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A LIST OF THE

ORIGINAL ARTICLES, CLINICAL NOTES, SELECTIONS, SOCIETY REPORTS, CORRESPONDENCE, EDITORIALS, Etc.,

IN THE

Dominion Medical Monthly

JULY TO DECEMBER, 1893.

Dominion Medical Monthly

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ORIGINAL ARTICLES.

(No paper published or to be published elsewhere as original, will be accepted in this department.)

A CASE OF SYMPHYSIOTOMY IN NARROW PELVIS—RECOVERY OF MOTHER AND CHILD.

BY DR. J. H. BURNS AND DR. A. B. ATHERTON, TORONTO.

As the case we are about to report is, so far as we can ascertain, the first that has been successfully attempted and carried out in the Province of Ontario, of delivering the child by division of the symphysis pubis, it appears worthy of being recorded.

A great deal of attention has been given to this subject in the past year, and as cases have been collected with considerable care by Harris, of Philadelphia, and others, we shall not allude to more than the particular instance with which we have had to deal.

Mrs. E., primipara, in her thirty-fourth year, considerably below middle height—about four feet six inches—and small in proportion, but without deformity of any kind, and with an excellent personal and family history, was taken, at full time, with very light labour pains about midnight on the 28th of June last. Very shortly afterwards the membranes ruptured, and a large quantity of liquor amnii escaped.

When first seen, ten hours afterwards, the os uteri barely admitted the finger tip. Examination revealed the head in the first position. During the following day, the 29th, the pains increased in frequency and severity, but there was no alteration in the position of the child, and no dilatation of the os.

The measurements of the pelvic canal appeared by manual examination to be normal, except the conjugate, which was less than three inches. These measurements were estimated. During the night of the 29th, a hypodermic injection of morphia, gr. ⅙, was given, which in the course of a few hours produced a lessening of the rigidity of the os. On the morning of the 30th, about five o'clock, the patient being chloroformed deeply, there was sufficient dilatation to readily admit the application of the forceps, which grasped the head favourably. Traction was made for some time, long enough to satisfy us that delivery by this means could not be accomplished with safety, when, the child being found

alive, symphysiotomy was resorted to at eight o'clock on the morning of the 30th, and by 8.30 a living female child was successfully delivered, thirty-three hours after the beginning of labour. The operation consisted in placing the patient in the lithotomy position with her buttocks well over the side of the bed. The mons veneris having been shaved, the external parts were rendered as aseptic as possible. With the forceps in position grasping the head, the soft parts were divided with a scalpel down to the pubic junction.

By passing a hernia knife carefully behind the symphysis from above downwards, being guided by the finger, the bones were readily divided They were prevented from springing apart, as usually happens when the cartilage is cut through, by pressure exerted over the trochanters, directed inwards. Traction was now made on the forceps, and the head was delivered with considerable difficulty. We estimated the greatest amount of separation of the bones which took place during the passage of the head to have been two inches.

The child, whose head bore marks of severe traction and pressure during the early employment of the forceps, weighed seven pounds, nine ounces, and measured nineteen and a half inches in length. The fœtal head was large and the anterior fontanel was nearly closed. Very little or no moulding of the head had taken place. Venous hæmorrhage, profuse in quantity, discharged through the incision after the bony parts were placed in apposition. This soon yielded to compression maintained by a wad of iodoform gauze. The perineum was torn to the sphincter, and was united at once by catgut sutures. The external incision was united by sutures of silk-worm gut, a drainage of iodoform gauze being left in the wound. The whole was dressed antiseptically, and a wide, strong bandage carefully applied over the hips and abdomen to keep the pubic bones in apposition and the parts at as perfect rest as possible.

There are no special features to note as to the after-treatment, except that on the second day the drainage was dispensed with, and on the seventh day the external sutures were removed, the wound being practically healed throughout.

The bladder has been emptied by catheter every eight hours. The bowels were moved by Seidlitz powder and enema of glycerine on the third day. The temperature has never risen higher than 100⅘°, and that on one occasion only, the third evening after delivery.

Lactation began on the third day, and at the time of writing—the sixteenth day—the patient is free from pain, and is nursing her baby regularly.

The secretions are normal, and she submits to the enforced recumbent posture and tight bandaging with great cheerfulness. Her temperature is now normal.

July 15th.

APPENDICITIS.*

BY DR. HOWITT, GUELPH.

MR. CHAIRMAN AND GENTLEMEN :—The subject which your Committee on Papers has chosen for discussion in surgery is one of great importance, not only to the surgeon but also to the general practitioner. The latter, in the majority of cases, is first called to attend, and on his judgment and capability to grasp the requirements may depend the life of the patient. Although of late years appendicitis has, under various and

*Read at meeting of Ontario Medical Association, To-onto, June 22nd, 1893.

confusing names, received much attention, yet the leaders of our profession in this particular line of surgery differ greatly in reference to the treatment that should be adopted in many of the manifestations of the disease. Then, so long as the advocates of operative procedures differ from each other, it is no cause for wonderment to find occasionally the physician or surgeon in consultation occupying positions in thought as widely separated as are the poles in space. More study of the interesting little organ and its functions, and more correct data regarding its abnormalities, let us hope, will in a short time enable one of our younger members to throw sufficient light on the subject to clear away the discrepancies that now exist.

I cannot altogether accept the opinion held by some that the appendix has no other place in the human economy than that of a relic of by-gone ages which has refused to comply with the laws of evolution, or that in man it now serves a detrimental rather than a wise purpose. To do so, I must necessarily place them on a very high pedestal indeed, and acknowledge their transcendental wisdom which enables them to suggest improvement in the human constitution.

Is it not feasible to entertain the belief that the glandular and muscular tissues of the organ fulfil a more or less important purpose in the perfect physical condition of man, and that disease of it arises not from imperfection of the part, but through defective knowledge of the laws which govern health?

The term appendicitis in this article is intended to apply only to disease arising in the appendix. The rare forms that may occur in the course of typhoid fever, tuberculosis and cancer of the organ will not receive attention.

Several years ago Treves corrected Gray in regard to the peritoneal investment of the caecum, and proved that in the normal condition it is not only covered by peritoneum, but has a mesentery which allows it considerable freedom of movement. The point is one worthy of more than passing note, for it amply demonstrates that the primary abscess resulting from disease of either appendix or caecum is with few exceptions intraperitoneal, and aids the statement which I wish to emphasize, that the abscess in appendicitis is not invariably situated in or even near the right iliac fossa.

Proportionately the size and situation of the appendix has more latitude than any other organ in the body. Gray describes its diameter as being about that of an ordinary goose-quill, and its length as varying from three to six inches. But it has occasionally been found shorter and frequently much longer. In two cases which I examined lately it measured seven and a half inches in one, and fully ten in the other. The former was attached by a short mesentery to the upper and posterior wall of pelvis with tip touching rectum, but the latter had no mesentery. The appendix is generally placed behind the inner side of caecum with tip directed towards spleen, but it may lie in any other direction. Sometimes it is free excepting proximal end, but generally has a short mesentery. When free and long with normal condition of caecum, the tip may reach any part of the abdominal cavity. When the caecum is not completely invested by peritoneum the appendix may be placed in part or wholly outside the peritoneal cavity, but this condition is extremely uncommon. The organ is often curved in its long axis, and at times has one or more decided bends. Dr. Cameron, of Galt, and myself saw a good illustration of this in the body of an infant which had been murdered a few minutes after birth. There were two decided angles which appeared to be caused by the arrangement of the mesentery. All bends of appendix are not the result of pathological changes.

Appendicitis as a rule attacks the apparently strong and robust of youth and early

manhood, often, too, without previous signs of warning, but may occur at any period of life, and possibly in any condition of health. The male is fourfold more liable to it than the opposite sex. There is reason to believe it is still frequently incorrectly diagnosed "idiopathic peritonitis," a disease which does not exist. It is a common disease, and is said on good authority to be more so in America than any other part of the world. Dr. Lange, of New York, attributes this to the two national failings, eating too much and chewing too little.

It is extremely difficult to give anything like correct statistics relating to the mortality, for the reason that a distinction is not generally made between it and troubles of less grave import arising in the caecum. In the less severe forms in which we have merely abrasion of mucuous coat and catarrhal inflammation with more or less involvement of its peritoneum of a simple character, the death rate, under judicious medical treatment, is very low. But on the other hand, cases in which an abscess forms, whether from perforation or otherwise, the mortaity is, excluding surgical treatment, high, possibly fifty per cent.

Post-mortem examinations reveal the fact that the disease is sometimes overlooked in life. The appendix has been observed completely destroyed as an organ, and the remnant buried in adhesion, yet no evidence of the disease was manifested during life.

In the early years of my practice, before the advent of surgery in the region under discussion, I had seven well-marked cases of the grave type, only one of which recovered. In four of the fatal cases a post-mortem examination was obtained. The examination showed suppurative peritonitis resulting from rupture of primary abscess as the cause of death in all; also perforation of appendix and one or two faecal concretions. Looking back at the cases, I believe that all would have recovered under early and judicious surgery. The single recovery was due to abscess rupturing into bowel.

Classification—For all practical purposes the following classification will answer:

1. Non-suppurative appendicitis.
2. Suppurative appendicitis.
3. Recurrent appendicitis.
4. Relapsing appendicitis.

1. Non-suppurative appendicitis includes the majority of cases that occur. Under injudicious treatment, especially in reference to rest and diet, many culminate in the next form.

2. Suppurative appendicitis embraces those in which we have an abscess and generally a perforation. Also the grave forms, fortunately rare, where no observable attempt is made to localize abscess by adhesions.

3. Recurrent appendicitis should be applied to those of more or less severity which tend to recur after apparent recovery at uncertain intervals.

4. Relapsing appendicitis is applied to those in which the patient only makes a partial recovery between the attacks. It generally portends pus.

Cause—Ulceration (recent or remote) of mucuous coat invariably precedes primary appendicitis demanding surgical interference. Probably the disease in every instance has this condition preceding the first attack. The ulceration, in my opinion, is nearly always the result of local irritation by faecal concretion or foreign body. True, these are not always found, but some may be too small for detection, while others may have been forced into caecum after the injury by a muscular effort of the little organ. The density and general contour of concretions favour this view, also the fact that the

muscular tissue of organ is generally increased in appendicitis. It must be clearly understood that in appendicitis and typhlitis there is always involvement of the peritoneum of the organs; and it is my opinion that in neither of them, as a primary attack, can the serous coat become affected from simple catarrhal inflammation independent of abrasion. Few, if any, will deny that simple ulcer of the caecum is caused in any other way than from pressure by hardened faecal masses or foreign body. Then, why make any distinction in the two cases? To do so, one is apt, as it were, to bury his head in the sand by employing the term "idiopathic."

Certainly one often finds the disease following exposure to cold, over-exertion, and the like, but these, in my opinion, are not primary causes, but merely act by lowering the powers of the system enough to permit the pathological germs to gain ascendancy in an already existing abrasion or ulcer.

Assuming the above to be correct, we can easily understand the many phases of appendicitis. If the appendicitis fails to expel the body, or when the ulcer becomes infected with certain germs, gangrene, perforation or abscess result. When the substance is expelled before doing much injury, the attack, other things being equal, is mild. In fact, no trouble may be manifested. The greater the damage done generally the greater the result. The healing of ulcer may cause complete or partial occlusion of the lumen at one or more points, and cause tension of distal portion from retained secretion; or the resulting inflammation of peritoneum of appendix and its mesentery may lead to adhesions and other changes sufficient to cause torsion. Also pus foci may be produced in structure of organ or in surrounding adhesions. Thus we have all the conditions necessary to give rise to recurrent and relapsing types of the disease.

Relapsing appendicitis is invariably the result of injury done by previous inflammation of the appendix, and does not necessarily require an abrasion of the mucuous membrane. It may be lighted up by catarrhal inflammation or other trivial cause. The same is true in regard to most cases of the recurrent type.

I am aware that Osler in his admirable work, when evidently referring to primary causes of appendicitis, says, "Catarrhal inflammation may induce the characteristic features of appendix disease," and adds, "the facts on which this statement is made are conclusive," yet all the cases which he cites as illustrations are certainly recurrent or relapsing ones, and favour in my opinion very much the view expressed above.

A rheumatic disease similar to that which affects the tonsils is said to be the cause of some of the recurrent cases.

Cicatrization, the result of typhoid fever, syphilis and tuberculosis, may lead to recurrent and relapsing forms of the disease.

The normal contraction of lumen near proximal end of organ plays an important role as a factor in the causation of the disease in every type.

Diagnosis.—The chief characteristics of appendicitis are pain in the right iliac fossa, fever, localized tenderness, gastric disturbance, and generally the presence of a tumor at site of pain within thirty hours. Rigour and shock are seldom absent in severe cases, and they generally indicate perforation or gangrene.

In the non-suppurative class, the pain may be intense, especially at the commencement, but it yields readily to treatment. There is seldom rigour and never profound shock. The pulse at first is full and firm. The temperature is often high, but with less fluctuations than in the suppurative type. If seen early there is neither lump nor area of dulness, but both may appear within twenty-four hours. The enlargement

does not tend to increase in size after first day or two, and it is fixed. It may be felt by finger in rectum. An anæsthetic facilitates examination. In all active stages McBurney's point is painful on pressure.

The suppurative type is as a rule ushered in suddenly by a rigour, sharply followed by more or less evidence of shock, acute pain and fever. While shock lasts the pulse is rapid and feeble, but when it passes off the pulse for a time becomes full and non-compressible. The lump may be felt at end of first day, and *tends to increase* in size, at times with great rapidity. The temperature chart shows decided fluctuations of an irregular character indicating more or less septic poisoning. Owing to intestinal adhesions we may have all the symptoms of bowel obstruction, though faecal vomiting is extremely uncommon.

When the appendix is long and lies away from the normal situation and the trouble arises in the distal end, the diagnosis is extremely difficult and often impossible.

Typhlitis is excluded by the less severity of the symptoms, the history of chronic constipation, and the presence from the first of a doughy, sausage-shaped mass in lumbar region. In it the chief seat of pain lies above McBurney's point; the temperature seldom rises above 101 F.; and a successful enema is generally followed by complete subsidence of the symptoms.

The extremely rare and severe forms of typhlitis due to perforation of caecum by foreign body, cannot be diagnosticated from appendicitis.

The history and vaginal examination in women will enable you to discriminate between appendicitis and the local forms of peritonitis caused by disease of pelvic organs.

Treatment.—At the onset, and for days after the acute symptoms have entirely passed off, the patient should be kept at rest in bed; just sufficient morphia given, preferably hypodermically, to allay pain and restlessness; and the diet restricted to those articles of food which are concentrated, free from indigestible particles and easily assimilated. Even the most suitable food at first should be given very sparingly indeed. Cold or hot applications tend to enhance the effect of the opiate. After the first twenty-four hours, if the pain has moderated a suitable enema will often hasten recovery. The opiate is of course to be repeated when necessary. Under this method of treatment the majority of cases will recover, even though a mass of considerable extent exists in the groin.

Calomel in one-tenth grain doses, frequently repeated, has lately been highly recommended by some, but I fail to see what indication it fulfils, and in certain conditions its action would be harmful.

When rigour and shock are prominent features of initial symptoms, or in any case when the disease, in spite of a fair trial of treatment, tends to becomes aggravated, with marked and irregular variations of temperature, and the lump in groin increasing in size, you cannot in justice to your patient rely on medicinal agents; nothing short of surgery will afford reasonable hope for recovery.

As a general rule operative procedure is seldom necessary before the third or fourth day, often later. In those terrible examples, fortunately exceedingly rare, in which either there are no protective adhesions, or where the primary abscess ruptures early, an operation in order to be successful must be done within a few hours of the attack.

The indications for treatment of recurrent and relapsing cases are, at the time of the attack, practically the same as stated above; but occasionally in the former and almost always in the latter, during the interval or quiescent stage, an operation with a view to remove the appendix is in conformity with good surgery. However, there is a point

to be remembered in regard to them as well as to the other types, namely: When an abscess forms and escapes from the body by surgical aid or otherwise, the patient almost invariably makes a complete and permanent recovery.

In appendicitis the time for operation has arrived as soon as you are sure that pus is present. It is seldom absent when the symptoms are severe, and you have an irregular fluctuating temperature and increasing area of dulness.

All precautions known to aseptic and antiseptic surgery should be observed before, during and after operations for suppurative appendicitis, for although the pus is horribly offensive, it lacks something which would make it more dangerous to life.

No arbitrary rules can be given that will cover all indications that may arise. However, in the majority of cases of suppurative appendicitis, the area of dulness in groin is well marked. By examination, under an anæsthetic, aided with finger in rectum, the attachments to abdominal wall are easily defined. If the wall is not unusually thick, all that is neccessary is to make an inch incision through skin and tissue to peritoneum over centre of dull area. A glance at peritoneum reveals the presence of pus beneath it. An opening is made sufficient to admit finger. With finger search for faecal concretion or foreign body, and also define situation and site of appendix. If the appendix lies free in sac, or can be readily reached without disturbing adhesions, you may enlarge incision and ligate and remove it. But this is, in my opinion, not necessary, and the advantages gained by removal of organ in these cases are not sufficient to compensate for the entire freedom from hernia after small opening and the saving of time.

Irrigation, a rubber drain, and possibly a suture or two complete the operation.

If abscess lies deep in iliac fossa, and covered by caecum or intestinal coils, you have the choice of two methods; in one of which you open the peritoneal cavity in the right linea semilunaris opposite the pus sac, protect general peritoneal cavity with soft sponges, and then separate adhesions till the pus escapes. After washing thoroughly, it is a good plan to perforate abdominal wall immediately over site of abscess, and through the perforation introduce rubber drain. This allows you to completely close large incision, by which you run less risk from hernia subsequently. You have also (which is a matter of importance) more direct drainage.

By the other method, which many prefer, the abscess is opened without disturbing the unaffected portion of peritoneal cavity. An oblique incision parallel with Poupart's ligament is made to the outer side of situation of appendix. On reaching peritoneum, it is separated from parietal wall in the direction of abscess till it is reached. An opening with point of finger is now made, and drainage secured in the usual way.

The operation for the removal of the appendix in relapsing and suitable cases of recurrent appendicitis, is done by making a three-inch incision at right angles to an imaginary line drawn from right superior iliac spine to umbilicus, two inches from spine with centre of incision at line. But if the appendix is known to be away from normal site, the incision must be made over it. Adhesions, if present, are separated, and the appendix brought into view.

It may be dealt with in different ways. Robt. T. Morris cuts it off close to the caecum, ligates the mucuous membrane that protrudes, and removes it close to the ligature, then inserts a layer of sutures to close caecal wound, scarifies the adjacent peritoneum of caecum, and sutures it over all. Treves advises, when practicable, a circular division of peritoneum near proximal end and reflection of it towards caecum. Amputation of appendix close to reflected peritoneum and removal of pre-

senting mucuous membrane with sharp spoon, then suturing muscular and peritoneal coats separately. I have found a flap amputation of organ near caecum with complete removal of mucous membrane to answer all indications. It can be done quickly and makes a secure stump. Fine silk is the best material for sutures.

When the appendix is firmly adherent to the bladder, ileum, or other important viscus, Treves cuts it off close to the attachment and then pares away the fragment.

The external wound is closed without drainage. The operation should be done during the quiescent stage.

It is possible, if seen early, to occasionally save a patient with the terrible form of suppurative peritonitis which either follows perforation of the appendix where no attempt is made to localize by adhesions, or rupture of primary abscess into peritoneal cavity. In such a case a large incision in right linea semilunaris fulfils most indications. It allows the surgeon to reach the appendix readily, and permits thorough irrigation of the abdominal cavity.

A case due to rupture of abscess occurred in my practice in 1890. The subject was a young lady, whose friends had refused earlier interference. Suddenly intense general abdominal pain set in with all the symptoms of profound shock. I operated within a few hours of rupture. The abdominal cavity contained fully a pint of free pus, and two faecal concretions were found between coils of small intestines at considerable distance from ruptured pus cavity. The appendix was merely a mass of rotten tissue. Direct drainage was used, through which pus, gas, and some faecal matter escaped for a few days. The patient recovered.

I have operated for the relief of appendicitis twenty-four times, with two deaths. In both the fatal cases the operation was too late to save life. The primary abscess had ruptured, and had caused general suppurative peritonitis in each of them before consent to operative treatment was given. In one of them the patient was unconscious, with surface cold and pulse oto weak to be detected at wrist. The operation was unjustifiable. The other fatal case lived for three days, and at one time hopes of recovery were entertained. With one exception, all the others are alive and well to-day, and no relapse has as yet occurred in any of them. The one dead, died eight months afterwards from the effect of an operation done in the attempt to remove a malignant growth from bowel.

The following are brief notes of six cases in my practice in which the seat of trouble was not in the right iliac fossa.

CASE 1.—D. K., builder, aged fifty, came to my office on the 20th of April, 1880, to consult me about a tumor in abdomen. An irregular, painless lump about the size of a goose-egg could be felt in abdomen immediately above umbilicus. It appeared slightly movable in all directions but upwards. A band could be detected running downwards from it. Patient had had several attacks of peritonitis, last only a month previously.

An eminent Toronto consultant who was called said it was a malignant growth, and I concurred in diagnosis. Two weeks after consultation the lump suddenly become painful and fixed to abdominal wall. Shortly afterward it gave evidence of fluctuation, and was opened. A small faecal concretion and pus escaped. Patient has never been ill since.

CASE 2.—Master P., aged 11, for six months had suffered from repeated attacks of localized peritonitis in left iliac region. Abscess formed during an attack in April,

1887. It occupied pelvis and left inguinal region. A large median incision disclosed that the origin of trouble was perforation of the appendix, which was long.

CASE 3.—J. D., aged 37, agent. Had had repeated attacks of localized peritonitis; otherwise healthy, and family history perfect. Tumor, like Case 1, in size and outline, but painful to touch and fixed. Situated close to right side of umbilicus. July 24th, 1887, a small incision confirmed diagnosis, and gave him complete and permanent relief.

CASE 4.—Miss M. N., aged 4, previous health excellent. Attack commenced suddenly on the 18th of May, 1891. Pain referred to left of median line immediately above pubes. Tumor formed at site of pain. On the 23rd, an operation disclosed end of appendix protruding into posterior part of pus cavity.

CASE 5.—A young girl, aged 9. Previous health good and family history excellent. I was called to see her on the first day of June, 1892. The day before my visit, she suddenly complained of severe pain in pelvis with constant desire to urinate. She had fever, gastric irritation and inability to stand erect. No lump nor marked pain at usual site of appendix. June 3rd, much better and anxious to return to school. Owing to my absence from home, I did not see patient till 7th, when an area of dulness extended from the pubes to umbilicus. The condition of the patient was critical. After passing a catheter, a small incision was made in median line midway between pubes and umbilicus; but no pus escaped. The finger introduced to explore, detected that I had opened the bladder which formed the anterior wall of sac. Limits of bladder defined by finger, and marked on abdominal wall. Then the wound was carefully closed, and another made outside bladder to right. Distal end of appendix was found attached to posterior wall of bladder. No harm followed wound in bladder.

CASE 6.—Mrs. C., aged 47, mother of ten children. Family history good. Five years ago had peritonitis and again last fall, otherwise had enjoyed excellent health till the 11th of April, 1893. Dr. Thompson, of Listowel, then saw her, and detected a tumor, which extended from floor of pelvis to three inches above umbilicus. The greater portion of growth was to the left of median line. Vaginal examination disclosed that tumor filled pelvis to within an inch of outlet. The cervix was obliterated, and os situated high in front of pubes. Pulse 100, and temperature 102½; chief pain in back, but abdomen painful to pressure, especially over bladder region. Constant desire to urinate, and marked bowel tenesmus. Two weeks later the doctor, owing to urgent symptoms, used aspirator, introducing needle into tumor through the vaginal roof behind os. A pint or more turbid fluid was removed, which gave marked relief for a time.

I saw her first late at night on the 11th of May. I found the temperature 102 and pulse 130. The only resonance on percussion was in the right side. The tumour had marked irregularities on anterior surface, but patient could not allow much handling on account of pain. She had not noticed any enlargement of abdomen before the beginning of April. Diagnosis, a suppurating intraligamentous cyst.

Early in the following morning the abdomen was opened. The uterus was noticed flattened, and spread over the anterior surface of cyst, and reached almost to umbilicus. All the omentum below transverse colon was firmly adherent to part above uterus, and the greater portion of it had to be left attached to cyst. On separating part of the omentum from tumor, a collection of caseous pus was exposed, and a rounded, pedicle-like body laid bare, which extended from fundus of growth downward to the right. An examination proved the body to be the appendix. Its length was fully ten inches,

and diameter near caecum was that of my middle finger. It had no mesentery, and before the cyst was tapped, extended from caecum to near upper part of tumor. The end was so intimately connected with cyst wall that it had to be cut and removed with the growth. The caecum in this case was not completely invested with peritoneum, and hence fixed. Owing to the presence of pus and pus foci, the remnant of the omentum was removed close to colon.

The growth had evidently commenced in left broad ligament, and had no pedicle. It had several daughter cysts, all of which contained pus.

My view of the case is that five years ago the appendix became attached by adhesion to the left broad ligament; last fall appendicitis again occurred, and pus formed near apex of organ, which by this time rested on the cyst growing in ligament. The omental adhesions permitted the pus to become encysted and caseous. The attack last April infected the cyst and caused rapid enlargement of it.

Last April I saw in the practice of Dr. Webb, of Waterloo, a very interesting case in which the pain and the area of dulness were chiefly to left of median line. Surgery was anticipated by nature, for the appendix, debris and pus were passed per rectum. Through the kindness of the doctor, I am able to present the specimen for your examination. You will notice that the distal end is perforated. Patient over fifty, and had always been healthy.

A surgeon at Galt operated on a case in which, before the operation, several medical men, including the operator and myself, had diagnosed a perinephritic abscess. Dr. H. A. McCallum, of London, has reported a remarkable one in which the abscess broke first through the eighth intercostal space of right side, and subsequently through the lung.

Reports of Societies.

THE ONTARIO MEDICAL ASSOCIATION.

The thirteenth annual meeting of the Ontario Medical Association was held in the hall of the educational department of the Normal School. June 21st and 22nd, Dr. R. W. Hilliary, of Aurora, presiding. The Vice-Presidents of the Association, Dr. Brock, of Guelph, and Dr. A. McKay, of Ingersoll, were present and took their seats upon the platform. Letters of regret were read from Dr. A. R. Robinson, New York; Dr. Saunders, Kingston; Dr. Anglin, Kingston; Dr. Moorehouse, London; Dr. Preston, Newboro'; and Dr. Gibson, Belleville. After the receipt of the report of the Committee on Papers, which was moved by Dr. Spencer, Dr. E. E. King, moved that an official stenographic report of the proceedings be made, and a committee consisting of Drs. Sheard, A. H. Wright, W. H. B. Aikins, A. A. Macdonald and E. E. King, Toronto, were appointed to conclude the arrangements, and Dr. Brown was selected to report the work of the sessions. Drs. McKay, of Woodstock, and Harrison, of Selkirk, were appointed by the President to act on the Committee on Ethics.

On motion of Dr. Welford, Woodstock, seconded by Dr. Macdonald, Toronto, a committee consisting of Drs. Barrick, Welford and Macdonald were appointed to draw up appropriate resolutions in the name of the Association, recognizing the service rendered to the Association by its late presidents, Drs. A. Worthington, Clinton, and W. H. Henderson, Kingston, and report to the afternoon session.

Dr. A. A. McDonald, of Toronto, read an excellent paper on "CHOLELITHOTOMY

WITH CHOLEDUODENOSTOMY, FOR THE RELIEF OF CHOLÆMIA," due to obstruction of the common bile duct. The following is an excerpt of the paper:

"Gall-stones may exist for some time in the gall bladder and produce no definite symptoms, but not so when they become impacted in the common duct. The treatment for this latter condition has heretofore been unsatisfactory, but now such an advance has been made in the way of surgical treatment that it appears that it will be placed on a scientific and satisfactory basis. Chronic jaundice depends upon obstruction to the flow of bile. Where the jaundice is due to a new growth, the following are some of the symptoms: emaciation, dyspepsia, flatulence, absence of bile in the fæces, its presence in the urine, etc. Death ensues usually within a year. When due to impacted gall-stones or stricture, the symptoms are not so constant, and the case may last for years. The presence of gall-stones in the gall-bladder cannot be accounted for, although they are frequently found at autopsies in subjects over sixty years old. The assigned causes are sedentary habits, too much starchy food, constipation, tight lacing, etc. In order to treat these cases successfully, the bile must re-enter the intestine."

Dr. Macdonald then outlined the history of a case. After an incision through the abdominal wall, the gall-bladder and the duodenum were opened, and through each incision was put one of Murphy's buttons. These were then approximated, bringing the two serous surfaces together. The patient's jaundice disappeared, but death ensued. A post-mortem showed non-union. The patient was too far gone at the time of operation.

Dr. N. A. Powell then gave the history of a case in which a similar operation had been performed, but the method employed was that of Gaston—the use of the elastic ligature. The operation was ultimately a failure, for the patient died. He thought the buttons an improvement on the elastic ligature.

Dr. Macdonald, in replying, pointed out the fault in Gaston's method to be the closing of the fistula made by the ligature by the process of healing as the ligature cut through. He then detailed some of the objections raised against the buttons, but showed that they were not at all serious objections. Concluding, he hoped before many months there would be many successful cases reported in this very interesting branch of intestinal surgery.

The President, Dr. Hilliary, then delivered his address. He said he felt much honoured at being elected to the position he occupied, more especially as he was absent from the last year's meeting, and also because the position had formerly been filled by such a distinguished array of men. He referred feelingly to the loss the Association had sustained by the deaths of Dr. Worthington, of Clinton, and Dr. Henderson, of Kingston,—both past-Presidents of the Association. He was glad to know that the matter of reciprocal registration of medical men between Canada and the Old Land rested with the home authorities but thought not much could be expected from them when we ourselves had not decided on reciprocal provincial registration. He (the speaker) advocated a Dominion Council and endorsed the raise in the educational standard for medical men in the Province. He detailed some of the evils of club practice and denounced it. In regard to the Medical Council, he saw much to approve and some things to condemn; but, as it was constantly improving in many ways, he thought it should be liberally dealt with. He favoured the increase of territorial representatives, and in regard to contested elections, he approved of the method of having the case tried before the County

Judge. In concluding his address, Dr. Hilliary welcomed the visitors present from the other side of the line, and hoped they would be treated by the members of the Association with the same cordiality and good feeling which Canadians received over there.

The chairman then introduced the Hon. G. W. Ross, Minister of Education, to the Association, who said that he did not come to discuss medical questions, but to inquire whether the members of the Association were comfortable in the hall. It was an honour to have them present, and he welcomed them. They would, he said, be welcome at all times they wished to honour the institution with their presence.

Dr. DeGarmo, of New York, said his chief duty was to present the greetings and good will of the New York Medical Association, the next was to read his paper on "THE TREATMENT OF HERNIA BY THE GENERAL PRACTITIONER." He began by saying that it was impossible to fully discuss so extensive a subject in the short time allotted. Too much time had been spent on the surgical side of the question; he proposed to devote his time to the palliative treatment—means within the reach of every practitioner. He then gave a short account of the history of trusses, pointing out the good qualities and the defects in them. Various trusses were shown. A good truss should hold the hernia completely within the abdominal cavity. No truss for inguinal hernia should have its pad attached by a descending arm; the centre of the pad should correspond to the centre of the spring. He also pointed out the value of the cross-bodied truss, The English truss, however, which had this good point, had too strong a spring. He then showed a truss of his own invention for femoral hernia, which filled the necessary requirements demanded in a truss for femoral hernia. After getting a perfectly fitting truss, the practitioner should watch his patient until cured, seeing him at least once a month to see that the hernia was securely held. In infants, the springs used were usually too strong. They should be light, waterproof, and should be left on at nights. The doctor had treated infants as young as ten days old. There was no lack of appliances, the doctor concluded, but there was of medical men who understood the application of them.

Dr. Barrick said that they were all indebted to Dr. DeGarmo for his able address, but he wished to refer to two or three points mentioned by Dr. DeGarmo. The first was with regard to the pad being in line with the spring; the second, the relation of the pad to the internal ring. He said that in all cases of hernia the internal ring was dragged down towards the external ring, therefore he thought that the English truss, condemned by the reader of the paper, was constructed on the right principle, the pad below the line of the spring.

Dr. Grasett said that he agreed in the main with what Dr. DeGarmo had said, but did not like to hear the English truss condemned so strongly, as in many cases of failure it was not the fault of the truss but was due to some accident by which it was broken or disabled.

Dr. Harvie then read the report of the Committee on Ethics, which carried.

The President then called on Dr. Powell, of Ottawa, who addressed the Association on "THE MANAGEMENT OF ABORTION." He said he had no new and startling developments to tell them of, but that he merely wished to bring this important subject under their consideration. Syphilis, either through the mother or the male parent, was one of the most frequent causes of abortion, and that in these cases mercury had been found to be very beneficial. Endometritis, fibroids, malignant disease, an everted or patulous os and malpositions were other causes. The last condition was readily treated by

keeping the fundus in its proper position for about three months. Sub-evolution was another cause of the aborting habit, and in these cases local applications and general medication were needed. In other cases no cause could be given. Rest was an essential part of the treatment, particularly in threatened abortion. He also recommended absence of sexual intercourse, the use of opium, bromide of potash and viburnum for the aborting habit. In primiparæ, where abortion had taken place, hæmorrhage was often arrested by the ovum itself filling up the cervical canal. In multipara the tampon was often necessary. He advised curetting where there was continued hæmorrhage accompanied by retention of a portion of the membranes which were beyond the reach of the finger.

Dr. Shaw agreed with Dr. Powell, but thought that a run-down and irritable condition of the patient was another frequent cause. Respecting opium, he would only use it in those cases where there was both pain and hæmorrhage. He would always make sure that the uterine contents were expelled.

Dr. Machell, not being present when the paper was read, asked to be excused from discussing the subject.

Dr. Temple said he did not agree with the paper in one or two points. First, hæmorrhage, in his experience, was more severe in primiparæ than in multiparæ; therefore he would, in treating them, use the tampon. Second, in primiparæ, he he believed that abortions were more frequently due to the patients not taking care of themselves, and were not so often due to syphilis. Third, he considered that the after results—septicæmia, etc., were far more to be dreaded than the hæmorrhage at the time of the abortion.

Dr. A. H. Wright said that he did not agree with Dr. Temple, that accident was the chief cause of abortion, as working women, in his experience, were least likely to abort. To prevent abortion his treatment was rest, opium and bromide of potash as an adjuvant. It was, he said, very difficult to decide that any given case was one of inevitable abortion. When it was inevitable he emptied the uterus of its contents as soon as possible. If the os was undilated, he used the tampon, but if dilated, he generally used his finger to get rid of the contents. He concluded by saying that cleanliness should be assiduously attended to and septicæmia would thus be avoided.

Dr. Powell then closed the discussion. He said that he did not agree with Dr. Temple, as he found that hæmorrhage in primiparæ was not so severe as in multiparæ, that the ovum filled the canal, and therefore no tampon was needed. He had not said that syphilis was the great and only cause of abortion, but that it was one of the most fruitful sources of it. With reference to what Dr. Shaw had said, he himself agreed that it was not wise to use opium where it was contra-indicated.

The meeting then divided into sections.

Medical Section.

Dr. Brock took the chair. Dr. Milner acted as secretary.

Dr. Wilson, of Richmond Hill, then read a paper on "The Treatment of Diphtheria." He strongly advocated the use of prophylactic treatment in the way of removing all sources of irritation from the mouth, nares and tonsils, and anything that would cause hyperemia of these parts. The general condition of the system should be kept in the best possible condition and the hygienic surroundings perfect. Early treatment, the Doctor said, was necessary in order to lessen the vitality of the germs and their virulence and power of reproduction. When the membrane was small in amount, it was possible to keep it rubbed off, and the

denuded surface then sprayed with bichloride solution. The membrane could be dissolved by Papoid, hydrogen, peroxide, etc. In many cases where we could not kill the bacilli, we could lower their vitality so that their virulence needed not to be feared. In cases with pain, the cold coil should be used. The constitutional treatment consisted in the use of rest, liquid diet, and the administration of tinct. ferri perchlor.

Dr. Milner, of Toronto, read a paper on "DIPHTHERIA, ITS CAUSE AND TREATMENT." He started out by saying that it was hard to say, in many cases, how the disease was contracted, but he had found it due to direct contagion most often. He then spoke of means to prevent its spreading—isolation, disinfection, etc. In speaking of treatment, he said an external application of turpentine was useful, and that among solvents the per-oxide of hydrogen was the most reliable. If the membrane formed very rapidly, obstructing respiration, it should be removed. Tincture of iron, he affirmed, was our sheet anchor in treating the constitutional symptoms. Stimulants, also, should be given from the first. The diet should be chiefly iced milk. Speaking of tracheotomy and intubation, he said that intubation should be used in infants under three and a half years old, also in adults. Tracheotomy should be performed in those between three and a half and five. The doctor then outlined two or three interesting cases he had had, one of which had been followed by paralysis and death.

A paper was then read by Dr. Bryce, on "THE PUBLIC SCHOOLS IN RELATION TO THE DISSEMINATION OF DIPHTHERIA." He showed by statistics gathered that the number of school children attending school under ten years of age formed about eleven and four-fifths of our population, and that 76.3 per cent. of the number of deaths from diphtheria occur before the age of ten, showing that school life is the particularly susceptible age. The doctor showed, both from epidemics at home and abroad, that the schools are a fruitful source of dissemination of the disease. Density of population, ill-ventilation, lack of sunshine, decaying matter, etc., are all helpful in spreading it. The doctor showed that the cubic amount of air space in the rooms used, the cleanliness of the floors, the frequency with which the air is changed, entered largely into the prevention of its spread. The altered humidity of the air in school-rooms in winter, he thought, was a potent factor in the spread of the disease, as it materially affected the condition of the mucous membrane of the respiratory tract.

Drs. Wilson, Burrows and Spencer took part in the discussion.

SURGICAL SECTION.

Dr. McKay, of Ingersoll, presided. Dr. J. N. E. Brown acted as Secretary.

Dr. E. A. Spilsbury read a paper on, "DEFLECTION OF THE NASAL SEPTUM AND ITS SURGICAL TREATMENT." He gave an outline of the pathology of the condition, its symptoms and surgical treatment. The etiology, he considered, was traumatic; the symptoms were those of catarrh, buccal respiration with its attendant evils, a change in the voice, etc. The treatment he recommended was removal of the obstruction by incision or by crushing. He gave a history of the different methods employed in operating on a projecting septum, and entered into the details of Delstanche's method, which consists in crushing the septum by using a pair of forceps, having the limb which enters the occluded nostril, and which comes in contact with the obstruction, armed with a stellate knife. After being thus straightened, he inserts a splint whose two arms, entering the nostrils and brought into contact with the nasal septum, hold it in position till healing takes place. The doctor then gave a history of several cases in which he had

employed this method with marked success.

Dr. Primrose, of Toronto, followed, his subject being, "THE ANATOMY OF THE CHILD." This paper was highly interesting because he had frozen sections wherewith to illustrate his paper, and also photographs of the same. He said this method of studying anatomy was particularly useful in learning the anatomy of the viscera and the structure of the joints. He contrasted the anatomy of the child with that of the adult. Many interesting points were to be seen upon examining the various sections, such as the relations of the antrum, the straightness of the nasal septum, the fascia of the eyeball, the horizontal position of the eustachian tube, the relative position of the temporary and the permanent teeth, the immaturity of the mastoid cells, the "sucking cushions" so-called, the mediastina, the high position of the apex of the heart, the highly developed diaphragm, the relatively large kidneys and suprarenal bodies, the small pelvis, the abdominal position of the bladder, the vertical position of the rectum and many other interesting features.

WEDNESDAY EVENING, GENERAL SESSION.

Dr. Arnott, of London, read a paper entitled, "A REVIEW OF THE DIAGNOSIS AND TREATMENT OF ASIATIC CHOLERA." He pointed out the difficulty of recognizing the disease before it got a foothold in the community, by reason of its similarity to sporadic cholera. He recommended that every case of diarrhœa be treated with all the sanitary precautions with which cholera is. In such a case the appearance of marked nervous phenomena should make us suspicious. The Doctor portrayed vividly the various symptoms of the various stages, and emphasized the necessity of becoming absolutely certain of the diagnosis by a bacteriological examination. He described various conditions of the body and of the surroundings which favoured the spread and strength of the disease. In regard to the treatment, he went fully into a discussion of the different plans employed—the eliminative, the astringent, the sedative, and the antiseptic, dwelling on the futility of any and all of them in many cases. The disease ought to be studied from cases uninfluenced by drugs. He opposed the use of alcohol in its treatment. His leanings were toward the eliminative treatment, and the application of heat externally and hot douches per rectum.

Dr. Sloan said that he did not agree with Dr. Arnott when he said that opium and alcohol were narcotics and not stimulants. He, Dr. Sloan, had treated many critical cases with alcohol and opium, which conclusively proved to him that they were stimulants.

Dr. Temple then said that he had seen several outbreaks of cholera in India, and had found that in many cases drugs were worthless; he thought alcohol was the best remedy for it. Warmth should also be applied. Dr. Spencer said that he had seen cholera when in the East, and agreed with Dr. Temple in every particular. Dr. Hunter then asked Dr. Temple if he would treat the disease among Europeans as he would the people of India. Dr. Temple replied that he would. Dr. Barrick said that he had seen an epidemic of cholera in London, Eng., and that it depended on the severity of the epidemic and not on the treatment as to the number of deaths. At the beginning of that epidemic the patients got alcohol and died. But as the epidemic got milder they lived in spite of the alcohol. He closed by saying that he agreed with Dr. Arnott as to the use of alcohol.

Dr. Arnott then closed the discussion by still holding his former position, that alcohol was not a stimulant. It was, he said, an anodyne and antiseptic. He quoted cases from his own experience to vindicate his position.

Dr. Philp, of Hamilton, then read a paper on "THE PREVENTION OF CHOLERA." He started out by saying that Asia was the breeding-place of this disease. The Doctor proved by citing several instances that the progress of the cholera could be checked by quarantine and thorough disinfection; also, that it was mainly propagated by the stools of the patient affected, therefore it was imperative that the water supply should in no way become contaminated with the stools of the cholera patients. All excreta, he said, should be sterilized by carbolic acid or sulphate of iron; all clothing should be thoroughly disinfected which had come into contact with the contagium, and that great cleanliness should be observed and the houses fumigated.

The following synopsis of a paper on "CHOLERA" was presented to the Association by Dr. Saunders. In speaking of the morbid anatomy, he stated that there were very few characteristic appearances to account for the violent nature of the disease. He described the condition in which the alimentary tract, heart, liver, lungs and kidneys were usually found. One of the most constant pathological conditions was that the blood was nearly always dark and thick. There were two views as to what caused this. He thought it was due to the chemical action of the morbific material excreted by the comma bacillus. It must be remembered that the bacillus was destroyed by a heat of 140 F. and by weak disinfectants. Cholera could be diagnosed by bringing a culture of the bacilli into contact with free acid in the presence of oxygen, when a bright red colour would be produced.

Dr. Rice, of Woodstock, then read a paper on "THE SYMPTOMS AND TREATMENT OF CHOLERA." He said that many cases of dysentery, diarrhœa, etc., under bad hygienic surroundings, would, if they occurred in infectious countries, be classed as cases of cholera. The Doctor then proceeded to give the symptoms which were found in the four stages of the disease. He then dwelt on the treatment, saying that there was no specific line of treatment, but five indications had to be met, viz.:—

1. The premonitory diarrhœa; 2. The loss of liquid by the bowels; 3. The low temperature; 4. The toxæmia; 5. The collapse.

The first condition could be met with calomel, followed by an astringent, with proper food and surroundings. In the second stage a large dose of calomel should be given, followed by successive small doses of the same, and opium or chloral or chlorodyne, the latter to be given for the pain, if present. The Doctor advised the use of hot antiseptic douches with tannin, for the serous diarrhœa. For the lowered temperature, he recommended the continuance of the douches with hot baths. We have, he said, no specific for the toxæmia, but calomel, iron and quinine have been recommended. In the stage of collapse hot baths were advised, with injections of whiskey, brandy, strychnia, ether, etc. But usually when this stage had arrived the patient was beyond help

Dr. Harrison opened the discussion on therapeutics by reading a paper on "BLOOD-LETTING." He said that it had been practised from time immemorial—that Virgil had mentioned it in one of his pastorals. He did not think there were many men who had graduated during the last fifteen years who knew how to perform venesection. Prof. John Hughes Bennet, he said, gave blood-letting its death-blow by his attack against it The Doctor thought that its indiscriminate use also assisted. But he felt sure that this was a very useful agent, which was now so universally discarded by the profession. He said that he had perfect confidence in it as an efficient remedy in pneumonia, in which he had often tried it

with success. It was useful, too, in emphysema. It was also useful in the various forms of heart-disease, particularly where the right ventricle was over-loaded. He also spoke highly of its use in his own practice in the treatment of apoplexy, and also in eclampsia. Even tuberculous patients were often helped. He stated that it was also useful in chlorosis by stimulating the blood-forming organs.

Dr. Olmstead, in discussion, said that he had not had much experience in blood-letting, but thought it was indicated in conditions of high arterial tension, lividity and engorgement of the right ventricle, such as is often found in pneumonia and some conditions of the heart. In using it in cerebral cases, we should be very careful, because if the case were one of thrombosis, blood-letting would be contra-indicated. In chlorosis, he would stick to iron.

Dr. McPhedran said he could not agree with Dr. Harrison's statement that pneumonia was more fatal in the hands of the modern practitioner than formerly, and he had seen statistics which proved this. The object of blood-letting was to relieve the right ventricle. This could be done, in a great many cases, effectually, by bleeding the patient into his own vessels, by using nitro-glycerine. The speaker had proved this by experience.

Dr. R. A. Reeve said that blood-letting, by means of leeches, was very serviceable in certain forms of disease in the eye and ear.

Dr. Brownlee related an interesting experience he had had with leeches.

Dr. Arnott, of London, said that he had proved the beneficial effects of blood-letting in meningitis and in inflammations of the eye and ear.

Dr. McKinnon, of Guelph, said that he had seen beneficial results from blood-letting in eclampsia, pleuritis and pneumonia, and strongly recommended it. Dr. Birkett, of Montreal, had seen good results in mitral stenosis in old people from blood-letting by nature's method, epistaxis.

Dr. Barrick related a case of eclampsia where everything else had been tried. Blood-letting afforded immediate relief. He would not advise its use in anæmia.

The President then said that in his younger days he had seen a great amount of blood-letting, and when it went out of use he had given it up, except in eclampsia.

Dr. Harrison closed the discussion by saying that he had tried nitro-glycerine, and was not so satisfied with it as was Dr. McPhedran; he preferred the lancet.

(To be continued in the August number.)

ASSOCIATION OF EXECUTIVE HEALTH OFFICERS OF ONTARIO.

The Eighth Annual Meeting of this Association, opened at Guelph on the 27th ult., and continued on the following day. The following gentlemen were present: Willis Chipman, C.E., Toronto, President; Dr. Allan Cameron, Owen Sound, 2nd Vice-President; Dr. Bryce, Secretary-Treasurer; Dr. Cassidy, Toronto, Chairman Provincial Board of Health; Dr. Macdonald, Hamilton; Dr. Knox, Brockville; Dr. Kitchen, St. George; members of the same. Dr. McLaughlin, Erin; Dr. Bogart, Whitby; Dr. McCrimmon, Palermo; Dr. Hodgetts, Toronto; Dr. Sheard, Toronto; Dr. Griffin, Brantford; Dr. McDonald, Tilsonburg; Dr. Wallace, Alma; Dr. Roberts, Little Germany; Dr. McNaughton, Erin; Mr. Strow, Waterloo; Dr. J. J. McKenzie, Toronto; Dr. Stewart, Palmerston; Dr. Hugh Watt, British Columbia; Dr. Groves, Fergus; Dr. Elliott, Seaforth; Dr. Hall, Chatham; Dr. Coventry, Windsor; Mr. Shutt, Ottawa; Dr. Cameron, Owen Sound.

From Guelph the following doctors attended: Dr. Kennedy, Dr. Howitt,

Dr. Stuart, Dr. Nunan, Dr. Lett, Dr. McKinnon and Dr. Cameron.

The meeting was opened at 11 o'clock by Rev. Dr. Ross offering up prayer. Dr. Howitt, Medical Health Officer, then welcomed the association to Guelph. The successful carrying out of their mission, meant, he said, a decrease in the population of the hospitals, poor-houses and gaols, a higher physical and mental standard for the people generally and ultimately immense saving of public and private funds. Suitable replies were made by President Chipman and Dr. McDonald.

Dr. Hodgetts, of Toronto, then read a paper on "How Diphtheria Epidemics are Propagated." He gave his experiences in Muskoka and other places, and spoke of an instance where a workman going into a lumber camp in Renfrew spread the disease within five weeks over seven townships. In the discussion that followed, Dr. McDonald, Hamilton, Dr. Sheard, Dr. Roberts and others took part.

Mr. Robert Barber, Provincial Inspector of Factories, read a paper on the "Sanitary Condition of Factories," and Dr. Griffin and Dr. McDonald followed with suggestions that attention should also be given to school and public building ventilation.

At the afternoon session Dr. Kitchen, of St. George, a member of the Provincial Health Board, spoke on the "Inspection of Cheese Factories." It was absolutely essential that milk should be free from adulteration. The need of cleanliness was nowhere more apparent than here. Milk was easily polluted by unclean cans, by being left on ground saturated with decomposing whey, or being left near piggeries or other outbuildings. The possibility of increasing the safety of cattle intended for dairy purposes by the tuberculin test was urged. Dr. McLaughlin, of Erin, Dr. Griffin and Dr. Bryce discussed the problem, and the importance of applying the test to all cows intended to supply the public with milk was specially referred to.

Mr. McRae then read a paper on the "Sanitary Needs of the Farmer."

Dr. Cassidy, of Toronto, took for his subject "Toronto's Water Supply." He advocated (1) a tunnel under the lake, extending from the pumping wells three miles out into Lake Ontario; (2) if this scheme should be found too expensive, filtration of the present supply through Hyatt filters, or (3) the use of spring water attainable at North Toronto and other places near the city. He thought that as the York Water Works Co. offered a supply one half cheaper than the present one, perfectly pure, with fifty pounds increased pressure on the taps through gravitation from a height of 420 feet, that their offer should be accepted. The North Toronto water could be connected with the Toronto system by a large main extending down Yonge street as far as Bloor street. The northern part of the city would thus secure a good supply and ultimately the whole city might be supplied. If this course were decided upon an agreement might be made giving the city the option of purchasing the sources of supply.

Shortly after 4 o'clock, the meeting adjourned and the members were driven to visit the waterworks, hospitals, schools, and other places of interest.

Evening Meeting.

In the evening the programme was especially interesting. The gathering took place in the Victoria Rink, where many citizens assembled to enjoy the calisthenic exhibition of Capt. Clark's pupils. After the drill and calisthenic exercises were over, Dr. Cassidy, on behalf of the Association, thanked the young people for the exhibition, and complimented Capt. Clark for the high state of efficiency in drill shown by his pupils. The pleasing and gracefully-executed manœuvres of these

four hundred tastefully dressed boys and girls had more than the charm of a pageant as they were the result of discipline and close mental application. After Mayor Smith had spoken a few words of welcome, Mr. Chapman delivered his annual address. Dr. Groves, of Fergus, followed with a paper, and Dr. Lowry, of Guelph, with one on "THE SPUTA OF CONSUMPTIVES AS A CAUSE OF DISEASE."

At the morning session, June 28th, Dr. Norman Walker, of Toronto, opened with a paper on "THE EPIDEMIOLOGICAL ASPECTS OF OUTBREAKS OF SPECIFIC DIARRHŒA." During the winter of 1892-93, he said, an epidemic of diarrhœa occurred in Toronto, the symptoms of which were of such a choleraic character that the name "cholerine" was applied to it. Inquiries were made concerning it by the Provincial Health Board, and it was shown that there had been at least 1,293 cases attended to by city doctors. From this it was believed that not less than 5,000 persons were attacked. All but three cases recovered. The chief symptoms were vomiting, nausea, increased temperature, cramps, pains located in the abdomen, with prostration and weakness. That polluted bay water caused this epidemic, the Doctor said, was quite certain. In some cases evidence had been secured showing that the trouble ceased when the people began to boil the water. Very few cases of this kind occurred outside the city. Reference was made to records of like epidemics elsewhere to show that it was traceable to the water.

Dr. Sheard, speaking on water supplies, referred to Dr. Cassidy's paper of the previous day. He deplored any tendency to injure Toronto by constantly attributing all sorts of illness and disease to the city water, and said that *efforts were being made* to provide the people with a pure supply. He felt confident that many statements made regarding the water supply were founded on pure rumour and not upon fact, and if more care was resorted to in investigating the supplies of other cities, both chemically and bacteriologically, he was quite sure the reports, if made public, would indicate that Toronto compared favourably with any of them. He also referred to the fact that during the past month there were only fifteen cases of typhoid in Toronto, and up to the time he left the city there were only eleven cases reported for June, which was a remarkably low average.

Dr. J. J. McKenzie, of the Provincial Health Department, laid stress on the value of the bacteriological analysis of water. A weekly or monthly test would be a guide as to any changes that might take place.

Dr. Griffin, of Brantford, suggested that the water supply for ordinary use might be taken from local sources, while the drinking water, which was a small proportion, might be brought from sources of unquestioned purity.

A few words from President Chipman and Dr. Cassidy, and the discussion concluded.

Dr. Coventry, Health Officer at Windsor, spoke on "THE DEFENCES OF THE PROVINCE AGAINST CHOLERA."

Dr. Bryce selected for his subject "THE DANGER OF A SMALLPOX EPIDEMIC."

The conclusions arrived at by the Doctor were: First—That a general vaccination before the re-entrance of children to the public schools is a public necessity; and, second, that the quarantine authorities should be petitioned to enforce a new order for the vaccination, either before embarkation or on ship-board, of emigrants, and for the inspection, and, in cases of neglect, of the vaccination, at quarantine of all emigrants arriving at Canadian ports.

Drs. Griffin, Walker, Cameron and Coventry took part in the discussion.

Dr. Wallace, of Alma, dealt with "PUBLIC ABATTOIRS," which he very strongly

advocated as essential to public health. He referred to the abattoir in Edinburgh, which, he said, was a model, both in construction and management. Two of the diseases which might be communicated to man from diseased cattle were tuberculosis and actinomycosis. In every city and town a properly constructed and thoroughly inspected public abattoir should be established, within easy distance from cattle markets, which should be convenient to railways, away from populous parts, easily drained, thoroughly ventilated, a bountiful supply of water, proper disposal of offal, and careful inspection of both animals and carcases.

Mr. Alan Macdougall, of Toronto, spoke on "SYSTEMS OF SEWERAGE AVAILABLE FOR ONTARIO TOWNS AND VILLAGES." He drew attention to the position of towns situated on rocky sub-strata, suggesting a mininum depth for the sewers of four feet, and the laying of all sewers in the rear of the houses. He stated that, from observations made, as well as from the published results of experiments made by the Massachusetts Board of Health, he found that sewage was not so liable to freeze in the winter as water mains. He advocated the extension of isolated house drainage, and the formation of districts for sewerage purposes; also the purification of sewage by downward irrigation, and the use of ferrozone and polarite filters where mechanical means were required.

Dr. H. S. Martin, of Erin, discussed the "PUBLIC HEALTH ACT IN RURAL DISTRICTS."

Dr. R. B. Grainger, the associate-editor of the ably conducted *New York Medical Journal*, was present at the meeting of the Ontario Medical Association. Dr. Hugh Watt, of Cariboo, B.C., Dr. H. S. Birkett., of Montreal, and Dr. De Garmo, of New York, were also present as guests of the Association.

Progress of Medical Science.

THE AUDITORY CENTRES IN RELATION TO LANGUAGE.—Giampietro, of Naples (*Ann. des Mal. de l' Oreille*, etc., March, 1893), enumerates these centres as follows: 1. Sensory bulbar centre, the destruction of which leads to total peripheral deafness, and, if it occurs before the age of two or three years, to irreparable aphasia. 2. Mnemonicovolitional centre in the optic thalamus on which depends the faculty of attention necessary for rational speech or writing; a vasomotor disturbance in this is the cause of transitory amnesia. 3. Ideophonic centre in the first temporal convolution (left?). When this is diseased the patient, though hearing words, is unable to affix to them or remember the idea they normally convey—"surdité verbale" (Charcot), "ideophonic amnesia" (Giampietro). 4. Ideomotor centre in the third left frontal convolution, for the remembrance of the movements necessary for the pronunciation of words, its disease causing typical motor aphasia. 5. Ideographic centre at the extremity of the second left frontal convolution, disease of which results in agraphia.—*British Medical Journal.*

KOCH'S TUBERCULIN IN CHRONIC CEPHALALGIA.—Dr. Charles Denison, of Denver, has recently had occasion to use tuberculin as a means of diagnosis in a case of suspected tubercular meningitis, marked by headache of several months duration. His patient was an overworked physician from the East, aged thirty-eight years, who had a pronounced tubercular family history and had been ill with pulmonary and basilar symptoms of a protracted and painful nature. The use of tuberculin was begun with a one milligramme injection. The diagnostic reaction began twenty-two hours later, and continued about twenty hours. The pulse,

previously 60, became 82 at the maximum; and the temperature, before 98·5 F, became 100·5°. Emesis was produced, also a constrictive feeling around the forehead and occiput. With a cessation of the tuberculin reaction the patient began to lose the pain in the head that had not been absent for six months. At the time of his admission to the hospital it was necessary for him to have the aid of two assistants to get to bed: four or five days later he was out of the hospital riding in the street cars and walking two blocks to reach Dr. Denison's office. In another week he was able to go riding daily, was out of doors nearly all day, and had no recurrence of headache, with the exception of once, when it seemed to have a gastric origin. After three weeks of continued treatment he took his departure for his home. The report of this case is published in the *Journal of the American Medical Association* for June 3rd. This is possibly the first recorded case of diagnosis of chronic tubercular meningitis made in manner.—*New York Medical Journal.*

JAMBUL IN GLYCOSURIA.—Vix (*Therap. Monatsh*, April, 1893) reports successful treatment with preparations of jambul bark used as a substitute for the fruit in cases of glycosuria. A fluid extract of the bark has been manufactured by Merck, being less costly than the first, and it has been found as efficacious, though slower in action, but pleasanter to the taste than the latter. Vix describes two cases of diabetes of some severity, 7 per cent. and 3 per cent. of sugar being voided respectively, but without marked polyuria. The diet was rendered strictly antidiabetic during treatment only, and daily doses of ten drachms, or about nine ounces in all, in the first case sufficed to render the urine normal during two years, when the patient succumbed to influenza and pleurisy. In the second instance the malady had been present for three years, and in this case also a few days' treatment absolutely freed the urine from the presence of sugar, the patient now being abroad. In ten other cases these results were confirmed, the urine always showing more or less improvement according to the extent and duration of the disease. The glycosuria being a symptom only, and part of a general process, the author lays stress on the necessity of general treatment also, and is confident that the drug is of the utmost value, its action always being reliable, and in his experience never having been attended by unpleasant symptoms. He recommends its administration, with or after meals, in water or wine sweetened with saccharin, the former being changed to a dark red color. This same coloration is also occasionally imparted to the urine and fæces.—*British Medical Journal.*

THE THERAPEUTICS OF THE HOT BATH.—Baelz, of Tokio, reported to the Medical Congress at Wiesbaden (*Münch. med Wochs.*, May 2nd) the results of a study of the hot bath made in Japan, where it is much resorted to by all classes of the population. The bath is often taken at a temperature as high as 106 F. The hot bath causes a rise of the body temperature to as high as 104° to 106 F.; this is due to absorption of heat, not to storage. The frequency of the pulse is increased, and the vessels dilate, losing their elasticity. The hot bath does not weaken or depress. It does not favor "catching cold," as does the warm bath (98° F. or less). On entering the hot bath hot water must be poured on the head to prevent cerebral anæmia. The hot bath is a derivative remedy, and is indicated in capillary bronchitis and lobular pneumonia. Three or four general baths should be given daily. The hot bath is also of use in rheumatism, nephritis, and at the onset of menstruation when accompanied by uterine colic. Baelz

affirmed that at the baths of Kusatsu, where the water contains sulphates and chlorides, the Japanese took daily five baths of three minutes' duration, at a temperature of 129° F. (54° C.). After six days an exanthem is produced, which resists all treatment, but eventually disappears spontaneously. The baths of Kusatsu are used in the treatment of severe chronic rheumatism, of gout, and of obstinate syphilis, as well as of leprosy. —*British Medical Journal.*

DRESSING FOR ABDOMINAL OPERATION WOUNDS.—Dr. Howard A. Kelly, of Baltimore, uses:

℞ Squibb's ether, or washed ether, and alcohol, absolute ..... eq. parts.
Bichlor. of merc (Merck's recryst.) enough to make the solution 1–16,000
Anthony's snowy cotton . . enough to make a syrupy consistence, added in small pieces, stirring.

As soon as this is poured over the wound evaporation begins to take place at once and the celluloidin hardens, gumming the gauze fast to the skin. To avoid delay in waiting for this to grow quite hard, and to prevent adhesion to the cotton applied above it, the whole surface is freely dusted over with a finely-powdered mixture of mixture of iodoform and boric acid:

℞ Pulvis iodoformi ..... ℥j.
Acidi borici ..... ℥vij.
M. Exactissime.
Sig.: Dust freely on wound.

This powder is of itself an invaluable protective. I use it constantly in obstetric cases, separating the labia and throwing it into the vagina, where it acts as a guard to the vaginal outlet against septic invasion from without.—*American Journal of Obstetrics.*

MIGRAINE.—

℞ Butyl-chloral hydrate .... gr. xv.
Tr. cannab. Ind ..... ♏ xv.
Tr. gelsem. ..... ♏ xxx.
Glycerin ..... f℥iv.
Aquæ ..... q. s. ad f℥iij.
M. Sig.: Teaspoonful at once. To be repeated in half an hour.—*Med. News.*

TUBERCULOSIS.—Picot (*El Siglo Medico*) employs the following combination:

℞ Guaiacol ..... gr. lxxv.
Iodoform ..... gr. xv.
Sterilized olive-oil
Liquid vaselin . . . āā ℥iij.
M. Sig.: inject hypodermically fifteen to thirty minims at a dose.—*Medical Bulletin.*

DYSPEPSIA WITH DIARRHŒA.—Dujardin-Beaumetz employs (*Gazette des Hôpitaux*).—

℞ Salol,
Bismuth subnitr.,
Sodii ..... āā ℥iiss.
M. et div. in chart. no. xxx.
Sig.: One or two powders after each meal.—*Medical Bulletin.*

HICCOUGH.—Dr. J. W. Allen, of London, recommends:

℞ Olei succini ver ..... ℥ss.
Liquor potassæ ..... ℥j.
Tinct. camphor comp ..... ℥iv.
Mist. acaciæ ..... ℥ij.
Aq. menth. pip ..... ad ℥vj.
M. Sig.: One-sixth every two hours.

Two doses usually succeed.—*Quarterly Therapeutic Review.*

THE BLOOD IN PURPURA HÆMORRHAGICA.—In the blood taken during life from a case of purpura Denys has found (*Centralbl. f. ailgem. Path.*, iv. Band, No. 5), great decrease in the number of red, marked increase in the number of white

corpuscles, and absence of blood plates; in addition, the blood contained certain elements which were probably leucocytes in process of disintegration. In two previous cases of purpura he has observed a marked decrease in the number of the blood plates. In the mucous membrane of the small intestine, which was the seat of ecchymoses, and in the solitary follicles and Peyer's patches large numbers of slender bacilli were found. The short rods and the cocci found in purpuric patches by other observers were not discovered in this case. Denys suggests the possibility of infection by way of the digestive tract in this disease. In the present case the disorder was ushered in by gastric and intestinal disturbances.—*British Medical Journal.*

PROTECTIVE SUBSTANCES IN THE BLOOD OF CONVALESCENTS FROM DIPHTHERIA.—Klemensiewicz and Escherich (*Centralbl. f. Bakteriologie und Parasitenkunde*), have succeeded in conferring upon animals a relative degree of immunity to diphtheria by means of previous treatment with defibrinated blood or with blood-serum obtained from convalescents from diphtheria. A similar protective influence could not be conferred by means of the blood of healthy persons that had not had diphtheria. As the immunity was not permanent, the opinion is expressed that it was dependent upon the presence of an antitoxin, of which the good effects were exerted until the supply was exhausted.—*Medical News.*

ACHILLODYNIA.—(*Weiner Med. Presse*). By Dr. E. Albert. The author has had several patients who were unable to stand or walk on account of pain at the insertion of the tendo Achillis, which pain disappears when the patient sits or lies down. He gives this condition the name of "achillodynia." There is swelling at the insertion of the tendon, but very little tenderness on pressure; sometime the os calcis also is thickened. Hot and cold applications, tincture of iodine, mercurial ointment, and all other measures he has tried have been of no use. It does not seem to be dependent on syphilis, gout, or gonorrhœa. The author thinks it is not the same thing as that which Raynal, and also Kermisson, described as "peritendonous cellulitis of the tendo Achillis," as nodular thickenings are found in the tendon itself in this affection, but believes it more like the "partial rupture and detachment of the tendo Achillis" described by Pitha, although in "achillodynia" Albert failed to find rupture or detachment of the tendon.—*International Medical Magazine.*

THE LESION OF PSORIASIS.—Audry (*Ann. de Derm. et de Syph.*) considers that the essential element of psoriasis is the absence of eleidin, accompanied by defect in the cornification of the epidermic cells. On this point he confirms what has already been stated by Suchard in 1882. On the other hand, he found in pityris rubra pilaris that the eleiden is increased, constituting an essential difference between the two maladies. In ichthyosis there is a regular hypertrophy of the eleidin, with an entire absence of inflammatory appearances.—*Brit. Med. Jour.*

A CAUSE OF BALDNESS.—Seiger gives, as the cause of baldness in men, the wearing of heavy and impermeable hats, which prevent evaporation of perspiration and secretions, and to a certain extent macerate the parts. The pressure of the rigid hat-band, by interfering with the circulation, is another factor in the causation of this disease.—*Medical News.*

Dominion Medical Monthly.

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TORONTO, JULY, 1893.

OUR PROGRAMME.

With this number the DOMINION MEDICAL MONTHLY makes its bow to the medical men of Canada. It may be thought by some that there is no need for an additional medical journal. To those who are placing this journal before you, the matter appears in a very different light.

There is much original material in this country that is not published; and the taste for carrying on and publishing home research should be encouraged. This shall be one of our constant aims.

Then again we will undertake to supply our readers with the very best of original matter from the pens of the best talent in the great centres of medical research in the world. Arrangements will be made to have on file a very extensive exchange list of the best journals published. From these shall be culled from month to month what is of general interest to the medical profession. Arrangements are also being made to have articles of merit which appear in foreign periodicals condensed for this journal.

In the next place this journal is absolutely free. It has no corporate body to defend. Its object will be to promote the good and welfare of the medical profession, and to supply its members with the very best of reading matter. Everything that is right will receive our hearty support; and everything that is wrong will receive our constant and unqualified opposition. In other words, this shall prove itself a journal by the profession and for the profession.

The profession has suffered, and is suffering, from some wrongs. One reform that we shall constantly keep before us is, that there should be a general medical council or licensing body for Canada. This can be easily accomplished. The Councils of the various provinces can arrange to accept each other's diplomas; or, can have a common curriculum of study; or, could have one central Examining Board for the whole Dominion.

It does seem strange that a medical man should be considered competent to take cases in medicine, surgery and obstetrics in the Province of Quebec, and not fit to do the same thing in Ontario. Or that a physician with the Ontario diploma must be re-examined in British Columbia. The Dominion should be free to every duly qualified practitioner. In principle, it would be as sensible to limit a man's license to Toronto; and, if he went to Hamilton, make him take another examination by the Board in the latter city.

We shall ever advocate a high standard of medical education. Once a man has satisfied such a standard in any one of the provinces, then let him have the freedom of the Dominion. After a man has been in practice for a great many years in one province, it is unfair to ask him to pass a new examination before he can practise in another province.

Further, this journal will always fearlessly defend the interests of the practitioner whoever he may be, and we shall speak with no uncertain voice as we travel along on our journey.

We solicit original articles, information, reports of societies and correspondence. We shall live up to the good motto,

"Audi alteram partem," in dealing with all matters affecting the medical profession, and shall criticise with a free hand the doings of all medical corporations, and endeavour to keep them from obtaining that influence or power that might prove dangerous to the weal of the medical man who stands alone, and is not identified with any strong combination. The general practitioner has never had such a channel for the expression of his views in the past, and we trust he shall make use of the pages of the DOMINION MEDICAL MONTHLY in the future.

THE MILITIA MEDICAL SERVICE AND THE ARMY MEDICAL REGULATIONS.

We are informed that the regulations of H.M. army are being sent to the surgeons of battalions and corps of militia. We should like to draw the Adjutant-General's attention to Part I, Section I, Paragraph 275, and to ask him if the equipment herein mentioned is to be furnished by the Department.

Further, relating to Paragraph 280, How can stretcher-bearers be utilized when they have no official existence—when ambulance drill and training have no recognized status? It is well known that General Herbert cut off the regimental stretcher-bearers from the pay list by declaring that only men bearing arms and bandsmen were to be paid. We believe the Minister of Militia is sincerely desirous of promoting the best interests of the force, but there is a haunting suspicion in the minds of many that there is an influence at work which nullifies his desires, which is misleading in fact, if not in intention—an influence which might better be exercised in governing insubordinate regulars than in terrorizing Canadian volunteers.

THE ONTARIO MEDICAL ASSOCIATION.

The Annual Meeting held in this city on the 21st and 22nd of last month, was, for many reasons, not as largely attended as on former occasions, but it was an enjoyable gathering both from a social and scientific standpoint, and Dr. Hilliary, the president, may congratulate himself upon having had such a well ordered and interesting meeting. He presided at the sessions with conspicuous tact, and was in the conduct of the meeting greatly aided by the Secretary, Dr. Wishart, and by the capable committees on business and arrangements. There were, unfortunately, points of weakness about this meeting which we understand, have been noted, and which, will be guarded against next year. Dr. L. McFarlane was wisely chosen as President for the coming year. Dr. Barrick, the retiring treasurer, is entitled to the thanks of the society for the careful manner in which he has for years attended to its finances.

SYPHILIS AND DEMENTIA PARALYTICA.

It is now fully admitted by the ablest pathologists that of all the causes of Tabes dorsalis, one, namely, syphilis, stands at the head of the list. According to Gowers, as many as eighty tabetics in the hundred owe their malady to syphilis.

Within recent years much attention has been directed to another degenerative disease of the nervous system. For a long time the pathology of dementia paralytica was a *terra incognita*. Thanks, however, to the labours of Folsom, Mendel, Hirt, Strümpell, Tuczik and others, the pathology of this fatal malady has been carefully studied. With the advance in its pathology comes an advance in our knowledge of its etiology.

According to Rieger, the man who has

had syphilis is sixteen times as liable to dementia paralytica as the man who has not been syphilized. Hirt states that out of two hundred and fifty-seven paralytics, one hundred and seventy-one had syphilis. Other authors could be quoted to show the same relationship of syphilis to dementia paralytica. This all goes to show the close relationship between this form of dementia and tabes.

When one looks at the pathological anatomy of dementia paralytica, the same analogy is still further borne out. Syphilis is specially liable to give rise to chronic inflammatory changes in and around the arteries. This is just what many of the best pathologists find to be the case in dementia. This is true to such an extent that so eminent a pathologist as Osler calls dementia paralytica a chronic meningo-encephalitis.

These views would bear out the treatment recommended by Sachs, of New York. He insists on rest, and then orders the iodides freely. He increases the doses until the patient is taking from 150 grains to 300 grains daily. This may be aided by mercurial inunctions. Small doses of iodides are quite useless.

CASE OF SYMPHYSIOTOMY.

On the first page there appears a brief account of a case of symphysiotomy, which is, so far as we can ascertain, the third case recorded in Canada. Drs. J. H. Burns and A. B. Atherton had charge of the patient, and are gratified by the successful issue of the operation. Dr. Springle, of Montreal, performed the operation for the first time in Canada, and reported the case in the January number of the *Montreal Medical Journal*. This operation was first proposed in 1768 by a French medical student and was rejected by the academy of Paris, but it was performed by him after graduation in 1777. The operation, however, soon fell into discredit, but was revived in 1866 by Prof. Morisani, and by his pupil, Spinelli, in 1891. The latter demonstrated it to Pinard, of Paris, who was the first to do the operation outside of Italy, in 1892. It has become rapidly popular, and the case here recorded may, as far as ascertained, be numbered about 279. Dr. Harris, of Philadelphia, gives the following figures: From 1777 to 1860 there were 100 operations, from 1866 till the end of 1892 there were 173 cases operated on. During 1892 there were 66 operations in nine countries with but 5 deaths.

THE TREATMENT OF TUBERCULOSIS.—Samuel G. Dixon, in the *Medical Times and Register* for April 29th, 1893, deals with this matter. It appears from his articles that he discovered the toxic agent known as tuberculin before Dr. Koch. Dr. Dixon has noted by careful study that the gouty condition is antagonistic to tuberculosis. He has produced the gouty reaction by throwing the bile salts into the cellular tissues of tuberculous animals. Taurocholate and glycocholate of soda were used. The action of taurin and urea on Lupus has been very satisfactory. In the same number of the *Times and Register*, the editors vouch for the value of the remedy in tuberculosis.

TREATMENT OF ASPHYXIA NEONATORUM.—Dr. R. J. Nunn (in the *Southern Medical Record* for May) gives the following method of resuscitating the asphyxiated new-born.

1. Put one hand behind the child's shoulders, taking the body and ribs into the palm. In this way the child can be firmly supported.

2. Grasp the child's legs with the other hand, placing the palm under the thigh. With the hand in this position the child's knees can be forced up against its abdomen and the diaphragm compressed.

The air is by this movement forced out of the lungs. When the legs are extended the air rushes into the lungs again.

3. The child's body, up to the neck, can be placed in the hot bath, which aids the efforts at resuscitation very materially. By this method one person can carry out all the needed movements, and administer the hot bath at the same time. The author speaks very highly of the success he has had by the above plan of treatment.

DIABETES.—Dr. George Harley, in the *British Medical Journal* for May 27th, divides this disease into the following groups:

1. Hepatic diabetes — including the gouty variety.

2. Cerebral diabetes — including all cases arising from nerve derangements.

3. Pancreatic diabetes—the most dead ly form.

4. Hereditary diabetes—where several occur in the same family group.

5. Food diabetes—from the ingestion of unwholesome substances.

The presence of sugar in the urine is due to one of two causes. Either there is an excessive formation of sugar, or there is a faulty and diminished saccharine consumption. The hepatic form might be taken as a type of the former; while the pancreatic might be taken as a type of the latter. In all cases of excessive sugar formation, a restricted dietary is necessary. A hearty man of 180 pounds uses up daily aoout two pounds of sugar. Now the same person as a diabetic may produce two or three pounds additional sugar, which is not required for the nutrition of the body, and runs off by the kidneys. It is in this class that dieting is so valuable.

The thirst may be appeased by bland liquids, as tea, coffee, lemon squash, salutaris, soda, koumiss, beef tea, milk, meat extracts. Alcoholic beverages ought to be avoided, as they very rapidly increase the output of sugar. Of the mineral waters, both the saline purgative, and the alkaline non-purgative waters are very useful. Phosphoric acid is specially valuable in quenching the thirst of these patients. In addition to the usual treatment for these cases, the following prescription is very highly commended:

℞. Croton chloral.....gr. ½.
Opii.....gr. i.
Ext. aloes barb.....gr. ⅙.
Ext. gentianæ.....gr. iss.

This is given in pill form three times a day. Under the use of the above, the urine in one patient fell from one and a half gallons to three and a half pints in twenty-three days; while the specific gravity decreased from 1036 to 1030.

BRAIN BRUISES.—Sir William Savage, in a recent number of the *Lancet*, claims that bruises of the brain are not uncommon after injuries to the head. In addition to the existence of concussion of the brain matter, there may be gross lesions. These injuries vary very much in extent, from a mere pinkish coloration to rupture of the vessels and the formation of blood clots. As it is quite impossible to say that the brain matter has not been lacerated, in the case of concussion, the prognosis should always be given guardedly. The author also thinks that if there is marked drowsiness, headache, loss of consciousness, marked loss of mental power, and difficulty in rousing the patient's attention, there is good reason to suspect brain bruises or lacerations.

FISTULA IN ANO.—Dr. T. J. Bennett (in *Daniel's Texas Med. Jour.*, April, 1893), states that he treats fistula in ano by the following plan: he thoroughly cleanses the rectum, he then floods out the sinuses with a twenty-five per cent. solution hydrogen peroxide, or carbolized water. The sphincter is then thoroughly

dilated. After this has been done the rectum and sinuses are again washed out. The sinuses are then flooded with pure water. Finally, they are washed out with a solution of silver nitrate, gr. xl. to ℥i. The parts are then dressed with absorbent cotton and vaseline. The only cutting ever required is to convert the internal blind variety into the complete form. The time required for the treatment is from four to eight days. There are no wounds to dress, and no scars left.

THE TREATMENT OF ALCOHOLIC DELIRIUM.—E. Lancereaux, in a recent number of the *Bulletin General de Therapeutique*, states that the following plan of treatment has been always adopted by him since 1873. He places the patient in a darkened room, so as to remove every source of irritation from the senses. Should the patient be very restless, all objects are removed from the room so that the patient cannot hurt himself. He strongly condemns the straight-jacket. It excites the patient, and often causes death by keeping up a useless struggle. The medicines to be used to procure, must be given in sufficient doses to give the desired result. He gives for one draught chloral hydrate ℥i., syr. morphiae ℥i., aq. sambuci ℥iv. If the patient has not gone to sleep in ten or fifteen minutes, he gives morphia gr. ⅙ hypodermically. To give chloral in insufficient doses only increases the excitement, and renders the case more likely to end fatally. When the patient awakens, if still delirious and restless, procure another spell of sleep by the administration of more of the medicine.

ETIOLOGY—PROSTATIC HYPERTROPHY.—Dr. G. F. Lydston, in *Medical and Surgical Reporter* for May 13th, 1893, has a lengthy article upon the above subject. From this article the following deductions are drawn:

1. The author sets aside former explanations of prostatic hypertrophy in the theories of senility, atheroma, and diathetic conditions.

2. While the prostate partakes of the nature of an involuntary muscular structure, it is peculiarly a sexual gland.

3. The relationship of the prostate to the function of micturition is purely accidental, as seen by the study of the urinary functions in eunuchs and geldings, where it is atrophied, and at an age prior to its development.

4. It is in the direction of its sexual and glandular function that we must look for an explanation of its hypertrophy.

5. Hypertrophy is caused by over-strain of the prostate. The main causes of this over-strain are excessive venery, and prolonged and ungratified sexual excitement.

6. The conditions that determine hypertrophy come on at an earlier age than is usually supposed.

7. The occurrence of hypertrophy in old age is the result of over-strain of the organ at an earlier period.

8. Senility, gout, rheumatism, and atheroma are not exciting causes, but they aid the increase of hypertrophy started by the over-strain.

9. In a perfectly normal old age the prostate should atrophy. Were it not for over sexual excitement and the over-retention of urine, so common in the mid period of life, this would be the case.

10. Careful rectal examination, from the age of twenty, upwards, reveals the fact that a perfectly normal prostate is the exception. This will be found specially true of the masturbator, and the sexual hypochondriac.

11. The vicious habit of retaining the urine too long, and causing over-distention of the bladder, causes prostatic hypertrophy. In this case the enlargement is a conservative one, and comes in as an aid to the bladder to retain the excessive quantity of urine so often in it.

THE TREATMENT OF INSANITY.—Dr. Shelby Mumaugh, in the May number of the *Medical Standard*, remarks on the treatment of insanity that the notion of the disease being incurable has dominated treatment too much. In many cases, the acute stage is allowed to pass, and very little done for these cases. The chronic stage comes on, when they are often incurable. Many cases that are really curable are allowed to become incurable by neglect. A sanguine view should be taken of such cases, and an effort made to restore the reason.

The nerve cells have been over-used, exhausted or perverted. We should try to restore the lost balance. An effort should be made to surround the patient with pleasurable emotions, and remove all corroding passions. The tonic and stimulating influences of moral confidence and hope are frequently the only frail and fragile props left us with which to invigorate the shattered mind.

Nutritious food is often a sheet-anchor. The feeding should be done with skill. Every effort should be made to improve nutrition. In cases where there is much exhaustion the free use of stimulants must be added. Forcible feeding by the stomach or Œsophageal tube—milk, raw egg, beef essence, pulped vegetables, ground meat, and meal may be introduced in this manner.

The closest attention should be paid to any disordered condition of the skin, kidneys, digestion, heart, etc. Great care should always be taken not to resort to the use of narcotics too freely. The use of chloral, opiates, etc., has done much harm. When it is really necessary to procure sleep, the best agent is one hundredth of a grain of sulphate of hyoscyamin, given hypodermically. A warm bath is sometimes very tranquillizing.

Constipation is frequent in these cases, and should always be corrected. A timely cathartic may ward off an attack of insanity. Their proper use relieves the mind of depressive emotions more certainly than any other class of drugs.

Exercise and tonics increase the appetite, produce refreshing sleep, and increase the bodily strength.

TREATMENT OF OBESITY.—J. N. Love, (in *Northwestern Lancet* for 15th May, '93) recommends strongly the use of phytolene in this condition. This remedy is prepared from the berries of the phytolacca decandra. He gives ten drops in water before and after the regular meals. When thus used, the clinical results have been very satisfactory. Phytolacca is frequently ordered for glandular swellings and rheumatism.

TREATMENT OF BRAIN INJURIES.—Dr. Adamkiewicz (*Deut. Med. Woch.*) shows that the brain is very readily irritated by certain chemical agents. Perchloride of mercury and carbolic acid are highly injurious in their action on the brain matter. He contends that all head injuries, where the brain is exposed, should be dressed antiseptically by employing boracic acid, which does not irritate the brain.

AN ENORMOUS OVARIAN TUMOUR IN A YOUNG GIRL (*New York Medical Journal*).—At a recent meeting of the Philadelphia Academy of Surgery, D. W. W. Keen presented an account of the case of a girl whom he had first seen when she was fourteen years old, at which time, although the abdomen was enormously distended, the child's father would allow no other operation than tapping to be performed. About fourteen months later the patient was brought to the Jefferson College Hospital, and Dr. Keen performed ovariotomy. The weight of the solid mass removed was twenty-seven pounds, and that of the liquid eighty-four pounds, making a hundred and eleven

pounds in all. The child herself weighed only sixty-eight pounds. It weighed just one and a half times as much as the patient. Her recovery had been most satisfactory in spite of a very poor and capricious appetite.

Items, Etc.

The Twenty-fifth Annual Meeting of the Nova Scotia Medical Society, was held at Bridgewater on the 5th and 6th of July.

The Annual Meeting of the New Brunswick Medical Association will be held at Fredericton on the 19th and 20th of the month.

The third Annual Meeting of the American Electro-Therapeutic Association will be held in Chicago, Sept. 12th, 13th and 14th.

We regret to learn that the finances of the Medical Faculty of Toronto University are not in a satisfactory condition. A special meeting of the Senate has been called to consider the matter.

The Annual Meeting of the American Association of Genito-Urinary Surgeons was held at Harrogate, Tenn., June 20th and 21st. Dr. George Chismore, of San Francisco, was elected President.

As will be seen, by consulting the advertising pages, Dr. J. E. White, of this city, has opened a "Medical Practice and Partnership Office." We trust Dr. White may meet with abundant success.

The *American Practitioner and News*, of June 17th appears in excellent form. It contains the first day's proceedings of the Thirty-eighth Annual Meeting of the Kentucky State Medical Society, and other matter of much interest.

THE BUSINESS ASPECT OF THE PRACTICE OF MEDICINE.—From the *Medical Age* we learn that the Detroit Medical and Library Association has adopted a fee-bill, which is a scale of charges that is intended to guide rather than govern members. For an ordinary office prescription the fee is fixed at from $1 to $5. Other fees range from $2 to $5,000. The last is the maximum for an operation for the removal of stone from the bladder. Three thousand dollars is the maximum fee for Cæsarean section, ovariotomy, cœliotomy, hysteritomy, abdominal and vaginal hysterorrhaphy and amputation of the hip-joint.

MEDICAL COUNCIL OF BRITISH COLUMBIA.—The following members and officers of the British Columbia Medical Council were elected last May. President, Dr. E. B. C. Hanington; Vice-President, Dr. J. M. Lefevre; Registrar and Secretary, Dr. Geo. L. Milne. Drs. J. C. Davie, W. J. McGuigan, W. A. DeWolf Smith, J. A. Duncan. The President concluded the annual address with these words: "I desire, also, to call your attention to the efficient manner in which the officers of the Council have performed their duties, and would particularly mention the Registrar, Dr. G. L. Milne, who has devoted much of his time to promoting the interests of the Council and of the profession, and who has discharged the delicate duties connected with his office in a manner which calls for the admiration of all."

OUR EXCHANGES.—We are already in receipt of a number of valuable exchanges, and desire to thank the various editors for the cordial expressions of good-will and the many kind wishes for the success of the DOMINION MEDICAL MONTHLY. The following journals have been received: *L'Union Médicale du Canada*, *American Lancet*, *Maritime Medical News*, *International Journal of Surgery*, *American*

Practitioner and News, Journal of Cutaneous and Genito-Urinary Diseases, The Medical Bulletin, The American Journal of Ophthalmology, The Medical Age, The Dietetic and Hygienic Gazette, The Journal of Balneology, Southern Medical Record, New York Medical Journal, Canadian Practitioner, The Alienist and Neurologist, Chicago Medical Times, Maryland Medical Journal, The Times and Register, The Post Graduate, The Canada Medical Record.

At the annual meeting of the Ontario Medical Library Association, the following officers were elected for the year: President, Dr. Albert A. Macdonald; 1st vice-president, Dr. Laughlin McFarlane; 2nd vice-president, Dr. H. Machell; curator, Dr. N. A. Powell; secretary, Dr. L. M. Sweetnam; treasurer, Dr. W. J. Greig; members of the board of trustees, Drs. A. McPhedran, J. F. W. Ross, R. A. Pyne, Gilbert Gordon, A. F. McKenzie, J. T. Fotheringham. The report of the curator showed that a very material increase had taken place in books and journals. The volumes added during the year numbered 480, and the library now contains 3,379 bound volumes and over 1,200 unbound. The library has been so indexed and arranged as to be of great value to those desirous of looking up references. The librarian, under the direction of the curator, sends books and journals to practitioners in any part of Ontario to assist in the preparation of journal or society papers. This is done without expense, other than express charges or postage. The financial report showed that though valuable assets had been acquired, the library is in need of substantial aid in order to make its future an assured success. Special efforts are being made not only for the collection of stock now due, but also for the acquisition of new shareholders. The possession of three shares of five dollars each will entitle any medical man in good standing to all the privileges of the library. Being situated in a central place (corner Bay and Richmond Streets), the rooms of this library are becoming more and more a resort for physicians from far and near. The librarian is at all times ready to assist in looking up references, and it is to be hoped that an increasing use of this valuable collection may help to repay those who have done so much towards its establishment and maintenance. To friends of the library the Board would say, that donations of spare books or journals are ever welcome and can always be utilized.

Personals.

Dr. L. McFarlane has gone on a six weeks' trip to the Pacific Coast.

Dr. R. McLearn was recently appointed Surgeon to the Infantry School Corps at Fredericton.

Dr. Murray McFarlane has been appointed oculist and aurist at St. Michael's Hospital, Toronto.

Dr. W. H. Pepler will shortly remove from 799 Queen Street West to corner of John and Adelaide Streets.

Dr. J. E. Graham, Professor of Clinical Medicine, Toronto University, is expected to return from Europe about the 1st of September.

Dr. Price Brown returned recently from New York, after attending the Annual Meeting of the American Laryngological Association.

Dr. E. E. King has been appointed one of the pathologists to Toronto General Hospital in place of Dr. W. H. B. Aikins, who has been placed on the active staff of physicians.

Drs. Temple and Reeve of Toronto, Sullivan of Kingston, and Harrison of Selkirk, were appointed as delegates from the Ontario Medical Association to the Canadian Medical Association.

Dr. Campbell, of London, was elected President, and Dr. Philip, of Brantford, Vice-President of the College of Physicians and Surgeons of Ontario, for this year. Treasurer, Dr. W. T. Aikins (re-elected), Registrar, Dr. R. L. Pyne (re-elected).

Professor Dr. Adam Politzer, the distinguished aural surgeon, of Vienna, who has been been appointed by the Austrian Imperial Government a scientific delegate to the Medical and Hygienic Exhibition, to be held at Chicago in connection with the World's Fair, will be in Toronto about August 10th, and will be the guest of Dr. Ryerson.

The officers elected at the recent meeting of the Ontario Medical Association for the ensuing year were: President, Dr. L. McFarlane, Toronto; Vice-Presidents, Dr. Rice, Woodstock, Dr. Smith, Seaforth, Dr. Mitchell, Enniskillen, Dr. Holmes, Chatham; General Secretary, Dr. Wishart, Toronto; Assistant Secretary, Dr. J. N. E. Brown, Toronto; Treasurer, D. J. H. Burns, Toronto.

At the meeting of the Association of Executive Health Officers of Ontario, held at Guelph, June 27th, the following officers were elected: President, Dr. Cameron, Owen Sound; 1st Vice-President, Alan Macdougall, C.E., Toronto; 2nd Vice President, Dr. Howitt, Guelph; Secretary-Treasurer, Dr. P. H. Bryce, Toronto; Executive Council, Dr. Hall, Chatham; Dr. Coventry, Windsor; Dr. Sheard, Toronto; Dr. Griffin, Brantford; Dr. McCrimmon, Palermo.

At the Annual Meeting of the Medical Alumni Society of the University of Toronto, held at the rooms of the Medical Library, Dr J. Ferguson in the chair, the following officers for the ensuing year were elected: President, Dr. E. Kitchen, of St. George; Vice-Presidents, Drs. A. A. Macdonald, L. McFarlane, E. J. Barrick, John Ferguson, of Toronto, and F. R. Eccles, of London; Treasurer, Dr. B. Riordan: Secretary, Dr. W. Harley Smith; Council, Drs. A. H. Wright, B. Spencer, E. E. King, J. D. Thorburn, W. H. B. Aikins, J. McCallum, C. J. Hastings, G. A. Peters, E. H. Adams and G. Carveth.

Book Notices.

The Popular Science Monthly. New York: D. Appleton & Co., 1, 3, and 5 Bond Street. Single number, 50 cents; yearly subscription $5.

The June number of this scientific monthly is unusually interesting, on account of the following articles: "Modern Miracles," by Prof. Evans; "The Phenomena of Death in Battle," by Geo. L. Kelmer; "The Revival of Witchcraft," by Dr. Ernest Hart; "Why Grow Old?" by Dr. N. E. Yorke-Davies; "Irrigation of the Arid States," by Chas. H. Shinn; "The Inadequacy of Natural Selection," by Herbert Spencer; "Sketch of Sir Archibald Geikie," etc.

International Clinics. A quarterly of clinical lectures on medicine, neurology, pediatrics, surgery, genito-urinary surgery, gynæcology, ophthalmology, laryngology, otology and dematology. By professors and lecturers in the leading medical colleges of the United States, Great Britain, and Canada. Vol. 1., third series, 1893. Philadelphia: J. B. Lippincott & Co., 1893.

This volume contains an excellent collection of clinical lectures delivered by leaders in the profession, such as Sir Dyce Duckworth, Dr. Wm. Pepper, Dr. F. X. Dercum, Dr. J. Putnam, Dr. J. Ashhurst, jr., Dr. A. G. Gurster, Dr. J. Bland Sutton, Dr. Wm. Godell, Dr. Paul Mundé, Dr. J. H. Musser, Dr. H. C Coe, Dr. D. W. Finlay. This series of clinical lectures is worthy the support of the medical profession.