ounce of whisky and seven ounces of saline solution.

Children, old persons, the insane, the feeble-minded, obstetrical patients, and individuals in a state of coma, should not be so treated.

For the administration of morphine, the following rules should be observed:

(1) When given, it should be given before, instead of after the operation.

(2) All athletes and alcoholics should have this preliminary dose of morphine.

(3) The very old, and the very young, if morphine is given at all, should be administered with great care.

(4) Whenever morphine is administered, a lighter narcosis should be maintained than when this drug is not employed.

Ninety per cent. of fatalities occur in the early stages of anesthesia with men in robust health. In the light of these statistics, it is almost criminal to place an alcoholic or an athlete on the table without endeavoring to eliminate the element of fear, by the use of small physiological doses of morphine.

With this use of morphine vomiting is prevented, the patient takes more kindly to the anesthetic, on account of the whole nervous system being obtunded, the kidneys and lungs have been saved unnecessary irritation by reducing the amount of the pulmonary anesthetic, and finally the anesthetist is able to discontinue the anesthetic much earlier.

One or two quarts of normal saline solution per rectum lessens the thirst which comes from the morphine, assists the kidneys, and brings the patient out in a better condition than when neglected.

For a sedative, an enema of one ounce of brandy, and seven ounces of saline solution is better than a repeated dose of morphine.

Morphine is also strongly indicated before local anesthesia, and spinal analgesia, as it is in a certain measure an antidote to cocaine and allied drugs.

Atropine may be used as a preliminary when chloroform or ethyl chloride is to be used, as it maintains respiration and prevents profuse salivation, nausea, vomiting.

The latest and best development in pulmonary anesthetics is the use of oxygen and nitrous oxide gas, supplemented, if necessary, by small amounts of ether and chloroform.

There are several apparatus in the market for this administration. It has been found that eighty per cent. of all surgical cases can be anesthetised by this combination.

Rectal Anesthesia:—After much experimenting with this method of narcosis, Dr. Walter A. Sutton, of Kansas City, perfected a system when he was interne in Roosevelt Hospital. The essential points are: (1) A mercurial manometer to prevent too great pressure within the colon, (2) A generator for the accurate admixture of oxygen and ether, (3) Two separate tubes, one for conveying the vapor into the colon, and one for withdrawing excess vapor, and also for trapping excreta. The whole apparatus is so arranged that it is controlled by the anesthetist, who sits at the head of the table.

Definite intestinal lesions are said to be the only contra-indication to this method.

The bowel is cleansed by a castor oil purgative at night, followed in the morning by 3 or 4 high soap enemata, given one and a half hours apart, until the fluid from the rectum returns clear.

Spinal Analgesia:—This method, although in use in selected cases, will never supplant pulmonary anesthetics.

By preliminary medication with morphine, nervousness, physical and psychical pain, nausea, headache, etc., are in a measure overcome. The points in its favor are, that the patient assists the operator by coughing when necessary, and that the service of an assistant may be dispensed with, which is particularly applicable in emergency, naval and military surgery.

With regard to the use of the ordinary anesthetics, chloroform is contraindicated as a preliminary anesthetic when the psychic element is present, then it should be given as a sequence to ether.

Ethyl chloride is particularly useful for alcoholics, athletes and the obese, although not so safe as nitrous oxide gas.

He pleads for special anesthetists to be attached to every hospital, and deplors the fact that internes and even nurses are allowed to administer anesthetics without being under the direction of experts.

THERAPEUTIC TIPS.

PARALYSIS AGITANS.

Berkeley (*Medical Record*) uses parathyroid nucleoprotein capsules of 1-50 of a grain each, giving two a day. It will also give good satisfaction in any form of tetany where the stomach can retain food. If not the remedy can be used in sterile hypodermic form.

PHIMOSIS IN CHILDREN.

Stuhl (*Deutsche med. Woch.*) describes a so-called bloodless operation, where no cutting instrument is used. Gradually the foreskin is pulled back over the glans at one or several sessions. When the meatus is exposed, adhesions are separated by a blunt sound. Paraphimosis is to be avoided by replacing the prepuce. From four to eight days are required for the treatment, a very narrow preputial orifice being gradually dilated. No narcosis is required. If frenulum is short it should be incised.

DOSAGE OF "606."

McIntosh and Fildes (*The Lancet*) inform us that Ehrlich in the earlier cases advised a dose of 0.3 gramme. It was found that this quantity was insufficient. The amount usually given now for an average adult is 0.6 gramme. More may be given without ill effects, but so far larger single doses appear to be unnecessary.

ANTERIOR POLIOMYELITIS.

Stern, Cleveland (*C. M. J.*), says the treatment of anterior poliomyelitis has undergone a complete change in the past two years. For the acute cases he employs absolute rest to the spine, preferably in a plaster bed; proscribes all counterirritants; general treatment same as for other acute infectious diseases. Right at the first splint carefully the paralyzed limbs to protect from injury and prevent deformity. The child should be kept in bed for a year at least and should not be allowed to walk when a partial recovery takes place. Massage and galvanic electricity are valuable in keeping up tone of muscles; faradic current from small batteries is useless, as the nerve shows the reaction of degeneration, and will, therefore, not respond to the faradic stimuli.

Reviews

The Physician's Visiting List, 1911. Philadelphia: P. Blakiston's Son & Co.

With the present issue "The Physician's Visiting List" enters upon the sixtieth year of its existence. Only those publications of decided merit outlive the generation with which they were born, and by far the larger number disappear after a few years of struggling existence.

During the life of this book medical science has made greater progress than during the preceding five hundred years.

It has been seen and used by the most famous of American physicians and investigators, as well as by thousands of others, whose names perhaps were never known beyond their own local scenes, but who, nevertheless, have done a large share toward the total sum of human happiness. It has made long journeys in the buggy or saddle bags of the country doctor. It has been at the birth and alongside the deathbed of rich and poor, famous and infamous alike. Its volumes hold the life records of numberless practitioners.

It is needless for the publishers to say that they take great pride in its stability; that they recognize in its success an appreciation of sixty years of effort on their part to provide a useful book, and that they realize the help and encouragement that has been given them by the profession for whom it is intended.

Canadian Almanac. 64th year of Publication. Toronto: The Copp-Clark Co.

The Canadian Almanac is such a well-known publication that scarcely any praise is needed in its favor. In it we see law lists and lists of clergy, and we would like very much to see incorporated a medical and dental directory of all Canada. Of great value to the medical profession now for the great mass of information it contains, it would be infinitely more so as well as to manufacturing concerns dealing with these two professions, if up-to-date medical and dental lists were included.

Syphilis. Special Number Interstate Medical Journal for January, 1911, Metropolitan Building, St. Louis, Mo.

Original Articles: Present Status of the "Noguchi Test," Hidego Noguchi, M.D., New York. On the Means of Finding the Spirocheta Pallida, with Special Reference to the India Ink Method (from the Laboratory Michael Reese Hospital), J. S. Cohn, M.D., Chicago. The History and Methods of Application of Ehrlich's Dioxy-diamido-arsenobenzol (from the Royal Institute for Experimental Therapeutics), Lewis Hart Marks, M.D., Frankfort, a/M. Recent Progress in the Treatment of Syphilis, H. Hallopeau, M.D., Paris. Treatment of Syphilis with Ehrlich-Hata "606," Abr. L. Wolbarst, M.D., New York. Syphilis of the Nervous System, Ernest Jones, M.D., Toronto. Syphilis and Pulmonary Tuberculosis, Robert H. Babcock, M.D., Chicago. Syphilis as a Cause of Pauperism, A. Ravogli, M.D., Cincinnati. Giant Cells in Syphilis, John A. Fordyce, M.D., New York. Personal Observations with the Ehrlich-Hata Remedy "606," B. C. Corbus, M.D., Chicago. Syphilis and the Public, Isadore Dyer, M.D., New Orleans. Sanitary Regulation of Prostitutes, Prince A. Morrow, M.D., New York. The Scaphoid Scapula Syndrome; Its Connection with Syphilis in the Ascendants, William W. Graves, M.D., St. Louis.

(Collective Abstracts (Critical Reviews of Recent Literature in Collective Form): Ehrlich-Hata "606," Wm. Engelbach, M.D., of the Editorial Staff. The Cerebrospinal Fluid in Syphilis and Parasyphilitic Diseases, S. Strouse, M.D., of the Editorial Staff. Serum Diagnosis of Syphilis, Carl Fisch, M.D., of the Editorial Staff. Diagnosis of the Osseous Lesions of Syphilis by the X-Ray, E. H. Skinner, M.D., Kansas City, Mo.

In addition to the above, the January number will present the usual features which have made the Journal so favorably known to the profession.

Subscriptions for 1911 will begin with the Special Syphilis Number, which will be issued early in January. The subscription price is \$2.00 per annum.

Diseases of the Pancreas. By EUGENE L. OPIE, M.D. Second Edition. Philadelphia, London and Montreal: J. B. Lippincott Co.

I have reviewed with much pleasure the new edition of Opie on the Pancreas.

The book is well arranged. There are numerous plates and diagrams, and the numerous photographs illustrating diseased conditions of the pancreas are excellent. The work is a splendid review of the literature on the pancreas, including both physiology and pathology.

The author's own work on acute and chronic pancreatitis and diabetes mellitus are of particular interest and should be read by every physician and surgeon.

W. W. J.

Syphilis. By SIR JONATHAN HUTCHINSON, F.R.S., LL.D., F.R.C.S., Consulting Surgeon to the London Hospital and to the Royal London Ophthalmic Hospital. New and enlarged edition, with many colored and black-and-white plates. 583 pages. 1909. \$3.25. London: Cassell & Co. Toronto: D. T. McAinsh & Co.

Although not saying the last word or even the latest pronouncement as regards treatment, the eminent standing of the author will ensure this book as a practical hand-book of syphilology. We commend it to general practitioners and students of medicine as a concise and accurate exposition of the subject.

A Manual of Chemistry. By ARTHUR P. LUFF, F.R.C.P., Physician to St. Mary's Hospital and Joint Lecturer on Medicine at St. Mary's Hospital Medical School, and HUGH C. H. CANDY, F.I.C., Lecturer on Chemistry in the London Hospital Medical College. New and enlarged edition. Illustrated. 622 pages. 1910. \$2.25. London: Cassell & Co. Toronto: D. T. McAinsh & Co.

An examination of this book proves that we can recommend it highly to medical students and others who wish to secure a good, practical knowledge of the subject. It is right up-to-date and exceedingly well set out. It will fill the bill as a practical working hand-book of any student of medicine.

The Mac's of '37: A Story of the Canadian Rebellion. By PRICE-BROWN, M.D., Toronto, Author of "In the Van," etc. Toronto: McLeod and Allen.

This is a story, as the title announces, of the stirring and troublous times of '37. Interest is better sustained in the latter than in the first part. The dialogue is rather jerky at times, but there is a good deal of matter throughout.

Dominion Medical Monthly

And Ontario Medical Journal

EDITED BY

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GEORGE ELLIOTT, MANAGING EDITOR

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TORONTO, JANUARY, 1911.

No. 1

COMMENT FROM MONTH TO MONTH.

Salvarsan—"606"—the name we take from "Current Comment" in the *Journal of the American Medical Association*—is to be marketed in the United States and Canada some time in January. There is evidently a wide-spread lay interest in this product, as evidenced in special articles in magazines and the public press. It is to be sincerely hoped that the marketing will be done through a very responsible house.

As quacks thrive upon the treatment of syphilis, skin diseases and genito-urinary diseases, they will be wise to this new production. Some have even already anticipated the treatment by "606" by exploiting something not "just as good," but far better, namely 1212.

The profession of medicine on this side the Atlantic Ocean should have some specific assurances from Professor Ehrlich that the remedy—to all accounts it now appears to be such—will not get into the hands of the laity except through the channels of regular medicine. The warning cannot, therefore, be too often or too strenuously sounded that the administration of Salvarsan is not unattended with danger, and especially so in inexperienced hands.

Through its Pharmacology Department the American Medical

Association seeks to safeguard the American profession as well as the afflicted themselves. From its examination by this body the chemical properties are scientifically fully set out, and those who propose its use should well qualify their knowledge in this direction. It is only by such means as this, along with its clinical usage, that its true therapeutic status may be determined.

Apparently there is every reason to state that its preparation for hypodermic administration should be supervised by trained laboratory men, and such being the case it will be wise on the part of the physician who may now be daily importuned to administer it to some anxious and fretful patient, to have it so administered under hospital auspices, and especially so if it is administered intravenously, which is said to be the better way.

Special examinations of the eyes, heart, liver, blood and urine are demanded, and it is said on competent authority that to those only who are organically sound, will its administration be free from danger.

Deaths From Tuberculosis In Ontario.—The educational campaign, the establishment of sanatoria, dispensaries, etc., seem to be having some material effect in staying, if not reducing, the ravages of tuberculosis in this province.

In the 39th annual report of the Registrar-General for the year ending 1908, the deaths from tuberculosis in that year numbered 2,511, of which 155 were infants under one year of age.

The largest number of deaths in any one year was 3,484, which was in the year 1900. Each succeeding year gave the following numbers: 1901, 3,284; 1902, 2,694; 1903, 2,723; 1904, 2,877; 1905, 2,667; 1906, 2,911; 1907, 2,530; 1908, 2,511.

From these figures it will be seen that the deaths in 1908 were 973 below those in 1900—the period when the best and most active work has been done in combatting the spread of the disease. This may well be considered encouraging, and is particularly gratifying, as in the last decade more people have been attracted to city life than ever before—and the statistics for the province give a death rate of 1.43 per 1,000 for the city group, 1.17 for the town group, and in the country 1.002 per thousand.

Can anything be plainer, therefore, that a still more active propaganda, the multiplication of sanatoria, dispensaries, day camps, etc., the diffusion of a more general knowledge through the lay press, lectures and exhibitions, as well as dissemination of

knowledge as to right living, fresh air, temperance, personal hygiene, home sanitation, pure milk, will result during the present decade in a yet greater diminution in the death rate and a larger decrease in the morbidity.

Cancer in Ontario.—Whilst tuberculosis is declining in Ontario, cancer is increasing. Towards reducing cancer nothing has been done, and the reason is all too obvious—its exact nature is not known to medical science.

The deaths from cancer are thus recorded: 1902, 1,048; 1903, 1,156; 1904, 1,253; 1905, 1,224; 1906, 1,411; 1907, 1,329; 1908, 1,348.

Having in mind, then, the undoubted good work which has been done in checking the spread of tuberculosis and the good work which may be done in checking the increase of cancer, there would appear to be every reason that the Government of the Province might wisely consider it a justifiable procedure to place a special competent official in charge of all the work pertaining to the prevention and spread of these two diseases in Ontario.

At The Beginning of a New Year the minds of the medical profession are very apt like those of other callings in life to take stock of the old or the past year.

Some like to recall the achievements medical science has brought about in the past twelve months; others recall the ravages of the man with the scythe; whilst yet others take a more mercenary view and take pleasure in counting up the shekels in the strong box—or bemoan their bad luck, if there are no shekels to count.

Having kept some tab on medical affairs financial, appearing as special articles and editorials in various exchanges, it looks very much as though the physician, meaning the general practitioner, is viewing a decreasing annual income with no inconsiderable alarm, and that he is looking around for the cause.

This is not far to seek. The multiplication of doctors, the abuse of medical charity, lodge practice, the inroads of sanitary science, specialism—these are all tending to abridge the work and the income of the man in general medicine.

The age is one where specialism in all departments of manufacture and commercial life is predominant; it is equally true of medicine. Sanitary science is on the up-grade, and will sooner or

later occupy a strong and commanding position. Our old friends medical charity and the abuse thereof and lodge practice are still strong and ever with us. Perhaps something could be done with benefit to the profession at large by combatting strenuously these two evils. Of the multiplication of doctors there seems no end. The outlook, therefore, is not a cheerful one.

The Ontario Medical Council has held its elections, but only a few new faces will be observed in the seats of the mighty—and most of these do not come as a result of the great amount of general dissatisfaction which was thought to be spread all over the province. As over half the electoral members were re-elected by acclamation or re-elected after contests, it is safe to say the great majority of the College are satisfied with the conduct of its affairs.

To Dr. Edmund E. King, Toronto, much sympathy is expressed at the untimely death of a well-beloved daughter.

THE following are the members of the Ontario College of Physicians and Surgeons as returned at the recent elections: Dr. Cruickshanks, Windsor; Dr. Welford, Woodstock; Dr. McArthur, London; Dr. Emerson, Goderich; Dr. Vardon, Galt; Dr. MacCallum, Thornbury; Dr. Griffiths, Hamilton; Dr. Merritt, St. Catharines; Dr. Gibson, Sault Ste. Marie; Dr. Stewart, Fort William; Dr. King, Toronto (East); Dr. Hart, Toronto (West); Dr. Bascom, Uxbridge; Dr. Young, Peterboro; Dr. McColl, Belleville; Dr. Spankie, Wolfe Island; Dr. Lane, Mallorytown; Dr. Klotz, Ottawa.

Homeopaths.—Dr. Hardy, Toronto; Dr. Jarvis, London; Dr. Wickens, Hamilton; Dr. Adams, Toronto; Dr. Routledge, Lambeth.

News Items

DR. C. J. ALLOWAY, Montreal, has gone to Florida for the winter.

DR. H. O. REDDEN, Outlook, Sask., has opened a private hospital.

DR. F. N. G. STARR has returned to Toronto after a trip to Nova Scotia.

DR. J. T. ROGERS has returned to Montreal after an extended stay in Europe.

DR. NORMAN KING WILSON, College Street, Toronto, has gone to Edinburgh for graduate work.

SCARLET fever is epidemic in Winnipeg. In November there were 139 cases with 19 deaths.

THE Government of British Columbia has given \$5,000 and the City of Victoria \$15,000 for isolation hospital purposes.

THE Canadian Hospital Association will hold its next annual meeting at Niagara Falls, Ont., the 23rd and 24th of May.

OUT of 2,051 cases of typhoid fever in the Montreal General Hospital from 1897 to May, 1910, there were 93 cases of perforation.

DR. J. E. LABERGE, Chief of the Infectious Diseases Department of the Montreal Health Department, has been appointed a member of the Quebec Board of Health.

DR. W. B. KENDALL, Superintendent of the Muskoka Cottage Sanatorium, has been granted leave of absence to study the latest phases of tuberculosis in Europe.

THERE are 92 students from British Columbia at McGill University. Two years of the university course may now be taken in Victoria and three years in Vancouver.

THE death is announced of Dr. John C. Munro, Boston, Mass. Dr. Munro delivered the address in surgery before the Canadian Medical Association in Montreal in 1907.

THE new Alberta Hospital for the Insane at Ponoka will be ready for occupation in April. The 150 patients from Alberta, at present in the Brandon Hospital for the Insane, will then be removed.

DR. VROOMAN, Winnipeg, formerly Superintendent of the Manitoba Tuberculosis Hospital, has been appointed Superintendent of the Tranquille Sanatorium in British Columbia, Dr. R. W. Irving resigned.

DR. GEO. E. ARMSTRONG, Montreal, President of the Canadian Medical Association, read a paper on the surgery of gastric ulcer before the Academy of Medicine, Toronto, on the evening of the 3rd of January.

Correspondence.

Walkerville, Ont., Dec. 22, 1910.

Editor DOMINION MEDICAL MONTHLY,

203 Beverley St., Toronto, Ont.

DEAR SIR,—We ask your kind assistance in the way of disposing of a false impression which may have been created in the minds of your readers by wholly erroneous reports which have appeared in the *Montreal Star* (December 17), the *Toronto Globe*, the *Toronto Star*, and the *Toronto News* (December 15).

All four of the papers mentioned made the picturesque announcement that we had just declared a cash dividend of 15% and that, in addition thereto, we had paid during 1910 30%! This is perfectly ridiculous. During 1910 we paid exactly the same dividend that we declared in 1909, namely, 12½% of the par value of the stock, plus an extra dividend of 2½%. That is all there is to it. In other words, we are paying for 1910 15% instead of 12½%. There is no "melon" in the case. Would that there were!

The purchaser of our stock at present market prices receives a return of less than 4% on his investment. Why an industrial stock—and, as you know, "industrials" are by no means the pets of prospective investors—should command a selling price so much above its par value, may be explained by reasons which are perfectly familiar to those who have employed our products: modesty forbids us to recite them!

Very truly yours,

PARKE, DAVIS & Co.,

Wm. M. Grant,

Manager.