Dominion Medical Monthly

And Ontario Medical Journal

Vol. XXVIII. TORONTO, MAY, 1907. No. 5

Original Articles.

A CASE OF OBSCURE AND SYMPTOMLESS RENAL HEMATURIA—NEPHRECTOMY.

By J. Price Kennedy, M.D.

Surgeon to Wingham General Hospital.

Under the designation of Symptomless Hematuria Henry Fenwick describes a group of cases, partly vesical, partly renal, in which the only symptom, at least for some time, is hemorrhage.

The causes of the renal variety he enumerates as follows: 1, Malignant Disease; 2, Bright's Disease; 3, Renal Syphiloma; 4, Cardiac Disease; 5, Rare Renal Stone.

He states that in malignant disease of the kidney, either carcinoma or sarcoma, hemorrhage, in many instances, is the first and for a time the only symptom. The hemorrhage is often sudden, unexpected and profuse. The bleeding may at times cease abruptly, due to temporary corkage of the ureter with a clot. Pain, tumor, frequency of urination occur later in these cases, although the latter symptom is not common apart from the frequency induced by clot retention. The urine in the hematuria of Bright's disease varies greatly in color, from a rosy hue to a dark red. The symptomless cases due to Bright's disease, Fenwick says, form about 12 per cent. of the obscure renal hematurias he has examined. Under the head of Bright's Disease, Schede, in the *Annals of Surgery*, p.

446, Vol. XVI., 1892, records a case of uncontrollable renal hemorrhage in which nephrectomy was performed.

Hemorrhage may occur from an interstitial nephritis, which may be unilateral, affecting sometimes only localized areas of the one kidney. In a case mentioned by Nimier, p. 342, Vol. V., Von Bergmann's Surgery, only a single papilla was affected, but the bleeding continued until the kidney was removed.

Sabatier also reports operating in a case of hematuria, expecting to find stone in the kidney. The wound in the kidney bled so freely it was removed. Pathologically it showed nothing but a moderate degree of interstitial nephritis.

Elliott says, " Although unable to explain the fact adequately, clinical records show that a small patch of interstitial fibrosis may be the only microscopic change found in a kidney which has bled severely and persistently. The area of involvement may be so small as to escape the most careful search, and it is perhaps on this account that even to this day cases of " essential renal hematuria " with an unexplained pathology are reported. Possibly this might account for the hemorrhage in a case in Howard Kelly's clinic reported by Schenck in the *Medical News,* December, 1904, in which the kidney was exposed, split in two, a liberal portion removed for microscopic examination and the kidney replaced after suturing. The hematuria was cured, but no pathological condition was found.

Well authenticated cases of renal hematuria without symptoms due to stone have been reported by Fenwick and others. As a rule, however, in these cases, the hemorrhage is not profuse and in time other symptoms supervene. Senator, in Jacobsens' Surgery, p. 704, 2nd Edition, reports a case of profuse hematuria, symptomless, in which nephrectomy was performed. The kidney appeared quite normal. As she belonged to a family of bleeders, Senator thinks that this case suggests that in some instances hemophilia is due to a local defect in the walls of the vessels. Grosglik, in Von Bergmann's Surgery, p. 342, Vol. V., reports a case of hemophilia inherited from both father's and mother's families, in which patient as a child suffered from profuse epistaxis, bled easily from the gums, and later had rectal hemorrhage. After the renal hemorrhages began the others ceased. Symptomless hematuria, as far as I have been able to learn, does not occur in renal tuberculosis. The fact that these cases are symptomless increases the obscurity of their etiology, and frequently renders a diagnosis very difficult and even impossible. In an interesting article in Vol. IV. of the sixteenth series of the International Clinics, Elliott, of Chicago, says: " Renal

Hematuria of obscure origin has been recognized since the earliest days of renal surgery and has constituted a puzzling problem in which physician and surgeon alike have been interested. Obscurity in pathology at all times adds interest to clinical investigation, and this must be particularly true of a condition which is frequently revealed only in its real character at an operation undertaken for the removal of stone or the ablation of a supposedly tuberculous or otherwise diseased kidney." These cases have been classified or reported under such designations as "Renal Hematuria" (Senator, Broca, Grosglik), "Hematuria from Healthy Kidneys" (Klemperer), "Mysterious Hematuria" (Rovsing), "Renal Epistaxis," "Renal Hemophilia," "Angio-Neurotic Hematuria," "Hematuria of Unexplained Origin" (Schenck), and "Essential Renal Hematuria."

This latter term has been especially used to classify a group of cases which are free from demonstrable lesion and possess two features in common, viz., unilateral renal hematuria and an obscure pathology. The tendency is, however, Elliott maintains, to incline to the view that every such case, if carefully studied, will show some pathologic condition, usually a chronic nephritis. The nephritis, as I have said, may be confined to one kidney, and even to localized areas of the renal tissue. Nevertheless quite a number of cases of renal hematuria of unexplained origin are reported when the kidney has been incised and carefully examined, but not studied microscopically. Schenck, however, in his above-mentioned paper, reports finding only two cases in literature in which the whole kidney has been examined microscopically and found normal; the one case reported by Klemperer, the other by Schede. In chronic Bright's disease, too, when both kidneys are diseased, the hematuria, if severe in character, Elliott says, is usually unilateral and almost always without symptoms.

The patient, Miss K., aged 28, whose case I wish to present to you to-day, called at my office, September 18, 1906, bringing with her a sample of urine of a bright red color, which she handed to me and asked what it meant. Unfortunately, I could not explain to her offhand what it did mean, nor, as you will learn, was I able to explain to my own satisfaction the real cause for some time afterwards. She stated that three days previously, viz., on September 15th, upon passing urine she noticed that the urine was of a red color. She had experienced no pain or frequency in urinating, felt well in every way, and looked the picture of health. Family history was negative. No history of tuberculosis, excepting two uncles. No history of hemophilia. Pulse 70. Temperature normal.

Examination of urine showed it to be acid, sp. gr. 1022. No albumen except that to be expected from the amount of blood. No sugar. Microscopical examination showed no casts, no pus. Nothing, in fact, but a field crowded with blood corpuscles. Here was certainly a case of symptomless hematuria. No history to point to a clue and no symptom but hemorrhage. The quantity of blood was so large, apparently so sudden was the onset of the trouble, and the patient looked so well, that I became suspicious of malingering, and consequently asked the patient to call again next day and bring another sample of urine, which was practically the same as the first sample. I also had her pass urine in the office under the watchful eye of a lady medical student who was spending the summer with me. There was no doubt about the matter. The case was one of hematuria. I gave some placebo, advised rest, and waited for the hemorrhage to stop or new symptoms to arise.

From the 15th of September to the time of operation, October 24th, patient passed blood constantly when urinating. Sometimes the urine was of a bright red color, other samples were very dark, with occasional small vermicular clots. During the first two weeks some samples contained considerable clotted blood. On the 12th of October I examined the interior of the bladder with a Bransford Lewis cystoscope, but could discover nothing abnormal in the bladder. I then concluded that either kidney must be responsible for the hemorrhage, and attempted to catheterize the ureters. In this I was unsuccessful. About this time she began to complain of a slight uneasiness along the course of the left ureter. She said it was not a pain but a slight dragging or aching sensation, which was indeed so slight that I believe it would have passed practically unnoticed had it not been for repeated examinations and questionings. Thinking of the possibility of stone, I took a number of X-ray pictures. These were all negative.

On October 17th I took her to Detroit, to Dr. B. R. Schenck. He kindly catheterized the ureters for me, and discovered that the blood was coming from the left kidney, and in large quantities. I wish to mention the fact just here that Dr. Schenck is very expert in the catheterization of the ureter. He uses the open method—the Kelly method. He passed the ureteral catheter in this case in less than seven minutes.

So alarming was the hemorrhage that Dr. Schenck remarked to me, "If you don't do something quickly, your patient will die." The afternoon and evening after the catheterization the

patient suffered severe pain in the loin and along the course of the ureter, due probably to ureteral clot. The following morning I brought her home to Wingham. She was now becoming blanched and anemic in appearance. Dr. Schenck also made a culture from urine and blood of diseased kidney, and on October 24th wrote me as follows: "The culture made from urine and blood from left kidney has remained sterile. This, of course, does not rule out tuberculosis, for tubercle bacilli will not grow in this way. I can find no pus in the sediment. If any be present, it is in such small quantities that it is impossible to find it in the presence of so much blood. The albumen is about that (in quantity) to be expected from the blood. I am much interested in the case, and trust that you will not fail to let me know the outcome. Thanking you for letting me see Miss K., sincerely yours, B. R. Schenck."

In the diagnosis of this case now, four causes suggested themselves: 1, Tuberculosis (possibly); 2, Stone; 3, New growth; 4, Nephritis.

The blood is not profuse in the early history of tuberculosis. The profuse hemorrhage in kidney tuberculosis being usually associated with its later stages of ulceration. Frequency of micturition is a very common, perhaps almost constant, symptom in renal tuberculosis, and while this symptom does not necessarily precede the hematuria, it almost invariably occurs before such profuse hemorrhage sets up.

These facts led me to eliminate tuberculosis. The patient had no evidence of cardiac disease. Stone had not necessarily been excluded by the negative radiographs as one form of stone, the urates, is not always shown by the X-ray. The extreme rarity of stone as a cause of symptomless hematuria, and the facts that hemorrhage in renal calculus is not profuse, led me to conclude that my case was due to either new growth, or nephritis. The latter, Elliott says, it is usually impossible to diagnose from the urine while the hematuria lasts, and, of course, there were no other symptoms to go by. As Fenwick laid so much stress on the hematuria being profuse in malignancy, I inclined to expect a malignant growth.

October 23rd. Patient has lost nine pounds in weight since September 18th, is pale, dizzy and light-headed on attempting to walk. Pulse 68, temperature normal. On October 24th, assisted by Drs. McAsh and Redmond, Dr. J. E. Tamlyn, anaesthetist, through the oblique lumbar incision, I brought the kidney out on the loin, and examined it. The lower part of the kidney was

quite dark and congested in appearance, and also a small part of upper end. Between the fibrous capsule and kidney proper was about an ounce of blood-stained serum. I explored the kidney and its pelvis for stone, but could find none. I then concluded to split the kidney, and if nothing else were found, to unite the parts with mattress sutures. On secondary consideration, however, fearing this might not relieve the hematuria, and confident that, even if patient were able to stand it, no further operative procedure would be permitted, I removed the kidney. Operation took one hour and twenty minutes. Patient made practically an uneventful recovery.

The 24 hours previous to operation, patient voided only twelve ounces of urine, and the same quantity in the 24 hours subsequent to operation. The next 24 hours fifteen ounces were passed. The urine gradually increased in quantity, until at the end of three weeks patient was passing from twenty-five to thirty-two ounces in 24 hours. Temperature never went above 100, excepting upon evening of third day it reached 100 4-5. The nurse telephoned on the ninth day that the dressings had suddenly become soaked with blood. I removed dressings and found that a rather severe venous oozing had occurred from wound, which was controlled by packing with gauze, saturated with adrenalin solution. This oozing, however, was quite free for two or three days. I can't account for this hemorrhage so long after operation. For several days after operation there was quite a considerable amount of albumen in urine. This, however, gradually disappeared, and in four weeks' time the urine was normal, as follows: S. G. 1022. Faintly acid. No albumen. No sugar. No test made for quantity of urea. Apparently normal from the S. G. Heavy precipitate, which dissolved on heating.

Microscopically:—Amorphous urates. A few calcium oxalate crystals. No casts, pus, nor blood.

I forwarded kidney to Detroit Clinical Laboratory, and received the following report:

LABORATORY REPORT NO. 1051.

Physician—J. P. Kennedy. Patient—Miss K. Date Received—Nov. 10, 1906. Date Reported—Nov. 21, 1906. Character of Specimen—Kidney.

The kidney shows an unusual amount of fat in the pelvis, extending into the calyces, and an obscuring of the normal markings, especially of the pyramids. There is no noticeable abnor-

mality of size and the capsule strips easily. There are persistent fetal lobulations.

Microscopically, the fat tissue is seen to be merely an excess of physiological deposit and not a product of degeneration or neoplasm. The whole renal structure shows a marked protoplasmic or parenchymatous degeneration; the intensity of this degeneration varies in different areas, probably determined by the vascularity. All the tubules, and especially the convoluted tubules, are affected, while the glomeruli show a marked shrinkage of the capillary tuft, an attenuated Bowman's capsule, and within the latter a collection of parenchymatous debris. Occasionally the capillary tuft is entirely wanting and the capsular space is entirely filled with debris. The blood-vessels share to a lesser extent in the degenerative process. There are numerous tubular plugs, hyaline and granular. No interstitial change is observed, and no sign of any neoplasm anywhere. The extensive necrosis may be partly due to poor post-operative preservation, but some of it is distinctly a vital process, especially the changes in the glomeruli. This latter factor warrants a diagnosis of glomerular nephritis.

(Sgd.) P. M. HICKEY, M.D.

The extensive necrosis mentioned in this report, I believe, was entirely and wholly a vital process, as the specimen was very carefully preserved.

Bergmann says nephrotomy has entirely supplanted nephrectomy in the treatment of these cases, and possibly splitting the kidney and uniting with mattress sutures, as I first thought of doing, might have been sufficient in this case, but the patient's condition had become so serious at the time of operation, and I had no means of knowing the pathological condition at the moment, and from the fact, as I have already stated, that I was assured no further operative procedure would be permitted. I adopted the radical method of freeing my patient from her diseased condition. Forchhiemer, in his recent work on treatment, page 442, reports a case in which the hematuria did not cease after nephrotomy, but in which he claims calcium chloride had an excellent effect. He does not say, however, that the case was cured. That such cases do die cannot be denied. V. Bergman says in his Surgery, p. 342, Vol. V., " that there may be an intense hemorrhagic nephritis, which affects only one kidney, the only symptom of which for a long time may be the repeated hemorrhages. The disease may prove fatal without affecting the other kidney."

Dr. West and Mr. Bowlby, in the Clinical Society's Transactions, Vol. XX., p. 147, report the case of a young girl who passed so much blood with the urine that the bladder was sounded for stone. Nothing further was done, and patient died. The autopsy revealed marked granular kidneys. It is now over six months since I operated on my patient. She has gained in flesh, looks well and is in very excellent health.

NOTES OF A CASE OF INVERSION OF THE UTERUS.

By Frederick Fenton, M.D.
Associate in Obstetrics, University of Toronto.

Mrs. K., aged 20 years, primipara, confined Sept. 28, 1906. Previous and antepartal histories unimportant. She is small and light, with thin bones and little superfluous fat. Pelvis is normal in size and shape.

Labor began about 11 a.m., Sept 27th, but pains were not very strong and were far apart till about 10 p.m.

I was notified at 1.30 a.m. (28th) at which time the membranes ruptured spontaneously. The child presented by the vertex and lay in a left occipito-anterior position. Labor was terminated about 4 a.m. (three and one-half hours after the rupture of the membranes) without forceps, chloroform being used to the obstetrical degree for the last hour.

On delivery, the membranes were found stretched over the head and face, and doubtless had much to do with the production of the inversion. On following down the uterus during the delivery of the body I was struck by a peculiar flatness of the posterior uterine wall, while the whole uterus seemed to lack tone.

About half an hour after birth the placenta was expelled, apparently in a normal manner, some pressure being made from above. As the placenta was expelled, the fundus was felt to pass from the grasp of the hand, and on examination the placenta was found to be adherent to a hard round mass which protruded from the vulva, and which proved to be the inverted fundus. The placenta was easily stripped off the fundus, and on grasping the uterus firmly there was no difficulty in controlling the hemorrhage.

The uterus was carried up into the vagina and its wall fed

back through the cervix until the fundus suddenly sprang back into its proper position.

Good contraction at once took place and was maintained. Not more than six or eight ounces of blood was lost throughout the case, and there was no shock, although the patient was not under an anesthetic at the time of inversion, nor during replacement. The puerperium was uneventful, as is shown by the accompanying chart; both fundus and temperature lines, as well as the pulse record, being satisfactory.

Traction upon the cord is the most frequent cause of inversion of the uterus, especially if the traction be applied very soon after the birth of the child, before the contraction and retraction of the uterine muscle has had time to adapt the organ to the new condition of affairs. In this case the traction upon the membranes by the advancing head was undoubtedly the starting-point, the downward traction of the placenta itself, the subsequent uterine contractions and the pressure of the external hand uniting to complete the inversion.

I have thought this case worth reporting because of the extreme rarity of the complete inversion, being the rarest of serious obstetric accidents. "Winkel had not seen a single case in 20,000 labors, nor had Braun one in 250,000. In 192,000 cases in the Rotunda, covering a period of nearly a century, only one case was reported." (Jewett.) "Beckman collected from literature 100 cases and found that 54 of them had occurred spontaneously." (Dorland.)

The mortality is variously stated at from 25 per cent. to 35 per cent.

75 Bloor Street East, Toronto.

MILK AS A CAUSATIVE FACTOR IN TYPHOID.*

By Lewis Henry Marks, M.D., Poughkeepsie, N.Y.

Milk is undoubtedly one of the causes of typhoid fever epidemics. All of our standard text-books state that it is a carrier and excellent culture medium. The bacilli of the disease are transmitted to the milk in various ways: by cans washed in infected water, by attendants who are in attendance on typhoid

*Published synchronously with *Albany Medical Annals.*

patients, by milk exposed to flies and dust laden with typhoid germs.

Dr. Ernest J. Lederle, president of the New York Board of Health, in a notice to milk dealers, advised that the rooms in which milk is sold should not communicate with one which is used for living or sleeping purposes, because,—

1st. Milk readily absorbs odors from the surrounding atmosphere and is thus rendered more or less unsuitable for use.

2nd. Milk furnishes an excellent medium for the growth of many kinds of disease-producing germs, and through it may be readily transmitted such diseases as tuberculosis, typhoid fever, scarlet fever, influenza, dysentery and probably some others.

If any person sick of any one of these diseases is present in a living or sleeping room, unless the greatest care is used, and even in spite of this, the germs producing these diseases may be conveyed through the atmosphere or by the hands or clothing of those in contact with the sick, and thus the milk becomes contaminated.

One of the characteristics of a typhoid epidemic caused by milk is the rapidity of its dissemination. Specific instances of epidemics traced to milk do not appear in our text-books, but rather are to be found in the reports of wide-awake health officers. Dr. Lederle reports a series of eighty-six cases occurring in one of the New York boroughs which were traced to one case of typhoid in the family of a milkman who had supplied all the families of those taken sick. The well was found contaminated, and ordinary sanitary precautions had been neglected.

Dr. Ernest Wende, of Buffalo, in a paper on "City Milk Routes and Their Relation to Infectious Diseases," which was presented to the Section on State Medicine at the twentieth meeting of the American Medical Association, held at Columbus, Ohio, 1899, reports three epidemics. They are interesting and instructive, hence are reported:

"On September 4, 1894, we were assured by the records of the register that nineteen cases of typhoid fever had developed with wonderful rapidity in families served by a milkman living in a sparsely settled section in the northern part of the city. The Health Department forthwith instituted an investigation, which showed the startling result that the wife of the milkman, surrounded by unfavorable conditions, was ill with the fever, however, on the borderland of recovery. She was still being nursed and cared for by the husband, who likewise was handling the milk and washing the cans in a most objectionable manner,

with water procured from an old cistern that had, during the preceding year, been the subject of several sanitary complaints. Another powerful factor that made the transmission of the disease, through the medium of the milk, eminently capable, was the fact that the patient was not isolated, but cooped up in a small, stuffy chamber joining the kitchen, in direct communication with the milkroom. It is hardly necessary to state that the sale of milk was interdicted, the cistern ordered abandoned, disinfected and filled, and everything pertaining to the dairy and the premises in general placed in a sanitary condition. By this and other procedures the spread of the disease was checked, no further case occurring on the route.

"On August 21, 1895, the Department again, through the intervention of the register, discovered eighteen cases of typhoid fever intimately associated with the milk route of a dairyman located on the outskirts of the city. An inquiry into the causes and circumstances of the outbreak revealed that his premises were not what they should be by reason of defective drainage and a badly constructed, ill-ventilated and unclean milkhouse, conditions, as might be expected, most favorable for the reception and multiplication of the typhoid bacillus. The peculiar interest connected with these cases was that the wife of an employee had propagated the infection that had contaminated the milk through the agency of her husband, who, at night, not only acted as nurse but fulfilled all the other necessary household duties, and who, during the day, handled and delivered the needed product to the confiding customers, without changing his clothing for days, or taking any precaution whatever. The sick wife was immediately removed to the hospital and the unsanitary conditions so promptly changed that, by August 30, just nine days after the discovery of the first, no further cases were reported.

"Again, on March 9, 1896, the register indicated the existence of fourteen patients affected with typhoid, on the route of a milkman residing in the western portion of the city. Here we acquired the information that the milkroom was in the rear of the first floor of the building which he occupied. Several months previous, a case of typhoid developed on the floor above, in a separate family, and ran its full course. These cases undoubtedly arose in consequence of the unsanitary conditions prevalent in and about the building, and for like reason the contagion remained active until finding expression in the dairyman's

route. A quick subsidence of the epidemic followed the suppression of the milk, thorough cleansing and disinfecton."

The epdemic which occurred at Williamstown, Mass., was found by its investigation to have been caused by infected cream eaten with breakfast food.

Some of the typhoid which we have had in Poughkeepsie may have been caused by infected milk, for our system of inspection is not yet perfected nor are our dealers pointed out as models of cleanliness, therefore our milk should be taken into consideration when many cases develop. We face the possibility of an epidemic from infected milk here as do all places where the supply comes from so many sources.

Another reason is because some of our fever cases are not traced, because they do not have the official stamp—that is, do not respond to the Widal test or the diazo reaction during the first week. It seems to me that cases which do not respond to the Widal test or the diazo reaction, yet present the clinical signs, should be reported and investigated for safety's sake at least.

While the majority of the cases of typhoid respond during the first week to the Widal test, there are cases in which the reaction is delayed or occasionally absent, therefore a negative result of the test does not exclude the diagnose of typhoid. (Dr. Welch, *Journal of the American Medical Association,* August 14, 1897.)

The diazo reaction is also open to criticism. Some cases are not subjected to tests, hence are not accepted.

Where two or three cases of typhoid are found along the route of a certain dealer, his place should be inspected, as should the homes of all those who deliver milk to him for distribution.

All physicians should co-operate with the Health Officer and report promptly all cases of typhoid. In this way the disease is not likely to obtain a very great foothold or make much progress.

The milk committee of this society, by its inspections of the city supply and by its demonstrations and instructions to dealers, are doing a good work for the city, by lessening the chances for infection by the milk route, and consequently should receive our hearty support and endorsement.

PSYCHOPATHA IN GENERAL HOSPITALS.

By Ernest A. Hall, M.D., Victoria, B.C.

"The Provincial (Ontario) Government has decided upon a step in regard to the treatment of acute cases of mental diseases which will mark a most radical departure from the systems now in vogue in any part of the American continent. The development which is expected to follow the initial step will have a most important bearing on the treatment of the insane throughout the Province, and the future of the asylums, or as they are now becoming named, Hospitals for the Insane. The steps referred to will, the *Globe* understands, be indicated in an item in the supplementary estimates, which will be introduced in the House this afternoon or to-morrow, for a psychiatic clinic to be established in connection with the new Toronto General Hospital. The item will be a preliminary one for plans, etc. It is intended that the clinic shall occupy a separate building in connection with the new hospital, with accommodation for 100 patients, and equipped in the most modern and approved manner for the treatment of the insane. The building, equipment, and the system of treating patients will, in fact, be modelled on that of Munich, Germany, established some years ago, and which has been followed by wonderfully successful advanced treatment, throughout the Kaiser's kingdom, of cases of acute insanity.

Reports of the cases at the hospital, the treatment and the results attained will be sent to the heads of the asylums and the medical staffs throughout the Province, with the purpose of aiding them in their work. Eventually psychiatric clinics will be established at other centres throughout the Province. It has been the experience in Germany that a considerable proportion of the patients so treated make absolute recoveries, and that the saving in the expense of caring for them in asylums, as well as the saving resulting from the general knowledge gained in regard to treatment of the insane, is very large."

The above cutting from a Toronto paper conveys information exceedingly gratifying to those who have endeavored to treat these unfortunate cases, either in private or in public hospitals. Ontario is to be congratulated upon this marked advanced step in the treating of this class of invalids. If the statistics of Hobbs, of Guelph, and those of the writer can be accepted as

an indication of the actual condition existing among the female insane population, fully seventy-five per cent. of the insane women in Ontario and British Columbia present sufficient well-marked and palpable physical conditions to make them eligible for treatment in this new hospital; and, if our results are what we claim, through this institution there may be given the opportunity of from twenty to twenty-five per cent. of the female insane population being returned to their homes and families. Not only is that hope offered for many of the insane, but many more who are losing hold upon themselves and gradually slipping into mental chaos may be rescued and restored to normal mentality. Such cases, so well described by the able superintendent of the Royal Asylum, Edinburgh, in the following extract, from whose ranks the so-called incurables are recruited, may have the olive branch extended to them.

"Long before such mental symptoms appear as constitute 'mental disease,' we often see subtle mental changes, such as changed emotional states, 'deadness' of feeling, hyperesthetic emotional states, morbid anxieties, accentuations of natural temperament, painfully conscious "nervousness," irritabilities, inability to fix the attention continuously upon work, loss of energy, stubbornness, antipathies, mental automatisms, morbid suspiciousness and the beginning of delusions of the nature of which the patient is then conscious."

Here we have a composite symptom portraiture of a large group of cases that come under the care of the general practitioner, cases which are frequently misunderstood and as often neglected, which should be transferred to the psychopathic department, and should give as great a percentage of recoveries as usually obtain in typhoid fever.

During the last eight years one hundred and thirty-six cases of insanity in women have come under my observation. The last case I will give brief notes of, as another that would properly come within the scope of this proposed department.

Mrs. H., age 32. Married seven years, never pregnant, family history negative. Complained of pain in left ovarian region. Had been treated for "tuberculosis of bowels and womb trouble." Anemic. Constipated.

Alternate spells of hysteria and melancholia. Cranky with everybody until, as stated by her husband, no one could live with her. After an outburst of hysteria she would be sick for a few days. Was practically incapacitated from managing her house. After curetting and removal of an ovarian cyst as large as a

navel orange she has been physically improved and mentally transformed, the only trace of former mental trouble being slight depression at rare intervals.

We are at last entering upon a period of enlightenment and intelligent treatment of the insane, but we must remember that the arena of true progressive medicine must be more and more that of prevention. The highest aim of the profession should be that of teaching nature's laws and an endeavor to "justify the ways of God to man." When we have arisen to this plane, and have developed sufficient courage to speak boldly upon the effects of alcohol, vice and venereal disease relative to this phase of degeneracy, we will be dealing with some of the most potent factors, especially in the male, of mental disease; but so long as traffic in vice for a consideration, whether in direct license fees through the municipality, or in dividends from companies, or in cheap groceries from the firm that sells poison for immense profits that it may sell food at cost or at a lower rate than a respectable firm can afford to sell it, so long as we decide to reap financial rewards through the debauchery and degeneration of humanity, just so long shall we have to pay for the support of prisons and hospitals.

Our beloved Osler, in his farewell address at Johns Hopkins, speaking of insanity, said: "The saddest chapter in the history of disease—insanity—probably the greatest curse of civilized life."

Pasteur stated many years ago, when bacteriology was in its infancy, that it was within the power of man to eradicate contagious disease. We make bold to state that it is within the same power to eradicate insanity; and while we welcome every advance of methods and conveniences of treatment, the conquest has but begun and must continue until the drug intoxications, including cocaine, opium, alcohol and tar preparations, and venereal diseases, are under control, as well as the local lacerations, inflammations, new growths and septic conditions whose treatment have yielded such satisfactory results at the hands of Dr. Hobbs and myself.

The silver-fork deformity is by no means necessary to the diagnosis of Colles' fracture.

Before putting an unconscious patient to bed, the hot water bags should be removed or sufficiently covered to prevent the occurrence of a burn.—*American Journal of Surgery.*

Clinical Department.

Foreign Bodies in the Urethra. By JOHN J. CONNER, M.D., Pana, Illinois, in *Am. Jour. Dermatology.*

"From early infancy to drivelling old age there is a tendency to manipulate the external organs of generation. This leads to many misadventures, and the physician is not infrequently called upon to remove foreign bodies from the urethra. Examples of inserted beads, pebbles, sticks, etc., are numerous in childhood. Think of a lad actually sliding a watch-chain down his urethra! After puberty the tendency becomes more marked as the sexual desire increases. A few years later we find the morbid recluse, especially among the shepherds and monks of former centuries, resorting to intra-urethral stimulation with sticks or other hard substances to arouse the overexhausted functions, waning from excessive masturbation of venery. Yielding himself to his vile erotic feelings, the instrument often slips from his fingers and is lost in the canal."—Dr. De Forrest Willard, in *Medical and Surgical Reporter.*

All mishaps of losing foreign bodies in the urethra are not due to vile manipulations of the external organs of generation, but many are the result of catheterization of patients, either by themselves or the physician; the catheter, sound or other instrument may become broken in the attempt to withdraw the urine from the bladder and is retracted deeply into the urethra or even into the bladder beyond the reach of the fingers and must be removed by instrumentation.

The publication of this article, I hope, will bring out some new and efficient mode of removing foreign bodies from the urethra. Of course, if the urethra is large and the foreign body is smooth and not sharp pointed it may often be grasped by a suitable and long pair of forceps, but if the canal is small and tortuous, or maybe swollen and inflamed, the attempt will not infrequently be attended with much suffering and bleeding on the part of the patient and much worry and disappointment on the part of the physician.

De Forrest Willard recommends the use of the litholapaxy excavator with large, straight, open-ended canula. He recommends for this purpose the largest size canula that can be introduced into the urethra, nicking the meatus if necessary to gain

entrance by the proper size. Unfortunately for the majority of physicians, who are called upon to remove foreign bodies from the urethræ of patients, they will not be prepared with a litholapaxy excavator, and they will have to use some more common method, often resorting to the knife and removing the object by an external wound.

In children the small round bodies usually slipped into the urethra will be found in the anterior portion of the canal, while the longer instruments introduced at all ages will soon be found in the membranous portion of the tube or in the bladder. A long foreign body usually finds its way into the deep urethra or bladder in a few hours; rarely, two or more days are required. In exceptionally rare cases, rounded bodies remain a long time in the urethra, the urine, flowing in a tortuous course around them, and, becoming incrusted, a pocket ultimately forms, or suppuration ensues. Many instances of very large urethral calculi are recorded.

How can the recedence of a foreign body into the deep urethra or bladder be explained? What is the *modus operandi* of the muscular action of a urethra swallowing a piece of catheter, stick or other object? There have been many theories to explain the recedence of foreign bodies in the urethra. It does not seem strange to De Forrest Willard, "that the compressor muscular fibres of the urethra, when stimulated to action by a body applied in front, should reverse their usual action as easily as do the muscles of the pharynx, intestines, etc. This action of swallowing a hard substance is aided by the erection of the penis, which in its subsidence (should the anterior end of the object become engaged), drives it farther and farther back with each successive engorgement. Tending to the same unfortunate end are the manipulations of the part, in the patient's endeavor to extract the offending body. When possible, no manipulations should be attempted for extraction without the body being firmly secured from further retraction."

I wish to report the following case:

A Hat Pin Four and Seven-Eighths Inches Long in the Urethra.

"On the 28th of September, 1906, at 9.30 p.m. I was called on at my office by Mr. X., a man about 60 years old, married and a grandfather, who I noticed as he came in must be in great pain and distress, as he was holding both hands low down upon the abdomen and was walking very much stooped over, and

without taking the proffered chair said, 'Doctor, I have acted a d—n fool, I guess. I have run a hat pin into my urethra. Can you take it out for me?' I assured him that I could, and after asking me to hold his name in confidence, he got upon the table as I desired him, and took down his pants. The underclothing was saturated with blood, as was also a cloth that he had placed to catch the same. He said, 'You can feel it here,' placing the end of the finger on the lower part of the penis. The end of some sharp object could be felt in the anterior portion of the perineum, a little to the right of the median line. Without giving an anesthetic or making application of cocaine I seized the object with a small pair of alligator forceps and made a careful traction, but the instrument slipped off. I again applied the forceps, but found that the object had slipped farther down into the urethra. I found it was not possible to pull out the object, for it had imbedded itself in the urethral mucous membrane, and the more I pulled, of course, the farther it projected through the urethral floor. I said to the patient that it was not possible to get in out in this manner, and it would be necessary to make an external wound and deliver it that way. He said, 'All right,' and I handed over to him the forceps that he might not allow the object to recede still farther into the bladder. I made an incision one-half inch long over the point of the object and grasped the end of it with another forceps. I had difficulty in drawing the object out, as it seemed to be very firmly held by some cause, and I soon found that the patient was still holding the alligator forceps in a tight grasp, and it was necessary to explain to him that he must now let go his end of it. He did so, and I soon drew out the shaft of the object, but found that I must enlarge the opening in order to let the bead end through. The bead on the end of the hat pin was large enough to just pass through a No. 28 French catheter hole in one of the cards the instrument dealers send out to patrons.

Immediately after getting off of the table he voided about two ounces of urine in which were a few small clots of blood. There had been so much laceration of the urethra that I deemed it prudent not to close the external wound. As said above, no anesthetic was given, nor was any preparation of the patient made in the way of rendering the perineum clean or aseptic.

September 29th, 10 a.m., patient returns, and reports no trouble in passing urine. The wound bled considerable in the night. He had been in such perturbation of mind the night before that I had not asked him the reason of introducing the

hat pin, but at this visit he said that the reason of introducing it was due to hindrance in voiding urine and he had passed it to open up the passage. He said that he had informed his wife he had consulted me "to get a stone cut out of his bladder." He also informed me at this visit that in introducing the hat pin he had held it firmly near the point, and of a sudden the point broke off and the other end had slipped into the deep urethra. I now deemed it safe and prudent to close the external wound, and it was done by inserting one silk stitch. The perineum was cleansed with tap water and soap, supplemented with peroxide of hydrogen, covered with an antiseptic powder and protected by gauze and absorbent cotton.

September 30th, 7 p.m., the external wound is well closed. The scrotum is *black,* but there is no swelling or crepitation beneath the skin. The discoloration is deepest on the *left* side of the scrotum and stops abruptly at the *base* of the scrotum. There is also a slight discoloration on median line of perineum running parallel with the external wound. The patient passed without difficulty one and a half ounces of amber-colored urine, urinalysis showing an acid reaction, sp. gr. 1.026, no albumen, no sugar, but on cooling there is an abundant deposit of earthy phosphates.

October, 1 p.m., patient has no difficulty in urinating, but there is bleeding after each act of voiding the urine; there is also bleeding during the night while asleep. No bleeding externally. The external wound is about healed. The scrotum is quite black, but it has begun to clear up. He has been bathing the scrotum with hot water at my request, and last night spts. camphor was applied at my suggestion, but the patient says he thinks the camphor is not so good as the hot water. The danger of stricture was explained to the patient, and the passage of bougies recommended to avoid that. He was afraid of bleeding and would not consent.

October 2, 7 p.m. Patient improving. The scrotum is now about the color of deep "cherry red;" the bleeding from the urethra much less; no difficulty in voiding the urine. I again advised the passage of the bougies to keep the urethra patulous and to prevent the formation of a stricture. It was explained to him that the bougie would in fact be a preventive of bleeding as it would press down the lacerated edges and cause them to more quickly and accurately unite than if left alone. He now consented. French bougies, numbers 18, 20, 22 and 24 were successively passed, and but very little blood was seen on the withdrawal of the bulbs.

On further conversation with the patient regarding the introduction of the hat pin into the urethra, he said that he had not had sexual intercourse for twenty years. I had had my suspicions of masturbation as the reason of the passage of the hat pin, and this confession of his sexual continence for so long a time tends to confirm me in that suspicion.

October 4, 8 p.m., patient doing well, French bougies numbers 22, 24, 26 and 28 passed.

October 8, 8 p.m., patient improving right along. The scrotum is clearing up in good shape. The wound has healed almost perfectly and the stitch removed. Bougies numbers 22, 24, 26 and 28 passed. The site of perineal wound thoroughly dusted with talcum powder.

The patient has not returned since, but I frequently see him on the street and he appears to be all right.

Foreign Body in Right Bronchus Removed by Aid of Bronchoscope. By SECORD H. LARGE, M.D., Cleveland, Ohio, in *The Cleveland Medical Journal.*

Mr. J. W. W., of Mansfield, age 28, was kindly referred to me by Dr. C. A. Hamann, with the following history:

On September 17, 1906, while driving along the country road, he was eating peanuts. The horse gave a sudden jump, causing him to take a deep inspiration, while he had part of a peanut in his mouth. He felt something go into the trachea and was seized with a violent attack of coughing. He immediately consulted his family physician, who sent him to Cleveland. Dr. Hamann diagnosed a foreign body in right bronchus.

I saw him on the 19th, two days later, and he was then having considerable pain in the right lung, aggravated on inspiration. His temperature was 99 4-5 degrees, pulse 84.

The larynx and upper part of the trachea were thoroughly cocainized with a 20 per cent. solution. He was then placed on a low stool, the head thrown well backwards, and the tube inserted. The first tube used was too short to bring the foreign body into view. By using the longest tube I had, which is 13 1-2 inches long, I was just able to see the foreign body. It was firmly lodged in the bronchus and was enveloped in thick mucus. On grasping it with long forceps it broke off and I had to remove it in four pieces. After its removal the pain imme-

diately disappeared. After swabbing out the mucus I made careful search for any abrasion, but was unable to find any. Iodoform in glycerine was instilled and the patient sent to Charity Hospital.

Next morning he came to my office and insisted upon going home. He said he had no pain but was feeling a little weak.

His family physician, Dr. Yoder, informs me that when he saw him the day after his return home, which would be September 21st, pneumonia had developed in the right lung. The patient is now entirely well.

As to what caused the pneumonia, I am not in a position to say, but I think that the foreign body was the exciting cause. During the entire operation no blood was seen and the patient had absolutely no pain. This is the first case of pneumonia I have had or seen, following the removal of a foreign body.

If these cases could be seen immediately after the accident, I feel confident that the danger of pneumonia following is very slight.

THE surgeon should not wait for redness before making a diagnosis of palmar abscess. Owing to the density of the fascial structures this sign is often lacking in the early stages.

THE radiography of the elbow of a child shows shadows of humerus epiphyses. One inexperienced with X-ray plates is very apt to mistake one or more of these for fractures. When examining the skiagraph of a child's elbow suspected of fracture or dislocation, it is, therefore, important to have the normal picture in mind, or better yet, in hand, for comparison.

AMPUTATION of a finger gangrenous as the result of carbolic acid application should not be performed until the line of demarcation is well established. The necrosis may be superficial and in such an instance the finger may be saved by means of skin graft.

IN "Ludwig's angina," the cardinal principle in the treatment is extensive incision. An incision that passes no matter how deep into the substance of the submaxillary gland proper, will prove of little avail unless the tissues within the wound have been broken up until they are practically pulpy.—*American Journal of Surgery.*

Society Reports.

PROPOSED PROGRAMME OF THE ONTARIO MEDICAL ASSOCIATION, MAY 28, 29, 30, 1907.

TUESDAY, MAY 28.—MORNING SESSION.

Medical Section.

1. Leucocytosis.—D. A. Graham, Toronto General Hospital.
2. Paper, a Resumé of the Development of Clinical Psychology.—J. G. Fitzgerald, Toronto Asylum.
3. Perforation of the Gall Bladder in Typhoid Fever.—E. Brandon, North Bay.
4. Feeding of Typhoid Patients.—J. A. Oille, Byng Inlet, and George E. Smith, Toronto.
5. The Care of the Degenerate, with Suggestions as to the Prevention of the Propagation of the Species.—R. W. Bruce Smith, Toronto.

Surgical Section.

Clinic at the Hospital for Sick Children. Cases will be presented by Surgeons on the Staff.

TUESDAY AFTERNOON.—GENERAL SESSION.

Symposium—The Profession in Relation to the Public.

1. "The Medico-Legal Aspects."—G. Silverthorn, Toronto. Discussion to be led by D. D. McTaggart, Montreal, and two others, names to be announced later.
2. "The Public Health Aspects."—J. W. S. McCullough, Alliston. Discussion to be led by C. A. Hodgetts, Toronto; R. Raikes, Midland; and W. R. Hall, Chatham.
3. "Ideals for Asylum Work in Ontario."—C. K. Clarke, Toronto. Discussion to be led by N. H. Beemer, Mimico; J. Russell, Hamilton; T. J. W. Burgess, Montreal, and W. N. Barnhart, New York.
4. "The Infection of Drinking Water."—J. A. Amyot, Toronto. Discussion to be led by T. A. Starkey, Montreal, and W. T. Connell, Kingston.

EVENING SESSION.

To be devoted to entertainment. A Smoking Concert will be given in St. George's Hall, to which all members are invited.

WEDNESDAY, MAY 29.—MORNING SESSION.

Medical Section.

1. Pathology, Etiology and Treatment of Neurasthenia.—S. H. McCoy, St. Catharines.
2. Modern Methods of Anesthesia.—S. Johnston, Toronto.
3. Allopathic Doses of Drugs.—T. O. T. Smellie, Fort William.
4. Desirability of Establishing an Institution to which Inebriates may be Committed by Legal Process.—Edward Ryan, Kingston. Discussion to be led by W. C. Barber, Kingston, and A. T. Hobbs, Guelph.

Surgical Section.

Symposium on the Treatment of Fractures:
(*a*) "Fractures of the Skull."—D. E. Mundell, Kingston.
(*b*) "Fractures near the Elbow."
(*c*) "Fractures near the Wrist and Ankle."—A. W. Stinson, Brighton.
(*d*) "Fractures of the Femur."—W. E. Gallie, Toronto.
2. Report of a Case of Tetanus with Cure by Amputation after Three Months' Treatment.—T. W. H. Young, Peterboro'.
3. Paper, Title to be sent.—A. E. McColl, Belleville.
4. Closure of the Incision in Abdominal Section.—N. A. Powell, Toronto. Discussion led by E. Meek, London.

WEDNESDAY AFTERNOON.—GENERAL SESSION.

1. Presidential Address: "The Operative Treatment of Goitre"—a Second Report.—G. A. Bingham, Toronto.
2. Address in Surgery: "Clinical and Experimental Observations on the Direct Transfusion of Blood."—Geo. W. Crile, Cleveland. Discussion led by D. E. Mundell, Kingston.

EVENING SESSION.

Annual Dinner, the particulars of which will be announced later.

THURSDAY, MAY 30.—MORNING SESSION.

Medical Section.

1. Alcohol and Life Insurance.—T. F. McMahon, Toronto.
2. Therapeutic Inoculation and the Opsonins.—G. W. Ross, London, England.
3. X-Ray in Medical Diagnosis.—S. Cummings, Hamilton.
4. Cerebrasthenia, or Brain Exhaustion.—D. Campbell Meyers, Deer Park.
5. Necessity for Separate Isolation Hospitals for the Minor Infectious Diseases.—J. J. Cassidy. Discussion to be led by Walter F. Langrill, Hamilton General Hospital, and J. N. E. Brown, Toronto General Hospital.

Surgical Section.

1. The Bier Treatment. S. H. Westman, Toronto.
2. Intestinal Obstruction.—Ingersoll Olmsted, Hamilton. Discussion led by W. G. Anglin, Kingston.
3. Mastoiditis with its Complications.—Gilbert Royce, Ottawa.
4. The Operative Treatment of Tuberculous Arthritis.—A. Primrose, Toronto. Discussion led by A. H. Perfect, Toronto Junction.
5. Diagnosis of Malignant Tumors. (*a*) Clinical Aspect—William Hackney, Ottawa; (*b*) Pathological Aspect—E. Stanley Ryerson, Toronto.

AMERICAN MEDICAL EDITORS' ASSOCIATION.

The Thirty-eighth Annual Meeting of this Association will be held at Atlantic City on Saturday, June 1st, and Monday, June 3rd, with headquarters at the Marlborough-Blenheim Hotel. This active Association now numbers nearly 150 members, with many applications in hand for action at the coming meeting. An interesting programme has been prepared, and the following are among the papers to be presented:

President's Address—The Future of Medical Journalism. By Jas. Evelyn Pilcher, M.D., Ph.D., LL.D.

Shortcomings of Physiology, The Chief Obstacle to Medical Progress, The Need of Editorial Intervention in Such Questions. By C. E. de M. Sajous, M.D., Phila., Pa.

How Can We Make Medical Journalism Better? (*a*) For

Our Readers. (*b*) For Our Advertisers. (*c*) For Ourselves. By W. C. Abbott, M.D., Chicago, Ill.

A Word or Two from an Ex-Journalist. By Samuel W. Kelley, M.D., Cleveland, Ohio.

The First Medical Journals. By O. F. Ball, M.D., St. Louis, Mo.

The Psychology of Medical Journals from the Reader's Standpoint. By T. D. Crothers, M.D., Hartford, Ct.

Further Reflection on the Official *versus* Independent Medical Journals, One Year's History. By Wm. J. Robinson, M.D., N. Y. City.

Journalistic Suggestions from a Semi-Disinterested Standpoint. By Wm. Porter, M.D., St. Louis, Mo.

The Situation. By C. F. Taylor, M.D., Phila., Pa.

Some Aspects of Medical Journalism. By W. F. Waugh, M.D., Chicago, Ill.

The Neglect of American Mineral Springs and Climatic Resorts by Our Medical Press. By G. T. Palmer, M.D., Springfield, Ill.

A Few Feeble Remarks. By W. A. Young, M.D., Toronto, Ont.

The American Medical Editors' Association, Past, Present and Future. By Joseph MacDonald, Jr., M.D., N. Y. City.

On account of the largely increased membership of this Association, it is anticipated that the coming meeting will exceed any prior meeting in point of attendance.

The annual Editors' Banquet, which is always the social event of the week, will be held at the Marlborough-Blenheim Hotel on Monday evening, June 3rd.

CARCINOMA of the prostate often does not recur for some time; meanwhile the patient may look surprisingly well. This should not beguile the surgeon into a too hopeful prognosis.

IF a bubo shows no sign of disappearing under wet dressings, ice bags, etc., and evidences of suppuration are developing, it is better to make a clean dissection and excise the gland without opening it than to incise and drain.

ALL swellings of the lower jaw accompanied by discharging fistula, especially multiple fistulæ, should be looked upon with the suspicion of actinomycosis until proven to be otherwise.—*American Journal of Surgery.*

The Canadian Medical Protective Association

ORGANIZED AT WINNIPEG, 1901

Under the Auspices of the Canadian Medical Association

THE objects of this Association are to unite the profession of the Dominion for mutual help and protection against unjust, improper or harassing cases of malpractice brought against a member who is not guilty of wrong-doing, and who frequently suffers owing to want of assistance at the right time; and rather than submit to exposure in the courts, and thus gain unenviable notoriety, he is forced to endure black-mailing.

The Association affords a ready channel where even those who feel that they are perfectly safe (which no one is) can for a small fee enroll themselves and so assist a professional brother in distress.

Experience has abundantly shown how useful the Association has been since its organization.

The Association has not lost a single case that it has agreed to defend.

The annual fee is only $3.00 at present, payable in January of each year.

The Association expects and hopes for the united support of the profession.

We have a bright and useful future if the profession will unite and join our ranks.

EXECUTIVE.

President—R. W. POWELL, M.D., Ottawa.
Vice-President—J. O. CAMARIND, M.D., Sherbrooke.
Secretary-Treasurer—J. F. ARGUE, M.D., Ottawa.

SOLICITOR,

F. H. CHRYSLER, K.C., Ottawa.

Send fees to the Secretary-Treasurer by Express Order, Money Order, Postal Note or Registered letter. If cheques are sent please add commission.

PROVINCIAL EXECUTIVES.

ONTARIO—E. E. King, Toronto; I. Olmsted, Hamilton; D. H. Arnott, London: J. C. Connell, Kingston; J. D. Courtenay, Ottawa.

QUEBEC—H. S. Birkett, Montreal; E. P. Lachapelle, Montreal; J. E. Dube, Montreal: H. R. Ross, Quebec; Russell Thomas, Lennoxville.

NEW BRUNSWICK—T. D. Walker, St. John; A. B. Atherton, Fredericton; Murray MacLaren, St. John.

NOVA SCOTIA—John Stewart, Halifax; J. W. T. Patton, Truro; H. Kendall, Sydney.

PRINCE EDWARD ISLAND—S. R. Jenkins, Charlottetown.

MANITOBA—Harvey Smith, Winnipeg; J. A. MacArthur, Winnipeg; J. Hardy, Morden.

NORTH-WEST TERRITORIES—J. D. Lafferty, Calgary; M. Seymour, Regina.

BRITISH COLUMBIA—S. J. Tunstall, Vancouver; O. M. Jones, Victoria; Dr. King, Cranbrooke.

Dominion Medical Monthly

And Ontario Medical Journal

EDITORS:

GRAHAM CHAMBERS, B.A., M.B. WALTER McKEOWN, B.A., M.D.

ASSOCIATE EDITOR:

T. B. RICHARDSON, M.D.

MANAGING EDITOR:

GEORGE ELLIOTT, M.D.

Published on the 15th of each month. Address all Communications and make all Cheques, Post Office Orders and Postal Notes payable to the Publisher, GEORGE ELLIOTT, 203 Beverley St., Toronto, Canada

VOL. XXVIII. TORONTO, MAY, 1907. No. 5

COMMENT FROM MONTH TO MONTH.

The use of alcoholic beverages in disease and with moderation in health is endorsed by the following well-known and eminent medical men of Great Britain in the *Lancet:* J. McCall Anderson, Alfred G. Barrs, William H. Bennett, James Crichton-Browne, W. E. Dixon, Dyce Duckworth, Thomas R. Fraser, T. B. Glynn, W. R. Gowers, W. D. Halliburton, Jonathan Hutchinson, Robert Hutchinson, Edmund Owen, P. H. Pye-Smith, Frederick T. Roberts, and Edgcombe Venning. Some of these names belong to men who are in the very front rank in medicine, surgery, psychiatrics and physiology. They place the matter in this way before the medical profession: "In view of the statements frequently made as to present medical opinion regarding alcohol and alcoholic beverages, we, the undersigned (the above-mentioned) think it desirable to issue the following short statement on the subject—a statement which, we believe, represents the opinions of the leading clinical teachers as well as of the great majority of medical practitioners.

"Recognizing that, in prescribing alcohol, the requirements of the individual must be the governing rule, we are convinced of the correctness of the opinion, so long and generally held, that in disease alcohol is a rapid and trustworthy restorative. In many cases it may be truly described as life-preserving, owing to its power to sustain cardiac and nervous energy, while protecting the wasting nitrogenous tissues.

"As an article of diet we hold that the universal belief of civilized mankind that the moderate use of alcoholic beverages is, for adults, usually beneficial, is amply justified.

"We deplore the evils arising from the abuse of alcoholic beverages, but it is obvious that there is nothing, however beneficial, which does not by excess become injurious."

This is a very important pronouncement, and subscribed to by such leaders in the profession as above, carries a great deal of weight with it. And there is abundance of proof in every-day life that the man who is even a total abstainer in alcoholic beverages, but an intemperate feeder, does not resist disease one whit better than he who practices moderation in all things all his life. It is the *abuse* of alcoholic beverages, as of other things, which tells against the human economy; and one should counsel moderation in all things.

Education in Canada being controlled by the provincial govments, our leading provinces should send delegates to the forthcoming second International Congress of School Hygiene, at London, England, in August. Those in charge of the education of our school children, particularly in this province of Ontario, which prides itself so much upon its common school education, cannot much longer ignore the growing importance which is everywhere being given to the care of the health of infants and school children, over whose little lives for the greater part of the day they have control. The Hon. the Minister of Education, in this province, himself a medical man, cannot have failed to have noted what a vital interest there is being manifested n the subject of the medical inspection of schools in the United States, in England and on the Continent. Nor can he be unmindful of the fact that great educationists, as even distinguished

members of his own profession, are taking a deep and earnest interest in this subject. THE DOMINION MEDICAL MONTHLY, therefore, urges the importance of Ontario being represented at this conference by a representative who has taken some active interest and done some active work in behalf of the betterment of the condition of school life and health amongst our school population.

The "White Line" of Sergent (1903) is a phenomenon known to and considered by French clinicians as valuable in the diagnosis of disease of the suprarenal body. It is the converse of the *tache cerebrale*. It is produced in the same manner. When the finger-nail is scraped rapidly over the patient's abdomen, this white line appears in from thirty to sixty seconds. It lasts from two to five minutes. It is not confined to conditions affecting the suprarenals alone, but can be brought out as well in specific fevers, septicemia, influenza, poisoning by bichloride of mercury, and in exhaustion from overexertion. The "white line" is probably due mechanically to reflex spasm of the capillaries. Low vascular tension is present in the above-mentioned conditions.

Grocco's Sign in the diagnosis of pleural effusion was advocated by Grocco, of Florence, in 1902. It consists of a paravertebral triangle of dulness on the opposite side to the effusion. With the patient in the sitting posture, percussing downwards on the healthy side, he thus defined a paravertebral triangle of dulness. This triangle, he asserts, can be obtained by percussing, two, three or more centimetres from the spine at the lower border of the thoracic resonance. This is the base of the triangle. The spines of the vertebræ represent another side, and a line upward and obliquely inward, the other. The sign is of value in distinguishing effusion from pulmonary consolidation; and it is one which has been confirmed by many observers. Thayer and Fabyan, in the *American Journal of the Medical Sciences* for January, record that in thirty out of thirty-two cases of pleural effusion they clearly demonstrated a paravertebral triangle of dulness on the opposite side.

Pathology of prehistoric man is an unusual and entertaining, though it be not a practical, subject. For six years, Dr. J. C. Reisner, of the University of California, has been employed in prosecuting excavations for antiquities for a museum the university is about to establish. In the hundreds of cases now being unpacked at the university, and which have been brought from Egypt, where their contents had been deposited 7,000 years antedating the Christian era, are some Coptic mummies, which will, no doubt, prove of interest to the medical profession. It is said the skeletons found were in perfect condition; that they furnish splendid anatomical material for finding out the racial character of the prehistoric people; that the contents of the intestines were so well preserved that even the food and medicines taken could readily be determined; that the diagnosis of the disease causing the death of the person could be determined; and that it could be determined that some had had gall-stones, some kidney disease, whilst others had had diseases of bones. This was 9,000 years ago. These mummies were preserved in salt and were further protected in their sepulture by matting made from halfa grass and woven reeds of the same plant. Thus did the Egyptians conceive the most notable way of integral conservation; for being afraid of fire, but not as a deity, they by precious embalments, and depositure in dry earths, made their remains mummies.

Cremation of human bodies, so far as is known, is only practiced in one place in Canada,—Montreal. Since the Macdonald Crematorium was established in Montreal in 1904, up to the 2nd of April, 1906, thirty-three bodies had been cremated. From the latter date until the end of February, 1907, nineteen more were subjected to the same process of hydriotaphia. Prior to the establishment, the Mount Royal Cemetery Company, of Montreal, had a charter to perform cremation. Their cremations numbered twelve, so that all told up to the end of February, 1907, there had been sixty-four cremations in Canada.

The treatment of eclampsia is ever an important subject for discussion at medical societies. In it all have their experiences. It is now well established to be an autointoxication affecting pregnant women. The exact cause, however, of the condition is yet obscure. Albumen is present in from 85 to 90 per cent. of the cases. This, then, is a very valuable premonitory symptom. In the cases in which albumen is absent, the constitutional symptoms precede the presence of albumen in the urine. Hirst, in a practical paper in a recent number of the *Therapeutic Gazette,* writes of treatment after having observed 86 cases of eclampsia and 278 of albuminuria. He classifies the different forms of treatment of the attacks under the following heads: Anesthetics, methods of reducing blood pressure, morphine, chloral, pilocarpine, thyroid extract, catharsis, diaphoresis, hypodermoclysis, and forcible delivery. The only anesthetic to be considered is chloroform, as ether is a marked irritant to the kidneys. It should be used when the premonitory signs of a convulsion appear, as a preventive of the attack. Morphine has this objection, that one does not always know whether you have a case of interstitial or parenchymatous nephritis to deal with. In the latter condition it is well borne; in the former not at all tolerated. If it is used, at least 1-2 to 3-4 grain should be employed. Pilocarpine is dangerous. If chloral, which is used extensively in the large European clinics, be employed, it should be given by enema and in doses of 30 to 60 grains. Thyroid extract has not yet been given sufficient trial. Hirst's description of securing catharsis,—and which he states to be the most satisfactory, is to wash out the stomach and to then introduce two ounces of castor oil and four drops of Croton oil through the tube; or an ounce of mag. sulph. in solution may be used in this way instead. To prepare a hot pack for diaphoresis, several hot bricks may be employed, each wrapped in a towel and four ounces of alcohol poured on each brick. These may then be placed under the wet blankets. The pack is continued for thirty minutes, and every four hours. For routine treatment he advises: 1. Avert the convulsion, if possible, with chloroform. 2. Give 15 minims of veratrum viride hypodermically. 3. Wash

out stomach and use castor oil as above. 4. Hot pack as above. 5. Hypodermoclysis, a pint of normal salt solution under the breast every eight hours, but not to be continued unless purging and diaphoresis have set in, for fear of edema of lungs. 6. If convulsions recur, repeat veratrum viride in 5 minim doses every hour, and if after three hours pulse is still bounding and patient cyanosed, perform venesection. 7. Under ordinary circumstances let labor alone.

"We paid no attention to the alienists," said the jurymen in the celebrated case recently before the courts in New York. In fact, one result of that trial was the discredit cast upon expert testimony. Through the sentimentality and hysteria which beclouded that case, that one result stands out clear and distinct. But closer at home, another case which excited some interest, brings out the fact that expert medical testimony is not weighed to much value by the people at large. But medical men are not the only people who can differ on questions of opinion. Indeed, if they were otherwise, and doctors ceased to differ, they might then be classed as wooden-heads. But the public is not satisfied. We doubt if the profession is. The system is at fault; and a better way of determining the right would be to have a medical commission appointed in these cases, whose sole duty would be to act in an advisory capacity to the court, and not be arrayed in opposite camps. This would better serve the ends of justice; and medical experts would in no sense be interested in the case of either the Crown or the defence. They would be simply interested in the ends of justice.

McGill University will have the earnest sympathy of the Canadian medical profession in the very severe loss it has suffered in the destruction by fire of its medical department. Particularly will all unite in sympathizing with Professors Shepherd, Ruttan and Adami, who lost their museums, and the two latter who lost their private libraries, which they kept in the building

for the benefit of their students. It is understood that—although at first announced otherwise—the manuscript of a new work on pathology which Professor Adami has been preparing for some years, has been saved. This is very gratifying to Professor Adami, and in it the profession in Canada will share. The fine library of some 25,000 volumes was completely destroyed. In this calamity which has befallen it, McGill will not be forgotten; for in that world-famous institution all Canada takes a just pride.

In the death of Dr. W. H. Drummond all Canada sorrowed. Although belonging to the medical profession, he had earned a just and full reward in literature. It was this which made him famous, and this will make his name live. Dr. Drummond's was a noble, generous soul. Big-hearted, kind-hearted, he was a fine type of citizen, an ornament equally to his profession and his country.

News Items.

DR. H. A. BRUCE, Toronto, will shortly go to England.

DR. J. D. MCKAY, Marion, Ind., was in Toronto, May 9th.

A NEW quarantine hospital is to be soon opened in Winnipeg.

DR. HALFPENNY, Winnipeg, has been visiting in Baltimore.

DR. ARCHER BROWN has removed from Coboconk to Cannington.

THE University Endowment Bill has passed the Legislature of British Columbia.

AN Army Medical Corps is being formed in Winnipeg, with Dr. Webster in command.

DR. SCOTT, of Winnipeg, has bought the practice of Dr. Cooper at Winkler, Man.

DR. THOMPSON, M.P. for the Yukon, is reported to have been appointed Commissioner.

HAY and Stephen Townships, Huron County, Ontario, have had serious outbreaks of smallpox.

THE number of deaths in Winnipeg for the first quarter of 1907 totalled 368, against 341 in 1906.

A NEW hospital is to be established at Saskatoon, and it will be under the control of the Grey Nuns.

DR. JOHN E. MARCH, quarantine officer at the port of St. John, N.B., died of paralysis on the 3rd of April.

MR. IRVING H. CAMERON, LL.D., will go to England this summer ; also Drs. J. A. Temple and Allen Bains.

STRATHCONA, Alberta, has been selected for the location of the Alberta University.

DR. F. W. SMITH returned to Aylmer recently after spending two years in special work in London, England.

THE estimate for expenditure for public health in Winnipeg for the current year is $146,000, being $30,000 more than in 1905-1906.

DR. LINEHAM, of Dauphin, Man., has removed to British Columbia. Dr. McKay, of Nova Scotia, has taken over his practice at Dauphin.

MAJOR LEONARD VAUX, M.D., Toronto, will be Canada's representative with the Imperial army at Aldershot. He sailed for England on May 1st.

SEVERAL members of the Ontario Legislature objected to the clause in the new Education Bill which provided for the medical inspection of schools.

THE deaths in Ontario in March numbered 2,736. Of these 16 were diphtheria, 13 measles, 29 typhoid fever, whooping cough 11, and consumption 212 cases.

MEMORIAL cots are being established in different hospitals in Canada. These will commemorate the death of Lady Grenfell, daughter of His Excellency and Lady Grey.

DR. J. R. JONES, professor of medicine in the Manitoba Medical College, who has been recuperating his health in Toronto, from a fractured pelvis, will proceed to England.

IN a recent address to the McGill medical students, Dean Roddick stated building operations would be proceeded with almost at once, and advised the students to stay at McGill.

THE doctors of Welland County met last week and organized the Welland County Medical Association, with these officers: President—Dr. Neff, of Port Colborne; Vice-Presidents—Drs. Schooley, of Welland, Brewster, of Ridgeway, and Thompson, of Niagara Falls. Secretary-Treasurer—Dr. Howell, of Welland; Executive Committee—Drs. Old, Glasgow, and Burgar.

ABOUT 500 students wrote on the examinations of the University of Manitoba, which closed April 26. In medicine there were 163, against 147 of last year.

DRS. MCPHEDRAN, Graham Chambers and Walter McKeown (Toronto) have returned from attending the Congress of American Physicians at Washington.

ROBERT A. FALCONER, M.A., B.D., Litt.D., LL.D., principal of the Presbyterian College in Halifax, N.S., has been invited to the presidency of Toronto University.

BY the will of the late Mrs. Peter Redpath, who died recently in England, McGill University will benefit to the extent of $150,000, and the Montreal General Hospital, $40,000.

LIEUTENANT-GOVERNOR CLARK of Ontario laid the cornerstone of the new Medical Building, Queens University, in April. The Ontario Government gave $50,000 towards this building.

WHILE standing on the platform of a train going into Winnipeg, Dr. A. McQueen, L.R.C.P., Edinburgh, fell and sustained a fracture of the skull from which he died almost immediately.

DR. W. E. BRYANS, whose home is in Grey Township, and who has spent the winter in charge of a large staff of men at Parry Sound, has taken a position in the Western Hospital, Toronto.

THE Provincial Board of Health of Manitoba is as follows: President—Dr. R. M. Simpson, Winnipeg; John M. Eaton, M.D.; John A. Macdonald, M.D.; F. L. Shaffner, M.D.; and Dr. Gordon Bell, bacteriologist.

DR. FRED. B. BOWMAN, a recent graduate of the University of Toronto, who has been pursuing post-graduate work at Johns Hopkins, Baltimore, has been appointed assistant in the U. S. Government laboratory at Manila, Philippine Islands.

DR. DONALD ARMOUR, London, England, Toronto University, 1904, and House Surgeon Toronto General Hospital, 1904-1905, has been awarded the Jacksonian Prize of the Royal College of Surgeons for 1906. This is the first time this prize has been won by a Canadian.

DR. F. J. BALL, son of Mr. James Ball, Rugby, has finished his post-graduate studies in the Mother Country. Finding his health needed toning up, he is taking a trip to the Mediterranean as surgeon on a P. & O. passenger steamship, and writes home from Alexandria that he is enjoying the experience thoroughly, and that his strength is fully restored.

DR. W. J. SMITH, of Stratford, has associated himself with the firm of Drs. Robertson & Robertson. The doctor has recently returned from Great Britain, where he spent over a year in special surgical work in the leading hospitals there. He received the degrees of member of the Royal College of Surgeons, England, and Licentiate of the Royal College of Physicians, London, and was highly complimented on his standing.

HAVE the tracheotomy instruments handy before operating upon a case of angina Ludovici.

COLD abscess and lipoma often simulate each other very closely, especially around the chest. If in doubt, aspirate.

A HISTORY of attacks with symptoms of esophageal stricture and intervening periods of well-being is suggestive of cardiospasm.

IT is a wise rule to submit all removed hypertrophied prostates to thorough examination by a pathologist. Carcinomatous degeneration may be found in some spot.

NEVER divide the annular ligament of the wrist. The hand is much weaker after it is divided than before.

IN the presence of a hard, diffuse chronic swelling in the neck having some of the appearances of a malignant growth, the possibility that the tumor is a so-called "woody phlegmon of Reclus" must be considered.

After tracheotomy the air of the patient's room should be kept reasonably warm and moist. Draughts of cold air provoke much irritation.

A SWELLING in the parotid region is not necessarily a part of the pre-auricular lymphatic gland. Such an enlargement may be associated with herpes of the forehead, or sometimes, it may be part of a chain of tuberculous lymph glands.—*Am. Jour. of Surg.*

Publishers' Department

AN ANNUAL VISITOR.—We have just passed through our annual epidemic of la grippe, which, as usual, claimed its victims among all classes and conditions, mainly, however, among the classes where the resisting power was below par, or among sufferers from some chronic ailment. While the sequelæ and complications of this disease may assume almost any phase of acute inflammatory character, its primary effect is upon the nervous system. Therefore, we have no hesitancy in saying, no matter what the local inflammation may require as a medicine, by all means give antikamnia tablets as a nerve sedative and to relieve the muscular pains always present. We have seen a violent cough of bronchitis treated upon the general plan, with the cough as distressing at the end of twenty-four hours as at the beginning, promptly yield to six antikamnia tablets during an interval of six hours. La grippe usually requires a double treatment, one directed to the influenza, and the other devoted to the complications present, be they of the respiratory organs or digestive tract. In all cases antikamnia tablets will be found to perform a prominent and successful part and purpose.—*Medical Reprints.*

AMPUTATION OF THE THIGH UNDER HYOSCINE-MORPHINE-CACTINE ANESTHESIA.—I wish to report the sucessful use of the hyoscine, morphine and cactine combination as a general anesthetic in an amputation of the thigh in the upper one-third.

The tablets used were those put up by The Abbott Alkaloidal Company, and contained Hyoscine Hydrobromide, gr. 1-100, Morphine Hydrobromide, gr. 1-4, Cactin, gr. 1-67. Injections (hypodermic) were given two hours, one hour, and half an hour before operation. Anesthesia was ideal and complete throughout operation and for several hours afterward. No ill effects whatever were noticed at any time. Muscular relaxation was not so complete as in ether or chloroform anesthesia, so that after the operation no subsequent contraction of flaps took place, and there was no more tension on the stitches afterward than at the time they were put in.

If this anesthetic will work in all cases as well as it did in this and numerous others reported in the medical journals, it

would appear to be the ideal anesthetic for field use and emergency work where one may be short-handed, as it does away entirely with the anesthetist and the space and care necessary in the transportation of ether or chloroform.

The absence of inconvenient after-effects is a most valuable feature of this preparation in field work, while the ability to perform serious operations promptly is of particular advantage; but of equal utility in active service is the possibility of securing complete rest and anesthesia in case of injuries too extensive to permit of immediate operative attention, such as in visceral injuries of the abdomen, chest or head. It seems a good thing for the military surgeon and should come into favor with him.

This tablet, in emergency work, in case of accident where a good many people are involved, like steamboat, railway, fire, factory, etc., has been found of the utmost service in alleviating the sufferings of the injured.—Henry G. Ebert, M.D., Assistant Surgeon in the Public Health and Marine Hospital Service, in the *Military Surgeon.*

A RECENT and very plausible theory ascribes rheumatism "to toxines formed in the alimentary canal as the result of disordered digestive functions, producing disturbances in metabolism and alteration in the tissues. The body suffering these effects of auto-intoxication has its vital resistance lowered and is therefore subject to microbic invasion." Tongaline, from the character of its composition, has an antitoxic effect on these microbes and by its stimulating action on the liver, the bowels, the kidneys and the pores it eliminates promptly and thoroughly the poisonous germs which are the cause of rheumatism, neuralgia, grippe, gout, nervous headache, sciatica, lumbago, tonsilitis and heavy colds.

THE BEST HYPNOTIC.—A patient who would sleep but cannot sleep should be made to sleep. In the choice of a hypnotic the physician should always seek that one which not alone is the most effective, but which presents the fewest disadvantages in the way of after effects. For years Bromidia has been the standard hypnotic prepared at the command of the profession. Through all the time that it has been known it has never failed in composition or efficiency. Its constituents have been of the purest, and, in fact, Bromidia has been the standard by which similar preparations have been measured. That the medical

profession have appreciated its worth and thorough reliability is well apparent, from the place it holds in the regard of every physician who appreciates stability and honesty.—*The International Journal of Surgery.*

SANMETTO IN ENLARGED PROSTATE AND CHRONIC CYSTITIS, IRRITABLE BLADDER AND URETHRA.—I have used Sanmetto in enlarged prostate and chronic cystitis in old men, with marked good results, and observed that there was decided aphrodisiac effects; also in irritable bladder and urethra in the early months of pregnancy, with very happy results.—*M. A. Rush, M.D., Anderson, Ind.*

FERMENTATIVE DYSPEPSIA.—I have been treating a case of Fermentative Dyspepsia for some time, and thought I would wait until the cure was certain and likely to be permanent before I wrote you, but as it is now four weeks since patient has taken anything in the shape of medicine and has had no trouble whatever during that time (although rather careless about his diet), I thought it would be safe to inform you of one more victory for Glyco-Thymoline.

The patient, age 60, occupation—farmer. As far back as he can remember has had trouble with his stomach; heartburn, sour stomach, and enormous collections of gas in stomach and bowels. This is his own way of expressing his troubles. His condition when I first saw him was about as we described it above. The collections of gas in stomach and bowels were so enormous that he could scarcely ever lie down. Spent his nights in a sitting position. He was very much emaciated and completely discouraged, did not consider life worth living, and, indeed, had made several threats of suicide.

Well, it was not a very promising case for any physician to take, but in thinking it over I made up my mind that this would be a pretty good opportunity to try Glyco-Thymoline internally, and so I agreed to do what I could for him. To begin with, I regulated his diet, and then, as he was very constipated, got his bowels to acting regularly, one evacuation every day. I then, every other day, washed out his stomach with one ounce of Glyco-Thymoline in a pint of tepid water and gave him a teaspoonful of Glyco-Thymoline in a tablespoonful of water before and after each meal, and directed him if he was much troubled with gas in the night to take another dose about midnight.

The change in this man's condition in one week was simply wonderful. All the unpleasant symptoms from which he had suffered so long were entirely relieved. The fermentation of the food and the resultant formation of gas was almost nil, and he began to think life worth living after all. He steadily improved day by day, and now, as I said at first, he has been four weeks without the Glyco-Thymoline or any other medicine, and considers himself a perfectly well man, although he is still fairly careful about his diet, and from present appearances it only remains for me to modestly receive the heartfelt thanks of his long-suffering wife, whose life for years he has made a perfect Hades upon earth; his own profuse thanks, and incidentally a little something on account, which by the way is not quite so profuse as the thanks.

Now, this is almost my first experience with Glyco-Thymoline internally, but if I get as good results in all cases I shall certainly ask for nothing better in this class of cases, and if the patients do any kicking they will surely be hard to please.—*G. B. Murray, M.D., Greenwich, N.Y.*

DERANGED UTERINE FUNCTION.—It is safe to say that to the average physician, who is confronted almost daily with the ordinary cases of suppressed and deranged uterine function, no other class of cases is so uniformly disappointing in results and yields so sparing a return for the care and time devoted to their conduct.

Patients suffering from disorders of this nature are usually drawn from the middle walk of life, and, by reason of the pressure of household duties or the performance of the daily tasks incidental to their vocation, are entirely unable, in the slightest degree, to assist, by proper rest or procedure, the action of the administered remedy. Many of these patients, too, suffer in silence for months, and even when forced by the extremity of their sufferings to the physician, shrink from relating a complete history of their condition and absolutely refuse to submit to an examination. Authoritative medical teaching and experience unite in forcing upon the attendant a most pessimistic view of his efforts in behalf of these sufferers under such conditions.

It is in this class of practice, where almost everything depends upon the remedy alone, that a peculiarly aggravating condition of affairs exists. A very limited list of remedies of demonstrated value is presented for selection, and I believe I

am not wide of the mark in saying that, in the hands of most practitioners, no remedy or combination of remedies hitherto in general use has been productive of anything but disappointment.

Some time ago my attention was drawn to Ergoapiol (Smith) as a combination of value in the treatment of a great variety of uterine disorders. Its exhibition in several cases in my hands yielded such happy results that I have used it repeatedly in a considerable variety of conditions, and with such uniformly good results that I am confirmed in the opinion that its introduction to the profession marks an era in modern therapeutics. In the treatment of irregular menstruation and attendant conditions I have found it superior to any other emmenagogue with which I am familiar, in the following particulars:

1. It is prompt and certain in its action.
2. It is not nauseating and is not rejected by delicate stomachs.
3. It is absolutely innocuous.
4. It occasions no unpleasant after-effects.
5. It is convenient to dispense and administer.

The following clinical notes will afford a general idea of its action in a variety of cases:

Case 1. Mrs. —— came to me presenting the following symptoms incident to a delayed menstruation: Persistent headache of a neuralgic character; dull, aching pain in limbs and lumbar region; cramp-like pains in abdomen, and considerable nausea. The menstrual period was overdue seven days, but as yet there was no appearance of flow. Her periods had always been occasions of intense suffering, but had never before been delayed. I began the use of Ergoapiol (Smith), with some misgiving, owing to the irritable condition of the stomach. One capsule every three hours was administered without any aggravation of the gastric distress. In twenty hours a normal menstruation was well under way; the flow was slightly increased over the observed on former occasions. The pains had subsided. Ergoapiol (Smith) was administered, one capsule three times a day, during the menstrual period, which terminated in five days. The patient was instructed to return for a quantity of the remedy several days before the next menstrual period. She did so, and following directions, took one capsule three times a day for three days before expected menstruation. She subsequently reported that during the period—lasting five days—there had been practically no pain, and the amount of flow was, as far as she could judge, normal.

Case 2. Miss ——, age 30, has been a sufferer for years with dysmenorrhea. For about three years had suffered with leucorrhea, particularly annoying after each menstrual period. Had undergone treatment at different times for the leucorrhea and dysmenorrhea, but had never experienced permanent benefit. She had been obliged to expend the couple of days of each period in bed. She consulted me about one week before her period. Examination revealed a purulent discharge oozing from os cervix and a rather large uterus. There was no displacement. She was put upon Ergoapiol (Smith), one capsule three times a day. The onset occurred one day earlier than expected, and was attended with considerable pain. The patient was, however, able to attend to her usual duties, a state of affairs such as had not been experienced for some years. At the onset of the flow Ergoapiol (Smith) was administered, one capsule every two hours. The effect was astonishing. In eight hours the pain had well-nigh subsided, and there was practically no discomfort, except some pain in back.

Case 3. Miss ——, age 21, had suffered for two years with irregular and painful menstruation. Had commenced to menstruate when sixteen, menses being very scanty, but regular, and accompanied with but slight degree of suffering. Was never of a very robust physique, but in the main healthy. When about nineteen, considerable nervous trouble was inaugurated by grieving over a great bereavement, and the menses became more and more painful. The anguish became such a horror to her that she frequently resorted to morphine, partly to allay pain and partly to procure sleep. Fortunately, she had not, as yet, contracted the habit, but the tendency was undoubtedly in that direction. When first consulted by her, examination was not granted. Menses appearing shortly afterward, was called upon to afford relief. Flow was very scanty and clotted. There were sleeplessness, terrific headache, pain in back, constipation, etc. Ergoapiol (Smith) was administered, one capsule every three hours. Flow was considerably increased, there was a gradual lessening of all the suffering, and almost complete relief in twelve hours. This young woman has been placed upon Ergoapiol (Smith), one capsule twice daily for one week preceding appearance of menses, and has passed through several periods with very little suffering. An examination made recently showed a marked retroversion and very sensitive cervix. A properly applied supporter will doubtless work considerable benefit in her case, but it cannot be disputed that the comparatively easy menstruations

occurring recently, in spite of the displacement, were due entirely to Ergoapiol.

Case 4. Miss ——, age 18, had always been regular in menstruating. Could get no history of any previous disorder within patient's knowledge. Contracted a heavy cold about time of menstrual epoch, and was much alarmed by non-appearance of flow. Discomfort was not marked. Ergoapiol (Smith), one capsule three times a day, was prescribed. Reported later that flow was established in twenty-four hours after treatment was commenced. The delay in this case was about four days.

Case 5. Mrs. —— consulted me, giving the following history: Three months previously had had a profuse uterine hemorrhage occurring about the time of menstrual period. As she had for a number of years menstruated only at intervals of about six or seven weeks, the fact that menstruation had been suspended for six weeks before the date of trouble was not especially significant. The hemorrhage, which was at no time alarming, had continued for several days. Since that time there had been an almost constant wasting and at times a considerable flow. Her condition was practically invalid. Examination revealed a gaping os, a cervix exceedingly tender and abraded, and a large uterus. Before resorting to curettement it seemed adisable to try other measures. Ergoapiol (Smith), one capsule every three hours, was prescribed. In about twenty-four hours there was a decided increase in the discharge, which consisted of clots and considerable debris. There were some pains of a cramp-like nature. The discharge began to grow less in about four days and ceased entirely in one week. There was a marked improvement in general condition. Local treatment entirely removed the tenderness and abraded condition of cervix. Ergoapiol (Smith) was administered several days before next menstrual period and resulted in a very satisfactory period. In this case it appears to me the remedy saved the patient the ordeal of curettement, acting as a prompt uterine stimulant. Her condition locally and generally has since steadily improved.—*James A. Black, M.D., Morganza, Pa.*

GONORRHEAL RHEUMATISM.—In gonorrheal rheumatism saturate the patient with calcium sulphide—the best obtainable—and apply colloidal silver ointment to the joint.

POWDER BURN OF FACE.—About a year ago I was called in a hurry to relieve the awful suffering of Carl Rucker, of this city, 10 years old, who when playing with other boys exploded about two ounces of coarse black shooting powder in a little earth mount, and not being quick enough to turn away got the most of the discharge into his face; even the conjunctivæ of both eyes were blackened, and from the burn and subsequent inflammation shut tight; one of the ears also got burned very badly.

To extract the powder from the skin I have in years gone by applied a thick layer of castile soap made into a sort of dough, and as I had to deal here with the inflammation and pain beside, I scraped a cake of shaving soap, mixed it thoroughly with Antiphlogistine, and applied it about one-half inch thick all over the face and ear, leaving a hole for the eyes, nostrils and mouth. About one-half hour later, the little patient, a very sensible child, rested very comfortable, free from pain, and slept a few hours soundly. About 24 hours later I removed the whole mask from the boy's face, and to my great delight and surprise the application had drawn out every kernel of the powder. The inflammation had been greatly reduced, pain was all gone, and the face appeared almost natural again, with the exception of the sclera of both eyes, which I treated with a solution of cocaine adrenalin.

Another remarkable circumstance is the fact that the boy at the same time got entirely rid of his freckles; not a trace of the latter could be detected.

For about a week the face got anointed with cold cream twice daily, and being well was discharged as cured.—*E. Kuder, M.D., Coffeyville, Kan.*