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EDITORIAL

WAR!

That great master mind, Shakespeare, who knew more about human nature than has ever been given to any other man to know, has told us:

Nothing so becomes a man in peace
As a quiet stillness and humility;
But when the blast of war blows in the ears,
Then imitate the action of the tiger,
Stiffen up the sinews, summon up the blood,
Disguise fair nature with ill-favored rage.

Ruskin, that master of form and logic, made plain that war has done much to enoble the human race. It has been the means, and is now the means, of bringing out the highest qualities which the race is capable of revealing. But, on the other hand, it also reveals the very lowest.

To fight for the cause of liberty and truth is to display the highest and best that man can reveal of what is within him; but to fight on the side of oppression and for the suppression of the rights of man will assuredly call forth the character of the one who rebelled against the just rule in heaven, and "fell flaming headlong."

As we see the forces of Europe arrayed against each other, we recall two sayings of Shakespeare's:

Life every man holds dear, but the brave man
Holds honor far more precious dear than life.
And the other one is:

It is glorious to be a giant, but it is tyrannous
To use one's strength as a giant.

How well the first suits one side, and how the second fits to the other, all can see!

Inestimable treasure, the accumulation of many years of toil and skill, is being wasted and destroyed. Innumerable lives are being cut off, and countless numbers are being maimed, that certain persons might

be gratified by playing at the awful game of war. Instead of the fires of industry, commerce and social life, we have

Commanding fires of death to light
The darkness of the scenery.

The present war has brought out much of the brute and the savage that still remains in man at his worst, when self-control is thrown aside, and free play is given to the degrading passions.

Cry havoc, and let slip the dogs of war. Yes, cry havoc! The wounded are shot and mutilated. Nurses are outraged, maimed and murdered. Doctors are treated as combatants. Ancient seats of learning and religion are destroyed. Women and children are driven from their homes, and lined up to make targets for gunmen. Again in the words of Shakespeare:

Each new morn,
New widows howl, new orphans cry, new sorrows
Strike heaven on the face, till it resounds
As if it felt with these, and yelled out
In like syllables of dolor.

There is a terrible lesson in all this. There is the mania for power—paranoia grandiosa. A condition in ordinary life that would be ground for commitment to a place of safety on the testimony of two medical men. But by the destiny of things this sort of mania for power is enabled to plunge a whole continent into war and call forth some 15,000,000 of armed men, equipped with the best known devices of destruction. Longfellow saw the evils of war and sang in fine strains:

Were half the power that fills the world with terror,
Were half the wealth bestowed on comps and courts,
Given to raise the human mind from error,
There were no need for arsenals and forts.

But truth, right, liberty, will prevail, and peace will return. For the future let us hope with Milton that:

Peace hath her victories not less renowned than war.

May the time be near at hand when nations shall say with Thomson:

O Peace! thou source and soul of social life;
Beneath whose calm inspiring influence
Science his views enlarges, art refines,
And swelling commerce opens all her ports;
Blessed be the man divine who gives us thee!

When such sentiments hold sway and replace the law of force the world will see the enthronement of Lincoln's ideal, "that government of the people, by the people and for the people shall not perish from the earth."

THE WORK OF WOMEN.

In this war, as never before in the world's history, women are assuming a new rôle and performing a noble work. All over the British Empire they have shown their capacity and their willingness to render signal services. The women of Canada set out a few weeks ago to raise \$100,000 for the purpose of equipping a hospital ship. In a short time they had secured about \$300,000, and were able to enlarge their plan into that of a soldiers' hospital in Britain.

But this is not all. They are now busy arranging to send with the Canadian contingent a large supply of useful articles, such as will tend to make his life at the front much more comfortable than it could otherwise be.

Then, again, they are busy gathering money and preparing supplies for the Red Cross work, and with great success.

Further, it should be noted, that at least one thousand nurses volunteered to go, while only about one hundred were required. When performing such noble duties the words of Milton are none too high:

O fairest of creation! last and best
Of all God's works! Creature in whom excelled
Whatever can to sight or thought be form'd,
Holy, divine, good, amiable, or sweet!

THE DOCTOR IN WAR TIMES.

It was truly said by the late Mr. Goldwin Smith that there are no persecutions chargeable to the medical profession; and the white-winged dove of peace has hovered over its banner. Here, perhaps, more than anywhere else does war call forth the traits mentioned by Tennyson:

Howe'er it be, it seems to me,
'Tis only noble to be good.
Kind hearts are more than coronets,
And simple faith than Norman blood.

All over France and Britain the medical profession is sending its full quota to the front to care for the sick and the wounded. But more than this is being done. Those who remain at home are arranging to care for the families of the soldiers who go to the fighting line, free of charge, when such is required.

But one of the noblest of the many acts of the medical profession in the present crisis is that of looking after the practices of those who leave home for army duties; and to turn over the proceeds to their

families, and relinquish these practices in tact on their return; and all free of charge. Of such acts Emerson was right when he said:

O friend, my bosom said,
Through thee alone the sky is arched,
Through thee the rose is red;
All things through thee take nobler form,
And look beyond the earth.

ARMY SANITATION.

It was with pleasure we noted that every precaution was being taken to safeguard the health of the Canadian contingent. Sir William Osler, who has the happy faculty of saying the right thing at the right time, in his fine epigrammatic way, tells us that "bacilli kill more soldiers than bullets."

With the view of securing as much safety against disease and infection, arrangements were made whereby Dr. Nasmith, from the Toronto Health Department, goes abroad with the troops. In the Russo-Japanese war, the success of the Japanese army was in a very large measure due to the care given to every sanitary detail.

Experts went in advance of the army and tested the water supply, marking what was good and what was bad. The moment a case of typhoid appeared the sufferer was at once removed entirely away from the army, so that infection could not be spread.

That Dr. Nasmith will do excellent service there need be no fear. It is the cruelty of war to lose men by shot and shell; but it is a shame to lose them by infection. Homer was right when he sang in the Iliad:

A wise physician, skilled, our wounds to heal,
Is more than armies to the public weal.

THE RED CROSS SOCIETY.

This society works with the regular army medical services. It is non-militant and impartial in its administration of the care of sick and wounded soldiers. It has no friends or foes, and is international. A white band with a red cross is the sign adopted by all countries.

In former wars wounded men would lie on the field until the battle was over. This was most disastrous in many cases. The French army was the first to introduce a system of field ambulance work, a plan which was soon adopted by other countries.

In 1864, at the Geneva convention, real progress was made and a code agreed upon for the regulation of the surgical and ambulance corps of opposing armies. In 1906 thirty-five countries agreed upon rules for the treatment of the wounded, both by land and sea. The Red Cross Society, while it has its own surgeons, nurses and ambulance service, co-operates with the army in the field.

In the South African war the Canadian Red Cross Society expended \$100,000 in the care and relief of the sick and wounded. In the present war the proportions are so gigantic that every effort must be put forth to meet the needs of the case. At the time of the South African war there were about 5,000 Canadians in the field. In the present war over 30,000 have gone to the front, and these may be followed by many more.

Great credit is due those who are working so hard in this splendid field of usefulness; and in this connection we specially mention Col. Dr. G. S. Ryerson.

In Shakespeare's day war was but in its infancy as compared with to-day, and yet his clear eye saw its horrors. In King John he tells us:

This day hath made
Much work for tears in many an English mother,
Whose sons lie scattered on the bleeding ground.
Many a widow's husband grovelling lies,
Coldly embracing the discolored earth.

It is for such as these that the Red Cross Society brings help. In Homer's Iliad we find these words:

Lulling the pain with force of soothing charm,
Refreshing drinks he gave, or grateful salve
Unto their wounds applied; employed the balm
To raise up others from their bed of pain.

And Shakespeare once more:

O, heavens! Can you hear a brave man groan,
And not relent, or not compassion him?

ELECTION TO ONTARIO MEDICAL COUNCIL.

Notice has been sent out that nominations for election to the Medical Council of Ontario are in order, and the time for receiving such will close on 13th November, at the hour of 2 o'clock p.m. For information write to the Registrar, Dr. J. L. Bray.

ORIGINAL CONTRIBUTIONS

THE DIAGNOSIS AND TREATMENT OF ACUTE PERFORATIONS
OF THE STOMACH AND DUODENUM.

A CLINICAL LECTURE GIVEN AT THE TORONTO WESTERN HOSPITAL BEFORE THE MEMBERS OF THE ONTARIO MEDICAL ASSOCIATION.

MAY, 1914. WITH EXHIBITS OF PATIENTS.

BY DR. S. M. HAY,

Associate Professor of Clinical Surgery, Toronto University; Chief of Surgical Service, Toronto Western Hospital; Consulting Surgeon, Toronto Orthopedic Hospital.

GENTLEMEN,—It is not my intention at this morning's clinic to discuss the symptomatology of gastric and duodenal ulcer as it appears in the physician's domain, but to confine myself to the symptoms which supervene on acute perforation of these ulcers, and to the surgical treatment of the same.

A history of the previous symptoms will help somewhat to decide whether we have to deal with a gastric or duodenal perforation. Quervain says that the only clinical differences before perforation consist in the facts that the seat of the spontaneous pain and the pain on pressure in the case of duodenal ulcer is a little more to the right than in gastric ulcer, and that spontaneous pain in duodenal ulcer does not supervene immediately after food, but was delayed for a few hours, indeed, until the need for another meal was felt, constituting the so-called "hunger pain." Sometimes the stomach may perforate so close to the duodenum, or the duodenum so close to the stomach that it is difficult to say even at operation which has perforated. One of my recent cases whom I am presenting here to-day is an example of this. In this man's case I diagnosed perforation of the duodenum because he had the typical pain coming on two to four hours after food, the pain relieved by taking food—true hunger pain. On opening this man's abdomen through the upper rectus, as you see here by the scar, I found a perforation at the junction of the duodenum and the pylorus. The opening would admit my thumb. There was a great deal of edema and inflammatory thickening around the opening and for a moment I did not know which viscus had perforated. However, I soon found I could pass my finger through the perforation freely into the stomach in one direction and as easily into the duodenum in the other. It matters very little any way in which the perforation is—the operation is practically the same. It is said that gastric ulcer is most frequent in the female sex, while those of the duodenum are practically limited to males. In my experience the majority of gastric perforations have been in the male sex,

and the location has been in most of them the lesser curvature, pyloric end and anterior surface of the stomach.

Regarding the diagnosis of perforation of the duodenum and stomach, I have frequently said on other occasions, and to me it seems of such great importance that I venture to repeat it here. As pointed out by Bishop some years ago a sudden and very severe pain in the abdomen, perhaps producing collapse, and usually vomiting, is common to a comparatively small class of cases, such are:

1. Ruptured ectopic.
2. Ruptured pyosalpinx.
3. Ruptured appendix abscess (into the general peritoneal cavity).
4. Ruptured gastric ulcer.
5. Ruptured duodenal ulcer.
6. Ruptured gall-bladder.

Perhaps everyone present has seen an example of these ruptures and some have seen all of them. It is worthy of note that these are all ruptures of important organs throwing suddenly an irritating fluid into a healthy peritoneal cavity. Now we commence to narrow down our diagnosis by exclusion. If your patient be a male the first two conditions are excluded at once. If not, a careful history of the case will soon exclude them. Abscess of the appendix will have laid the patient up for some days previously and will have presented the usual symptoms. And so on until we have only perforation of gastric and duodenal ulcers left.

Early diagnosis is very important. Cases operated on within 12 hours usually recover. After the first 24 hours about 75 per cent. will die. The initial pain is never absent, but it may be less severe if the perforation be very small. The pain often radiates into the back and towards the left shoulder and arm just as pain in hepatic colic does to the right shoulder. We have rigidity of the upper abdomen at first, but soon extending all over the abdomen. The patient has an anxious expression, may have cold perspiration with weak slow pulse at first; indeed, at first the pulse may be hardly altered in frequency or volume. The extremities and general skin surface is cold and clammy. The patient usually assumes some fixed posture—generally bent forward. This posture is in striking contrast to the flopping around the bed of the one suffering from an attack of renal or hepatic colic. This fixed position of the patient is at times so marked that it is with great difficulty we get the body straightened out sufficiently to make an examination of the abdomen. However, I recall one of my patients with a perfor-

ated stomach who rolled around the bed, and assumed the knee-chest position as you would expect of a patient with hepatic or renal colic.

This rigidity soon becomes board-like all over the abdomen and this taken with the sudden pain mentioned is quite characteristic of a rupture of some internal organ.

After perforation the gastric contents flow towards the anterior surface, usually under the liver and towards the right lumbar region, from here on past the "McBurney" region into the pelvis. As more accumulates it extends up the left side. We frequently get dullness at this time in the region of the appendix and we are apt to think the appendix is in trouble. I well remember the first case of gastric perforation I ever operated on; there was so much dullness in the region of the appendix (eighteen hours after the perforation had taken place) that I may my incision over that region at first. My mistake was soon observed and I at once opened the upper right abdomen and found the perforation in the stomach. The patient recovered.

In percussing the abdomen in these cases we may find a disappearance of the liver dullness; this is very significant. As the stomach contents pass through the perforation so does air, and this air raises the abdominal wall from the liver surface and we get tympany when we normally get liver dullness. Of course, we may get a disappearance of liver dullness from an *over* distention of the abdomen from any cause—for example, in the over distention of intestinal paresis in typhoid. But a very *moderate* distention of the abdomen with a disappearance of the liver dullness must not be disregarded. And again we must not always wait for this symptom, as I once did to my regret and the patient's disaster.

Percussion will also tell us whether we have free fluid in the abdominal cavity. In nearly every case the amount of free fluid is considerable and it can be detected quite early accumulating in the flanks. There are three other conditions of acute abdomen in which we may get a considerable amount of fluid, there are: (1) Ruptured appendix abscess, (2) ruptured ectopic, (3) ruptured pyosalpinx.

In this connection Dr. Tubby, of London, has had an interesting and instructing experience which I have referred to in previous articles and venture to do so again here. He reports a case where he saw, with the family physician, a patient in the evening suffering from pain and other symptoms of gastric perforation. He saw her again early next morning and as the liver dullness had then disappeared he diagnosed gastric perforation. The diagnosis was confirmed at operation and the patient recovered. In about one year later the same patient was seen by the same doctors, and she had very much the same symptoms. When

Dr. Tubby saw her the collapse had disappeared, the abdomen was not distended, there was no tympanities and no vomiting, but there was still pain. The liver dullness was normal. He decided not to operate then because the acute symptoms had passed away, the liver dullness was present, and he said he was aware that some of these cases of gastric ulcer occasionally have attacks which are extremely like those of perforation, except for signs showing the presence of free gas in the abdominal cavity. The patient recovered without operation. The presence or absence of liver dullness has helped men to a decision on more than one occasion.

The treatment of these perforations is surgical—there is no medical treatment. When a patient takes this sudden pain, like the thrust of a dagger—perhaps coming on during sleep or after some slight exertion, and if to this be added the history of some stomach trouble, we should at once think of perforation. In such a case even the delay of half a day to “carefully watch the case” is scarcely justifiable and certainly reduces the chance of recovery. Every hour you delay increases the danger to your patient.

Our diagnosis having been made and our line of procedure decided upon, we may give our patient a quarter or half a grain of morphia to relieve the awful pain. Morphia should never be given before the diagnosis is made, and the relief and comfort which it brings to the patient should never make us weaken in our decision to operate. The patient should now be placed in the semi-sitting position and removed to the hospital if one be nearby. I once brought a patient in this way, in the winter time, seven miles in a taxicab, with comparative comfort. I mention this to emphasize the fact, which I consider very important, that to remove these patients very carefully in the semi-sitting posture is not serious; in fact, it is much safer than to undertake to operate even in the homes of the well-to-do.

We make our incision through the right rectus muscle above the umbilicus. During every step of the operation we should keep a sharp lookout for any sign that would be likely to be of help as we proceed. On opening the peritoneum proper, note if a puff of gas escapes, which would indicate the rupture of some air-containing viscus. This is frequently quite audible, as I have been able to demonstrate more than once to visiting doctors. However, it is not constant. A little thin clear and cloudy liquid may also escape. In gastric perforation the fluid encountered will contain lymph or particles of food. The fluid may be bile-stained if the duodenum be perforated. This is in contradistinction to the offensive gas and fluid which escapes when the appendix is the offending organ. Introduce the fingers or perhaps the hand, into the abdominal cavity with the greatest possible gentleness.

No rough manipulation should be used. Every movement should be made with gentle quickness and definite purpose. If we gently pass the hand towards the upper abdomen we will probably find one spot where there is a thick localized deposit of lymph. On disturbing this an extra amount of fluid is liberated. This is a reliable guide to the location of the perforation.

We will suppose that in our hurried, systematic and gentle examination we have located a perforation on the anterior wall of the stomach, which is a common site. We at once proceed to close the opening. This is best done by using a small round curved needle threaded with No. 1 or No. 2 chromic catgut, or fine silk may be used. Two or even three layers of Lembert sutures are employed. The edges of the perforation are not cut away, but merely inverted by your method of suturing. The purse-string suture is not as good as the Lembert, as it is apt to tear out on being tightened on account of the edematous and friable condition of the tissues. In some cases you may be unable to close the wound in the manner described, or you may not be certain of the security of the closure. In this case you may bring over a portion of omentum, without tension, and stitch it over the opening, or the imperfectly closed opening. Then you should place a narrow piece of gauze drain over and around the site of your work and allow the other end to come out of the abdominal wound.

If the stomach wall has been extensively damaged by long continued or extensive disease you should, after closing the perforation, perform at once a posterior gastro-enterostomy, providing your patient's condition will permit of it. This patient you see lying here, on whom we operated five days ago, was too exhausted to allow of the gastro-enterostomy being done, while Mr. S., sitting there, had the perforation closed and a posterior gastro-jejunosotomy done at the same operation. We should be very careful to cleanse well, with moist swabs, the upper peritoneum, especially beneath the diaphragm, and thus lessen the risk of subphrenic abscess.

Having completed the operation on the stomach we next make a small opening in the centre line of the abdomen above the pubes, for the purpose of cleansing the lower abdomen and also for drainage purposes. Moist hot gauze swabs on sponge holders are used to clean out the usually abundant collection of turbid fluid which frequently fills the pelvis. Then we place a liberal sized drainage tube into the pelvis with a strip of gauze beside it. The tube is removed half an inch or an inch in about 24 hours lest its end should cause a pressure necrosis by too long continued pressure against a coil of intestine or other tissue.

The upper wound is completely closed unless we have left a small gauze drain down to the stomach wound, in which case it emerges

through a very small opening left at one angle of the wound.

The patient is put back to bed and placed in the Fowler's position as soon as fully recovered from the anesthetic, and a normal color has returned to the face. This was done with Mr. S., who is sitting in that chair, just referred to. However, on my return visit a few hours afterwards his pulse was almost imperceptible and his face pale, so we had him at once placed in the horizontal posture until the next morning, when his condition was so much improved that we were able again to return him to the Fowler's position. The drainage tube is cleaned every two or three hours by using a large glass piston syringe, to which is attached a rubber catheter. A pint of normal saline is also given every two or three hours per rectum. Hypodermic stimulation may be necessary for a time.

If there be no vomiting the patient may have sips of hot water in six or twelve hours after the operation, albumen water in 24 hours, and Horlick's malted milk in 36 to 48 hours. The diet should be regulated with great care for some weeks after operation.

DIAGNOSTIC APHORISMS IN GYNÆCOLOGY.

(SELECTED)

BY ARTHUR E. GILES, M.D., B.Sc., F.R.C.S.

Surgeon to the Chelsea Hospital for Women; Gynaecologist to the Prince of Wales' Hospital, Tottenham.

AN "aphorism" is defined as "a concise statement of a principle in science," and this definition expresses with sufficient accuracy what I wish to convey in the present remarks. That is to say, that I want to place before you in concise terms some of the principles that are helpful in gynæcological diagnosis.

I must premise that the statement of a principle implies a generalization, and a generalization is an expression of a substantial truth combined with a fractional element of error.

Aphorisms are not free from this flaw. They are general truths containing a germ of error: in other words, they formulate the general rules and probabilities, and do not take cognizance of the exceptions and possibilities.

Such aphorisms as I have to offer you are therefore intended to suggest the truth in diagnosis; but they do not claim to represent "the whole truth and nothing but the truth."

OF DIAGNOSIS IN GENERAL.

A few observations on diagnosis in general may be permitted. The first is that a diagnosis based on symptoms and unsupported by an ex-

amination of physical signs contravenes the fundamental principles of medical ethics; and anyone treating a patient on the strength of such a diagnosis might very well be regarded as "guilty of conduct infamous in a professional respect."

Without entering upon the merits or demerits of the Insurance Act and contract practice, I may say that if the "panel system" fosters the treatment of the poor on the basis of their symptoms and without due examination, that system is a dishonor to the medical profession.

I have seen the phrase, "We make mistakes; other people commit sins." A wrong diagnosis after due examination (a thing that happens to all of us) is a mistake, and a pardonable one; a wrong diagnosis arrived at without due examination (a thing that happens to the other fellows) is a sin; medically speaking, it is "the unpardonable sin."

That an examination was not allowed is no excuse for a wrong diagnosis. If you cannot convince the patient that an examination is necessary, quit the case; for it is better to lose a patient than to lose reputation. Moreover, do not treat first and examine afterwards; for then you may be called upon to treat not only the disease, but also the effects of your own treatment.

After an examination has been made, if still in doubt admit it. If you do not know enough about the case to satisfy yourself, it is not safe to assume that you know enough about it to satisfy the patient; this is not only indifferent ethics, but also bad policy. A celebrated American politician once said: "You can fool all the people part of the time, and you can fool part of the people all the time, but you cannot fool all the people all the time."

While I am giving advice I may offer this piece to the beginner: When in doubt, do not commit yourself to a diagnosis and then call in a specialist, for this may tax the specialist's ingenuity too severely.

A final word of advice may prove wholesome for the specialist as well as for the beginner. In the presence of the obvious, do not overlook the possible; it does not follow, because you have found something, that there is nothing else.

OF PREGNANCY.

Probably more mistakes are made about pregnancy than about any other condition in gynecology.

When a woman says that she menstruates during pregnancy, either she does not menstruate or she is not pregnant. Menstruation is a preparation for pregnancy, and when this has arrived nature is not so futile as to go on preparing for it.

Pregnancy can never be excluded on *à priori* grounds of spinsterhood, widowhood, separation, social position, religious belief, political

“convictions,” or the alleged previous removal of organs; nor on the patient’s affirmation that it is impossible.

Some women cannot be convinced that they are pregnant until they see the baby, and not always then.

It is unsafe to state, on the ground of the condition of a woman’s pelvic organs, that she cannot become pregnant unless you have yourself removed her uterus, ovaries and tubes, and even then it is wiser to say that it is improbable.

There are many symptoms and signs of pregnancy, and all of them can be simulated save one: the one infallible sign is to hear the foetal heart.

In doubtful cases it is to be remembered that pregnancy may be complicated by the presence of other conditions.

OF TUMORS.

Speaking generally, during the child-bearing period, a tumor with missed monthly periods is pregnancy; a tumor with unaltered menstruation is non-uterine; a tumor with increased menstruation is a fibroid. When a woman has a large tumor, if she is very thin it is probably ovarian; if she is very fat it is probably uterine fibroid. We may vary this observation by saying that cystic tumors are associated with wasting, and solid tumors, except malignant ones, with adiposity.

A fixed tumor in a woman at or past the menopause suggests malignancy; in a young woman it suggests an inflammatory mass or an inflamed tumor.

A supposed ovarian cyst can sometimes be removed by passing a catheter, and a supposed solid tumor by giving an enema.

When a woman in her teens or early twenties has an irregular tumor suggesting fibroids, look out for pus tubes. Fibroids are rare before the age of twenty-five.

A swelling in connection with the uterine appendages may be a small ovarian cyst, tubo-ovarian inflammation or tubal pregnancy. The physical signs of the three conditions may be indistinguishable, and the diagnosis will turn on the history. Speaking generally:

An adnexal tumor without symptoms is ovarian.

An adnexal tumor with or following xanthorrhœa is tubo-ovarian.

An adnexal tumor with scanty hæmorrhage following mixed periods is pregnancy.

If a swelling is unilateral the probabilities are against tubo-ovarian inflammation; if it is bilateral, the probabilities are against tubal pregnancy.

It is well not to assume too readily that there is a tumor only on one side merely because none can be felt on the other.

When a small, firm tumor can be felt on the left side, it is well to

make a rectal examination. Such a tumor may be a carcinoma of the rectum or of the sigmoid.

With an adnexal tumor, the temperature is an indifferent guide. It may be normal with pus-tubes, and it may be raised with tubal pregnancy and with an ovarian tumor with twisted pedicle.

When symptoms and signs point to an inflammatory mass in the pelvis, the channel of infection should be sought. Infection conveyed up the unbroken genital tract leads to salpingitis, pus-tubes and peritonitis; infection carried through the broken genital tract leads to pelvic cellulitis and pelvic abscess. When the symptoms and signs of a pelvic tumor are not classical, operative difficulties and complications may be expected.

OF UTERINE CANCER.

When hemorrhage occurs after the menopause, with no previous history of menorrhagia, the condition must be regarded as carcinoma until the contrary is proved.

Cancer of the vaginal portion of the cervix is found only in parous women. Cancer of the body of the uterus is found nearly exclusively in nulliparæ. Endo-cervical cancer is found in both, but much more often in parous women.

The treatment of uterine hemorrhage without examination at or after the menopause closely resembles manslaughter.

The scantier the hemorrhage the greater the urgency; for profuse hemorrhage is nearly always due to simple tumors, whereas hemorrhage due to cancer is nearly always scanty, except in the late stages. Hardness of the cervix is not a sign of malignancy; friability is. Wasting and offensive watery discharge are not essential to the diagnosis of cancer, but they are signs that the disease is far advanced. When a woman has cancer of the uterus, the younger she is the worse is the prognosis.

OF EXTRA-UTERINE PREGNANCY.

A history of missed periods, followed by a brown discharge, leaves the thoughtful physician pondering on the subject of tubal pregnancy until the diagnosis is settled.

With a history of early miscarriage and no foetus passed, a ruptured tubal pregnancy must be thought of.

Missed periods followed by median pains and free loss suggest uterine miscarriage; but, if followed by lateral pain and scanty loss, extra-uterine pregnancy.

When tubal pregnancy is associated with uterine hemorrhage, the tube has always ruptured or aborted, and the gravid tube and hæmatocele become a fixed mass. Therefore, a mobile tumor associated with uterine hemorrhage is not a tubal pregnancy.

Tubal pregnancy may be closely simulated by a retroverted or laterally deviated gravid uterus, and by a small ovarian cyst or distended tube associated with an early impending miscarriage.

OF THE MENOPAUSE.

Normally, the menopause is no more a critical period than is puberty; the cessation of menstruation should be as uneventful as its onset, but both epochs are liable to be associated with some functional disturbance. The menopause may engender functional disorders but does not cause disease. Disease may, however, be synchronous with the menopause.

Menstrual infrequency or diminution in the flow may be functional, and attributable to the approaching menopause.

Increase in the frequency or the amount of loss is due to disease.

Increase in hemorrhage at or near the time of the menopause, or any hemorrhage at all after the menopause, renders an immediate examination necessary.

The menopause does not cure disease any more than it causes it. To tell a patient to wait for the menopause is as bad as sending her to a quack.

OF SYMPTOMATIC DISORDERS.

Dysmenorrhœa and menorrhagia are not pathological entities, but symptoms of which the cause must be ascertained.

When dyspareunia is present from the first, it is usually due to vaginal stenosis or vaginismus; when it comes on later, it is usually due to tubo-ovarian disease.

When coitus is followed by hemorrhage in later life, look out for urethral caruncle, cervical polypus, and malignant disease.

When sterility is primary and associated with dysmenorrhœa, it is probably due to stenosis and ante-flexion; when it is associated with a history of xanthorrhœa, it is probably due to salpingitis.

When sterility is not associated with definite physical signs, the husband should be examined before the wife is treated.

When a woman complains of pelvic pains assume that there is a definite physical cause until such has been excluded.

Never call a woman neurotic when you do not know the condition of her pelvic organs.

THE LAST WORD.

There is no sign or symptom that may not be fallacious. The most experienced judgment is fallible.—Selected from *Medical Press*.

CURRENT MEDICAL LITERATURE

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MEDICINE
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MEDICAL EDUCATION STATISTICS FOR 1914.

The Journal A. M. A., August 22, 1914, the annual Educational Number, contains statistics of medical colleges, students and graduates for the year ending June 30, 1914. There were 16,502 students studying medicine this year, 513 less than in 1913. These are divided into 15,438 in the non-sectarian colleges, 794 in the homeopathic colleges, and 270 in the eclectic colleges.

There were 3,594 medical graduates this year, 387 less than in 1913, and 889 less than were graduated in 1912. The non-sectarian colleges had 3,370; the homeopathic had 154, and the eclectic had 70. This is the lowest number of graduates since 1890.

There are six less colleges than in 1913, the total now being 101, consisting of 87 non-sectarian, 10 homeopathic, and 4 eclectic colleges.

Since 1904, 85 medical schools have been closed, 49 of which were merged into other medical schools and 35 became extinct. During the same time twenty-four new colleges were organized, making a net reduction of 61 colleges. This reduction in the number of medical schools is not restricting the opportunities of students to study medicine but is insuring them a better training. The large over-supply of medical schools in this country, is giving way to a more normal supply of better equipped colleges. Of the 85 colleges which closed, 62 had been rated in Classes B and C by the Council on Medical Education of the American Medical Association. A large majority of those closed, therefore, were inferior colleges.

The marked reductions in the numbers of medical colleges, students and graduates is the reaction which would naturally follow the stupendous over-supply which this country possessed ten years ago. There would be no possibility of a scarcity of physicians in this country for years to come, even though the number of medical schools was again reduced by half.

Women students constituted 3.8 per cent. of all students, and of all graduates, 3.4 per cent. were women. Statistics show that college terms are being gradually lengthened. In 1901, 100 colleges had annual sessions of only 23 to 28 weeks each. Now only two colleges have such short sessions and about 95 per cent. have sessions of from 31 to 36 weeks. In 1904 only 42 per cent. of the colleges had sessions of 31 or more weeks.

Tabulated statistics of college fees, including matriculation, tuition and laboratory fees, show that 14 colleges charge \$100 or less for each student per year, 66 colleges charge between \$100 and \$175 per year, and 21 charge \$175 or more. Among the colleges charging fees of less than \$100 are several strong state university medical colleges. On the other hand, eleven colleges listed by the Council in Class C charge fees from \$100 to \$175 per year for each student. Considering the fact that diplomas from Class C colleges are reported as not recognized as a qualification for a license by thirty-one state licensing boards it would be poor economy to attend one of these colleges because of the slight difference in fees charged. In some cases it is a fact that in the same time and for even less money the student could attend one of the best equipped colleges, the diplomas of which are recognized in all states. Financial reports from 65 acceptable medical schools show an average actual expenditure for each student for one year of \$435, while each student paid on the average in fees only \$122. This shows that to furnish an adequate training medical schools must have more income than is derived from students' fees, in the form of either state aid or private endowment.

Of the 101 existing colleges, 84, or over 83 per cent., now require one or more years of work in a college of liberal arts for admission, and several others have announced the higher requirement to take effect in 1915. Of this number, 34 require for admission two or more years of collegiate work. That marked progress in this respect has been made, is shown by the fact that in 1904 only 4 colleges (less than three per cent.) required any collegiate work for admission. Twenty state licensing boards have established the requirement for preliminary education of one or two years' work in a college of liberal arts, thereby supporting the better class of colleges which have adopted that standard. Seven of these require two years of collegiate work, the equivalent to that required by university medical schools for the six year combined course for the B.S. and M.D. degrees.

Of the 3,594 medical graduates in 1914, 807, or 22.5 per cent., were also graduates of colleges of liberal arts, as compared with 19 per cent. last year. This shows a decided improvement in the qualifications of those who are to practice medicine.

In recent years medical colleges have been greatly improved by the securing of endowments, new buildings, better equipped laboratories, better dispensary and hospital facilities, and—most important—larger numbers of expert, full-time teachers. Improvements have been particularly rapid since the creation by the American Medical Association of the Council on Medical Education, in 1904.

PYLORIC AND DUODENAL OBSTRUCTION.

Dr. F. Buckmaster, in the *New York Medical Journal* for August 15th, concludes his article on this topic as follows:

1. Of the patients with stomach complaints each one must be studied individually and completely by (a) a written history taking in all details; (b) complete physical examination, not only in relation to the stomach, but to all other parts, as the cause of ninety per cent. of all stomach distress rests outside the stomach; (c) associated with these the various test meals and special stomach and X-ray examinations should be made regularly.

2. Clinically, pyloric or duodenal blockade begins to be important at the time when gastric drainage is interfered with, just as is the case in blockade in the vesical neck. In either case with retention once initiated, fermentation and added infection result, and the condition progresses from bad to worse, in proportion to the amount of retention, as determined from time to time by the obstructing lesion. In both organs we may have an early muscular hypertrophy, with cramps and spasms of the outlet, and pains due to irritation and inflammation of the mucous linings; and in both, as the degree of obstruction increases, we will get motor insufficiency and dilatation, together with a sagging down of the base of the organ; and, finally, a complete inability to function. A correct diagnosis can be made early of these conditions of retention, before great damage is done, and the proper treatment applied to the cause, which is better than to treat the one case indefinitely for chronic gastritis, and the other for chronic cystitis.

3. A diagnosis of chronic gastritis, nervous dyspepsia, dyspepsia and indigestion, hyperchlorhydria, hypersecretion, gastralgia, etc., in itself means nothing and these should be dropped as diagnostic terms.

4. It is as homicidal to wait for hemorrhage before we diagnose ulcer; or for tumor, emaciation, cachexia and coffee ground vomit, to diagnose cancer; or extreme emaciation, large dilated stomach, and daily vomiting to diagnose pyloric blockade; as it would be to wait for colic, jaundice and passing of stones by the bowel to diagnose gall-stone disease, or for abscess or peritonitis to diagnose appendicitis.

5. Most cases of pyloric and duodenal obstruction are clinically curable. The doomed malignant ones may receive much relief by gastric drainage, hence early diagnosis and proper treatment in these cases is a very important matter to the sufferer. Likewise more attention should be given to the timely treatment of the causative conditions.

THE PSYCHIC TRAITS OF THE TUBERCULOUS.

Those who have been puzzled by the peculiar psychic traits of the consumptive will learn much from two articles written by Fishberg—"The psychology of the Consumptive," *Medical Record*, April 16, 1910, and "Some Psychic Traits of the Tuberculous," *Interstate Medical Journal*, March, 1914. Not only physicians and nurses, but social service workers, will have their special problems clarified by a careful perusal of these papers. Those who have to deal intimately with the consumptive frequently note apparently inexplicable things about him, and the more intellectual the type of patient the more pronounced the peculiarities. Fishberg discusses the exaggerated ego of these patients, their colossal selfishness, and their susceptibility to suggestion. The last explains their credulity with respect to the Friedmann twaddle, and also their apparent improvement under the turtle treatment. Fishberg tells how Mathieu and Dobrovici, at the Andral Hospital, in Paris, announced to their patients a new cure, which they dubbed *Antiphymose*, and which consisted simply of physiological salt solution. They were kept waiting for the "specific" for a long time and only "suitable" cases were selected. There was phenomenal gain in weight, hemorrhages ceased, temperatures became normal, and all other symptoms were ameliorated. *Even physical findings in the chest showed distinct signs of amelioration of the process.*

Next to this trait of suggestibility comes selfishness, developed in the course of self-centered hygiene. The patient may vanquish the disease, but often survive as an unlovely character, spoiled forever.

Those who have had much to do with this class of patients will recall the most invariable ungratefulness that they show for benefits received. Before entrance to a state or city sanatorium their lives may have been most precarious, yet after subsisting on the public bounty almost luxuriously for periods of one and two years they will usually criticize captiously the diet and care that they have received. Those unacquainted with consumptives' traits will easily be misled by their testimony. One begins to understand where the trouble lies when he finds the consumptive or the arrested case systematically capturing the best food in the home, even though children suffer deprivation. Sacrifices on the part of others are accepted complacently, or demanded brutally.

Of course, the toxemia must be taken into account in considering the consumptive's traits, and it must be remembered that he reveals traits at times which, while related pathologically to the toxemia, are quite the reverse of unlovely. If he happens to be a person of high talent or positive genius his powers are often augmented and exalted

by the stimulus of the tuberculous by-products, the excitative effects of which upon the psychological switchboard have become familiar in the persons of such well-known personages as Robert Louis Stevenson, Keats, Schiller, etc. Optimism and intellectual brilliance have often been noted by Fishberg in his patients of the better classes.—*The Medical Times*.

URINARY ANALYSIS.

The tests for sugar in the urine would appear to be sufficiently numerous, but the fact remains that errors frequently occur, and the substance in general use—Fehling's solution, has numerous disadvantages. Many of these are avoided by using Benedict's solution, which consists of:

Copper Sulphate	17.3 gm.
Sodium Citrate	173 gm.
Anhydrous Sodium Carbonate	100 gm.
(or Crystalline Sodium Carbonate)	200 gm.

Dissolve the copper sulphate in 100-105 c.c. of distilled water, and add slowly with constant stirring the other ingredients dissolved in distilled water and filtered; this should amount to about 800 c.c. Finally, make up to 1 litre with distilled water. For use, take about 5 c.c. of the solution, add about 8 drops of the urine to be tested, and boil for one or two minutes. When glucose is present, there will be a bulky precipitate of a red, yellow or green color. The solution keeps well, and is not appreciably affected by creatinin, uric acid, chloroform or the simple aldehydes.

In testing for bile pigment in blood and urine, Pakuscher and Gottmann employ a 5 per cent. solution of iodine in ether. One c.c. of this reagent is added to 5 c.c. of urine and shaken. After separation, the lower layer (of urine) is colored green if bile is present, and this color becomes more accentuated if the urine is subsequently shaken up several times with fresh ether. To apply this test to the serum, the albumen is first removed by shaking with alcohol (2 of serum to 3 of alcohol) and filtering. The filtrate is diluted with water, acidified with 25 per cent. hydrochloric acid and tested with the ethereal solution of iodine as before—*Practitioner*, No. 3, 1914.

HYPERTHYROIDISM.

The relations of pathologic conditions in the nose and throat to the origin and treatment of hyperthyroidism is the subject of an article by S. P. Beebe, New York (*Journal A. M. A.*, August 29, 1914). He

first notices the theories of the internal secretion and its functions and shows how experiments and clinical observations have demonstrated its antitoxic actions and protection against various pathologic conditions. The relation of thyroid disease to previous infections has been noted clinically by many observers. The terminal event in hyperthyroid patients is often an infection which has begun in the tonsils, and Beebe says that he has not seen a necropsy in these cases which did not disclose the characteristic pathology of status lymphaticus. He also mentions the common occurrence of hyperthyroidism in women and its relation to the function of the sex-glands as bearing on this question. A large percentage of patients with exophthalmic goitre have enlarged tonsils and adenoids, and give a history of repeated attacks of acute tonsillitis. It is not uncommon for them to date the beginning of the goitre to one of these. Infections of the nose and throat are undoubtedly the commonest to which man is subject, and many of our ills might, if one was so disposed, be credited to them. Recent experiments as to the specific infection of hyperthyroidism are mentioned by Beebe and he says if the thyroid secretion is an important element against infections it is not impossible that it is stimulated to over-activity when occasion calls for it, and if this is too often repeated the gland may become enlarged and a pathologic condition induced. It is not a rare thing to find that a rapid enlargement of the thyroid with characteristic symptoms of over-activity has immediately followed a particularly severe tonsillar infection. Such patients bear these infections badly; are prostrated and slow in getting well. In exophthalmic patients there is no more dangerous or troublesome factor than the tonsil infections to which they are liable and they should be carefully guarded against them. If the patient's condition permits, tonsils and adenoids should be removed. This should not be done, however, during active thyroid intoxication without appreciating the fact that these patients bear operations badly, and every precaution should be taken to avoid shock. It becomes at times more important in exophthalmic goitre when considering operation to first attend to the infected areas. Beebe says that every young patient with an enlarged thyroid should have a careful examination of the nose and throat, and the converse is equally true. Between the age of 12 and 20 is the beginning point of most thyroid enlargements and it has been his observation that the combination of an enlarged tonsil and adenoids, gastric disturbances and constipation and an enlarged thyroid is the beginning of the condition which does not usually attract much attention unless the patient is annoyed by the cosmetic defect in the neck. Hyperthyroidism can be checked in such patients before serious damage is done if its beginnings can be recognized. Too frequently it is overlooked.

SYPHILIS AND INSANITY.

Sir George Savage, of Guy's Hospital, London, observes that syphilis may be a cause of congenital mental defect; it may be a cause of preventing healthy development of the brain; or it may interfere with the development by the senses, and may thus lead to defective education. It may give rise to convulsions, which may either become established, as epilepsy, or may lead to mental weakness. It may also affect the moral development; and cases with a syphilitic inheritance have, in my experience, not infrequently, been morally defective in one way or another, and incapable of recognizing their social duties. Syphilis may cause hypochondriacal feelings, and the presence of stigmata may make the patient believe that he is a suspect, and may thus give rise to delusions of suspicion, melancholia, and suicide. Congenital syphilis is almost certainly the cause of adolescent general paralysis. Ordinary general paralysis, locomotor ataxy with mental symptoms, are associated, in nearly all cases in my experience, with a history of syphilis. Besides this, there are many forms of dementia depending on arterial degeneration which may produce general brain decay, or local troubles, such as softening or apoplectic seizures.

He concludes: "I am constantly being asked this question: Is it justifiable to treat a patient suffering from chronic mental disorder associated with syphilis, such as general paralysis of the insane, with salvarsan? I say, 'Yes.' But if I am asked whether I have much hope, I say 'No.' But it seems to me that, on the one hand, we say to the friends, 'Here is a perfectly hopeless and incurable patient; I can do nothing for him. There is a remedy that is now being used, and, if you have no objection, I should like the experiment to be tried.' I have heard of one or two cases in whom the treatment has produced some material physical benefits, and in one at least of whom the mental and physical systems have both steadily improved."—*The Medical Times*.

 THE MODERN TREATMENT OF INEBRIETY

I. H. Neff outlines the following scheme which represents the system adopted by Massachusetts in the treatment of inebriety: (1) A state hospital for inebriates developed on the colony plan with a sufficiently ample and flexible equipment for the different types and grades of cases of habitual drunkenness. (2) An out-patient department with broad and well-defined duties. (3) Detention hospitals serving as adjunct institutions to the central hospital. These hospitals are to be situated in the cities and towns of the commonwealth. The hospital

need not be especially built for the purpose, but should have special features for the care and treatment of acute alcoholism. Briefly defined, the purpose of these hospitals would be as follows: (a) For the treatment of delirium tremens. (b) To serve as an observation and receiving ward for the parent hospital. (c) To provide a clinic for incipient cases of inebriety. (d) To serve as sub-offices for the out-patient department of the main hospital. (e) To provide medical officers to visit prisons, to examine cases arrested for drunkenness, and to determine their fitness for treatment of the hospital.—*Medical Record*.

GYNÆCOLOGY

UNDER THE CHARGE OF S. M. HAY, M.D., C.M., GYNÆCOLOGIST TO THE
TORONTO WESTERN HOSPITAL.

ROENTGENOTHERAPY IN UTERINE HEMORRHAGE

G. E. Pfahler, Philadelphia (*Journal A. M. A.*, August 22, 1914), remarks that treatment of uterine hemorrhage by the Roentgen ray is one of the most brilliant achievements of roentgenology. The sexual glands are the most sensitive of all the glands in the body to the Roentgen rays, and this explains the fact that the ovaries are especially affected toward the menopause when the resistance of the gland is reduced. The good results, as given by him, are the cessation of the menses, decrease in size of the myomas and decrease or cessation of the hemorrhages connected with them, cessation of preclimacteric pains or hemorrhages, sterilization when indicated, obliteration of postclimacteric hemorrhage, control of menstrual disturbances at any age; it is especially in the myomas of elderly women and the accompanying hemorrhages that they are useful. The results will be the more generally satisfactory in older patients. Under 40, roentgenotherapy is not the method of choice. Good results may be obtained, but more treatment will be required. The intramural or interstitial tumor gives the best results. The contra-indications are: "1. All cases of myomas in which the tumor is pedunculated or which can be exercised without destroying the reproductive powers of the patient. 2. Fibroids that have undergone malignant degeneration, or that have become gangrenous, should not be treated. 3. Fibroids associated with disease of the adnexa. 4. Fibromas which are producing such marked symptoms that the patient is endangered more by waiting two or three months for results of roentgenotherapy, than by the result of an operation." The decrease of the hemorrhage is more prompt the older the patient or the nearer she is to

the menopause. The first series of the radiations may cause an increase in the hemorrhage, especially in patients who are very anemic, and in such special effort should be made to keep the patient in bed and if necessary be prepared to use a tampon. Later the vitality of the cells is depressed and destroyed. With the cessation of hemorrhage the general health improves. The decrease in size of the tumor is slower, but sometimes it appears before the hemorrhage ceases. Some good reports have been recorded from treatment of malignant disease of the uterus, but permanent results are hardly to be expected, and at present we should recommend roentgenotherapy only for inoperable and recurrent cases. Pfahler recommends the Coolidge tube as a great advance. It enables one to adjust the degree of vacuum at will and maintain it uniformly with a large quantity of current. The tube should be one that can keep a constant high vacuum of from seven to eight Benoist. The most practical distance for the target of the tube from the skin of the patient is about eight inches, and the rays should be confined to the area treated as much as possible. Filters should be used to cut off rays that are mostly absorbed by the skin. The time required to give any particular series of treatment would depend on the character of the equipment and technic; generally he uses from one to three days to give any series of treatment, and the period between series should be preferably three weeks, but not less than two. The disadvantages of the treatment are the long time it takes, the danger to overlying tissues if the rays are not properly applied, and it has been claimed that it is more expensive than operation, but considering the lack of the expense of board and hospital care, Pfahler considers it not more expensive. The advantages are: Absence of pain, lack of shock of operation, preservation of the internal secretion to a certain extent, as he believes, no interruption of the usual habit or confinement in a hospital, safety in the hands of a skilled operator, the gradual production of the menopause and the ability to grade the treatment to the needs of the patient.

CANCER OF THE UTERUS.

Charles Ryall's analysis of 760 cases of this disease confirms Leitch's observations that the greatest frequency of onset of this form of cancer is in the age period of forty to forty-five years, that is before the menopause and during the period of motherhood. The condition is far more frequent in parous women than in nulliparous, and the relative proportion of parous women with uterine cancer to nulliparous in the general population. This applies only to cancer of the cervix,

that of the body being about equal in the two classes. The commonest cause of death is from involvement of the ureters, a condition found in 75 per cent. of cases at autopsy. In the treatment of inoperable cases the author recommends the ligation of both internal iliac and both ovarian arteries, combined, if possible, with removal of the infected glands. This does not materially prolong life, but it gives great relief from the distressing symptoms and allows patients to live their remaining days in comparative comfort.—*Lancet*.

CESAREAN SECTION.

T. F. Green reports a series of sixty cases in which this operation was performed. One mother died. There was no fetal mortality. Of the mothers four were under twenty years of age; 13 were from twenty to twenty-five years old; 13 were from twenty-six to thirty years old, and 16 were from thirty-six to forty years old. There were 34 first, 16 second, 1 third, 5 fourth, and 4 fifth pregnancies. Of the sections, 51 were first and 8 were second sections, and 1 was a third section. The following were various indications: Eclampsia with varying degrees of justo minor pelvis, 7; eclampsia with large baby (nine pounds) in primipara, 1; malposition of uterus after Alexander operation, 1; old tuberculous anchylosed hip with deformed pelvis, 2; placenta previa complete in primipara with justo minor pelvis, 1; chronic heart with general edema plus pelvic deformity, 1; primiparous twin pregnancy with breech presenting in flat pelvis, 1; flat pelvis, 17; varying degrees of justo minor pelvis, 29. The author emphasizes the fact that the Cesarean operation should be an operation of election. This means that the obstetrician puts himself in the position of a prophet foretelling the outcome of labor. It is true that he may be criticized, but his results will be far more satisfactory to mother and child than if he puts his trust in chance. Opening the abdomen of a woman exhausted by long labor and exposed to the risk of infection is a task from which any may well shrink; but if for religious reasons, one recognizes that the child in utero has a right to life, there is left no other method of delivery, and its results justify the wisdom of the choice.—*Medical Record*.

RADIUM IN GYNECOLOGY.

F. Jayle describes five cases, of malignant growths of the uterus or ovaries, in all of which good health has been maintained from three to five and a half years since radical operation and local radium treat-

ment. In two the operations had been incomplete, some malignant tissue remaining. Jayle advocates the use of radium is a supplementary measure in certain malignant gynecological cases. In some cases of cancer of the cervix, especially with marked extension to the vagina, radium may be applied with advantage both before and after the operation. In a case without vaginal extension, in which hysterectomy was performed, radium was successfully used to destroy a large, suppurating, cancerous iliac lymph node. Local induration following the use of radium in strong doses is due, not to recurrence, but to a sclerosing action, and disappears in time.—*Presse Medicale*.

THERAPEUTICS

A NEW RAPID CURE FOR SCABIES.

Ehlers, in *Paris medical* for March 7, 1914, recommends the use of an ointment of potassium pentasulphide prepared as follows: One part of sublimed sulphur is dissolved at a low heat in two parts of a 50 per cent. solution of potassium hydroxide. The resulting fluid is filtered and represents a 33.3 per cent. solution of potassium pentasulphide, with a beautiful orange yellow color. To an ointment base made up as follows:

℞ Petrolati albi ℥viiss (225 grams)
 Adipis lanæ anhydrosi ℥viiss (225 grams)

Misce.

are then added, little by little, 12.5 ounces (375 grams) of the potassium pentasulphide solution, forming an ointment. In the latter is further incorporated a little of the following preparation:

℞ Zinci sulphatis ℥vii (28 grams)
 Liquoris sodii hydroxidi (20%) ℥x (40 grams)
 Benzaldehydi ℥lxxx (5 grams)
 Petrolati liquidi, q. s. ad. Oii (1000 grams)

Misce.

The procedure in administering the treatment is as follows: The patient first takes a twenty-minute cleansing bath, using neutral soap (not green soap). He is then rubbed with the ointment for half an hour, and a dusting powder applied, after which he puts on his clothes. Twenty-four hours later, another cleansing bath is taken, and clean clothes donned. Disinfection of the discarded clothing is unnecessary, the author holds.

The treatment is both harmless and invariably curative. The burrows are caused to vesicate by the ointment—possibly because of liberation of hydrogen sulphide from contact with the sweat, acid, and burrow secretions—and the parasites are promptly destroyed. They can easily be obtained from the burrows and examined under the microscope. The only disadvantage of the method is an odor of hydrogen sulphide. The ointment is an eminently good one for rubbing in and can be washed off with astonishing readiness.

Previous to trying the foregoing procedure, Ehlers employed Weinburg's ointment in scabies:

R	Styracis	.....	.....	.....	pars i
	Sulphuris sublimati	.....	.....	.....	pars i
	Calcii carbonatis præcipitati	.....	.....	.....	pars i
	Saponis viridis	.....	.....	.....	partes ii
	Unguenti simplicis	.....	.....	.....	partes ii
M. et fit. unguentum.					

While there were only extremely few recurrences after the use of this combination, a longer period of treatment was required, three rubbings at twelve hour intervals being necessary.—*New York Medical Journal*.

THE VALUE OF ANTITYPHOID VACCINATION.

The following letter appeared in *The British Medical Journal* of 22nd August, from the pen of Sir W. B. Leishman:

Sir,—With the permission of Sir Arthur Sloggett, Director-General of the Army Medical Department, I beg to ask the hospitality of your columns in the following matter.

Antityphoid inoculation remains, unfortunately, on a voluntary basis in our army, and it is only possible to secure the benefit of its protection to our troops by persuading the officers and men, first, of the reality of the danger of typhoid fever; and, secondly, of the protective value of the vaccine.

Needless to say, no efforts are being spared by the Medical Department of the Army to give effect to Lord Kitchener's strongly expressed wish that as many men as possible should be inoculated, with due regard, naturally, to the exigencies of the military situation. Steps have already been taken to impress this upon all concerned with the medical care of the home forces, as had already been done in the case of the expeditionary force.

Many, however, of the medical officers of the territorial force, as well as the newly-enrolled civil surgeons, are less familiar than Royal Army Medical Corps officers either with the danger of typhoid in epidemic form, to which the home forces will most certainly be exposed, or with the high protective value of antityphoid inoculation. I have no doubt that these officers, and also members of the profession outside the ranks of the army, will be consulted on the subject by many who are in doubt as to the value or the necessity of the process. In such cases I venture to appeal for the strong support which it will be in their power to give to the efforts we are making to secure the protection of the territorial force.

The facts relating to inoculation and its results have been widely published in recent years and the pronounced benefits and harmless nature of the procedure are admitted by all who have had experience of it. I may, however, refer to a few points which, although well known to army surgeons, are less familiar to others.

1. No army in recent wars has escaped typhoid fever, which, in several campaigns, has killed more men than the enemy. In the South African war, for instance, there were 57,684 cases of typhoid, of which 19,454 (33 per cent.) were invalided and 8,022 (13.9 per cent.) died. The deaths from typhoid exceeded the total number of men killed in action.

2. It would be most rash, in the opinion of those who have studied the question, to assume that the forces serving at home will not be exposed to the dangers of typhoid in epidemic form.

3. The benefits of inoculation are so well recognized in the regular forces that we find little difficulty, in foreign stations, in securing volunteers for inoculation; for instance, about 93 per cent. of the British garrison of India have been protected by inoculation, and typhoid fever, which used to cost us from 300 to 600 deaths annually, was last year responsible for less than 20 deaths.

4. Inoculation was made compulsory in the American army in 1911 and has practically abolished the disease; in 1913 there were only 3 cases and no deaths in the entire army of over 90,000 men.

The organization for the preparation and distribution of the vaccine should be equal to all the demands made upon it. In view of the possibility of such an emergency as has now arisen, arrangements were made some years ago at the R. A. M. College to prepare and maintain a very large reserve of the vaccine, and from this reserve we have been able to issue, since mobilization, more than 170,000 doses for the use of the troops. The Vaccine Department at the R. A. M. College, under Major D. Harvey, will continue, for the present, the preparation of

the vaccine, and we are also fortunate in receiving most generous and valuable assistance from the staff of the Lister Institute and from Sir Almroth Wright.

The ideal of universal protection is, I fear, too much to hope for, but, with the support of the profession, on which I feel sure we may count, we may hope to save many valuable lives and to minimize one of the gravest causes of depletion of the fighting force.—I am, Sir, yours obediently,

War office, August 16th.

W. B. LEISHMAN,
Colonel, R.A.M.C.

ANTISEPTIC PASTES OR OINTMENTS.

Blondel, in *Paris médical* for January 10, 1914, is credited with the following combination:

℞ Acidi borici ʒiiss (10 grams)
Olei eucalpti ʒiiss (10 grams)
Petrolati ʒiii (100 grams)
M. et ft. pasta.

This combination can be used for lubricating specula, in preference to mercurial pastes which tarnish instruments. The following pastes may be used for other purposes:

℞ Hydrargyri chloridi corrossivi....gr. iss (0.1 gram)
Olei eucalpti ʒiiss (10 grams)
Petrolati ʒiii (100 grams)
M. et ft. unguentum.

Lucas Championnière used a paste having the following ingredients:

℞ Acidi borici pulveris ʒv (20 grams)
Petrolati ʒiii (100 grams)
Glycerini q. s.
M. et ft. unguentum.

—*New York Medical Journal.*

TREATMENT OF NARCOTIC DRUG ADDICTION.

G. E. Pettey, in his recently issued book on *Narcotic Drug Diseases and Allied Ailments*, states that, while many physicians treating narcotic drug addiction depend entirely upon saline cathartics to empty the intestinal tube, these cathartics alone do not give satisfactory results, allowing considerable quantities of toxic matter to remain, the presence of which accounts for the nervousness, nausea, and other distressing symptoms from which patients thus treated suffer. The following are given as examples of physiological balanced purgative combinations:

I.

- ℞ Hydrargyri chloridi mitis gr. x (0.6 gram)
 Extracti rhamni purshianæ gr. x (0.6 gram)
 Ipecacuanhæ pulveris gr. i (0.06 gram)
 Strychninæ nitratis .. gr. 1-8—1-6 (0.008-0.01 gram)
 Atropinæ sulphatis gr. 1-50 (0.0012 gram)

M. et ft. capsulæ No. iv.

Sig.: One every two hours, preferably at 4, 6, 8 and 10 p.m.,
 fasting.

II.

- ℞ Hydrargyri chloridi mitis gr. v (0.3 gram)
 Resinæ podophylli gr. i (0.06 gram)
 Extracti rhamni purshianæ gr. x (0.6 gram)
 Ipecacuanhæ pulveris gr. i (0.06 gram)
 Strychninæ nitratis .. gr. 1-8—1-6 (0.008-0.01 gram)
 Atropinæ sulphatis gr. 1-50 (0.0012 gram)

M. et ft. capsulæ No. iv.

Sig.: One every two hours on an empty stomach.

For aged persons, when mercury is objectionable, the following
 combination is useful:

III.

- ℞ Resinæ podophylli gr. i (0.06 gram)
 Ipecacuanhæ pulveris gr. i (0.06 gram)
 Aloini gr. ii (0.12 gram)
 Extracti rhamni purshianæ gr. x (0.6 gram)
 Strychninæ nitratis .. gr. 1-8 1-6 (0.008-0.01 gram)
 Atropinæ sulphatis gr. 1-50 (0.0012 gram)

M. et ft. capsulæ No. iv.

Sig.: One every two hours on an empty stomach.

In all patients addicted to a narcotic drug, the strychnine in each
 of the foregoing formulæ should be increased to the extent of from 50
 to 100 per cent.

The following pill is considered by the author one of the best of
 its kind ever formulated. It is, strictly speaking, rather an evacuant
 than a purgative:

- ℞ Aloini gr. cc (0.03 gram)
 Strychninæ gr. 1-60 (0.001 gram)
 Extracti belladonnæ foliorum...gr. 1-8 (0.008 gram)
 Ipecacuanhæ pulveris gr. 1-16 (0.004 gram)

M. et ft. pulula No. i.

—*New York Medical Journal.*

WAR SURGERY

SURGERY IN MODERN WARFARE.

Dr. Antoine de Page, of Brussels, publishes his recent address before the fourth congress of the International Society of Surgery in the *Annals of Surgery* for August, 1914. We pass over with a sigh Professor de Page's proud statement that it is the privilege of little Belgium to offer a meeting place for the learned of all countries, as she is covered by Europe herself with the shield of peace and liberty, to note his conclusions drawn from the Russo-Japanese and Balkan wars.

The fate of the wounded to-day depends above all on the aid given on the line of battle, for as long as the engagement lasts the ground is inaccessible to the ambulance men; hours pass during which the wounded are helpless. It is therefore necessary to instruct every soldier in the principles of first aid and to furnish him with a properly fitted surgical packet. He must realize fully the danger of infection from earth, dust and water. Of what use is a sterilized compress, if it becomes soaked in polluted water? If he is wounded in the abdomen, the soldier should know that it is best to remain absolutely motionless, even for hours. No operating should be done in the temporary hospital stations at the front; they should serve simply as places where the sick and wounded are sorted out. Violation of this rule in the Balkan war produced deep suppuration in wounds. Operations must be reserved for the hospitals of the second line, which remain fixed and unchanged and should be manned by experienced surgeons.

Civil consulting surgeons should be attached on regular duty; the presence of these surgeons at the hospitals would give them a neutral character, which they have not at present. The capability of these consultants would assure the utmost caution being used at the critical moment, when the fate of the wounded is in the balance; in short, these tried men would oppose the performance of all operations of which they did not clearly see the urgency. We all know that a man surprised by traumatism opposes less resistance to a general shock than another who has had the time to prepare and arm his organism. The wounded leave the battlefield discouraged, worn out, and join in general the number of "bad cases"; therefore there is still more reason to be careful. Respect for human life should be the only guide. The finest operation is not always the most well directed, and neither the battlefield nor the surgical clinic allows of experiments on human beings.

Professor de Page denounces the use of shrapnel and thinks it

should be abolished by international agreement. In conclusion, the distinguished Belgian surgeon expresses the hope voiced by H. G. Wells in his recent story, *The World Set Free*, that some day the United States of Europe may exchange friendly greetings with the United States of America.—*New York Medical Journal*.

THE SANITARY OFFICER IN THE FIELD.

Major Frederick Schavoir, of the medical corps of the Connecticut National Guard, contributes to the *Military Surgeon* for September an article on the wartime duties of the sanitary officer, which contains some surprises for the general practitioner who is unfamiliar with the mass of non-medical knowledge which the army surgeon must master in addition to his needful professional knowledge. The sanitary officer, it appears, is first a military officer and secondly a medical man; his responsibility is as great as that of any other officer, although the performance of his duties may be less spectacular. In addition to maintaining the health and efficiency of the troops in camp and on the march, and attending to the sick and wounded and their transportation to points where they may be patched up for duty, the sanitary officer must not only read and interpret topographical maps, but be prepared and equipped to sketch a map himself. This enables him to calculate the time required for troops to cover certain distances and to dispose of his sanitary forces accordingly. The chief surgeon should know exactly the size, location, and transportation facilities of the sanitary troops under his orders. He will ascertain the probable location of casualties, taking under consideration the terrain, time, distance, weather and climate conditions, as well as the presence of streams, wells, and other water supply, the location of buildings or shelter for wounded, the availability of wagons for their evacuation to the rear, in fact, anything which may play a part in the work of the sanitary troops. The ideal disposition of sanitary units and their appurtenances, such as first aid stations, dressing stations, ambulances, field hospitals, etc., is that which enables them to be always within reach, yet never in the way. The latter is a most important point and an ill considered move may have the gravest consequences.

As to his subordinate officers, the chief surgeon should always give his orders in writing and be careful that there are as complete and as clear as possible; he indicates where he is and with what organization, gives the hours and minute of writing, and states the rate of travel, such as ordinary, rapid, or urgent.

We commend to those interested Major Schavoir's article, of which we are able to give but a very imperfect summary. After showing how a battlefield is evacuated, and commending to students actual experience with troops, the author concludes with ten cardinal rules, as follows:

1. Read or write orders, messages and reports thoroughly to avoid misunderstandings.
2. Study your map and locate yourself exactly.
3. When choosing cover, be sure of its efficiency.
4. Always try to select vicinity of a water supply.
5. Refrain in touch with your superior officer and keep him informed of your whereabouts and doings.
6. Never leave any body of troops without some sanitary protection, but concentrate at important points.
7. If short of litter squads, remember the band.
8. If short of ambulances, remember returning supply train wagons. Rent or impress civilian help if necessary.
9. Be always on hand but never in the way. Avoid blocking of roads which are used for the movements of combatant troops ; hunt out parallels if there are any.
10. Do not expose yourself nor your personnel unnecessarily and remember that your services are too important to the general success to risk being disabled.—*New York Medical Journal.*

BIOLOGICAL ASPECTS OF WAR.

The time is long past when there were many who believed with Shelley that

“War is the statesman's game, the priest's delight,
The lawyer's jest, the hired assassin's trade—”

Whim or momentary passion can no longer be said to precipitate a nation into a fiendish combat with another. The causes of war are deeply rooted in the laws that direct or the difficulties that beset the evolution of the race. The thoughtful physician whose training in the diagnosis of human ills tempts him to essay the diagnosis of the ills that afflict the body politic, may look upon the present insensate war, which has burst with such sudden violence upon almost every country of Europe, with keen interest.

According to Lombroso, war is the lineal descendant of crime. Whether or not this view be accepted there can be no doubt that war is frequently based upon criminal aggression, and is always accompanied and followed by an increase in the crimes perpetrated by individuals. But in a larger sense the so-called political causes of war are based upon fundamental racial antagonisms and aspirations. Economic necessity, such as the "law of diminishing returns" in agriculture and the overcrowding of population, may also plunge a nation into the mania of conquest. Apart from these primal causes there are transient but no less potent factors that act as compelling forces in driving an entire people into the throes of conflict. One may speak of national hysteria, of the hypnotic influence of leaders, of the insensate violence of mobs, of the madness resulting from suggestion and imitation, and also of an unreasoning, though perhaps none the less to be respected, national pride.

The physician is interested in war not as a more spectator, but as an active participant. War would be so fearful as to be almost impossible without the ministering arm of the medical profession. It is to be regretted that the very skill which tends to alleviate the horrors of battle is in itself a means of prolonging and rendering more effective its fiendish onslaughts. The ingenuity of the gunsmith, the wizardry of the chemist, the daring of the aviator, are all aided by the dexterity of the surgeon. Yet, aside from being an indispensable part of an army, the physician is usually inspired by motives of patriotism. He is thus urged on by a twofold impulse—that of service to his country and that of service to his fellow man.—*Medical Record.*

PROSPECT OF CASUALTIES IN THE EUROPEAN WAR.

There is an almost prophetic note in a volume recently published in Paris by Dr. Octave Laurent, of Brussels, on the surgical aspects of the recent Balkan wars between Bulgaria and Turkey.

"Bulgaria put into the field during the two wars more than 500,000 soldiers, drawn from a population of about 4,300,000. In the first war 30,000 men were killed and about 53,000 were wounded. In the second war the killed numbered 16,000, and the wounded about 62,000. The totals for the two wars were: Killed, 46,000; wounded, 115,000. The total killed and wounded, 161,000, represented one-third of the effective force of the whole army, or three per cent. of the entire population of the country. The deaths were one in twelve of the whole army, one in four of the wounded, and one in a hundred of the population. Dur-

ing the month of July, 1913, 150,000 men were killed or wounded on both sides; and more than half of these, at least 80,000, fell on the banks of the Bregalnitsa during the six days from June 30 to July 5.

“If you put a zero behind each of these numbers you will have some idea of the effective strength of the armies and the losses that must be presumed to take place in any war which would to-morrow set the armed forces of any two first-class powers of Europe on the fighting line before each other. There would be not less than 1,500,000 dead and wounded in the course of the first month.”

“The high proportion of the killed to the wounded during the Balkan war is a modern feature that would be likely to be repeated. Artillery fire, meaning by that the use of explosive shrapnel, was responsible for more than half of the deaths, but for less than one-fifth of the wounded. Rifle fire was therefore relatively ineffective by its failure to produce those massive destructive effects which follow so swiftly on the skilful use of artillery. It is precisely the reliance on the large use of artillery fire which would mark the operations of the great European armies, and from that one has little excuse for forecasting any but high figures for the killed.—*Boston Medical and Surgical Journal*.

VITAL STATISTICS AND WAR.

The Department of Health of New York has recently issued a compilation of statistics which “explain why the Kaiser is able to put so large an army of young fighters into the field, and perhaps also indicate why Germany preferred fighting now to postponing the conflict.” In 1880, it is stated, Berlin had the highest birth-rate of the large European cities, 40 births per 1,000 of population. This lead it held from 1880 until 1893, at which time London took the lead. The following year the birth rates of both London and New York were larger than that of Berlin. “It is clear,” says the *Bulletin* of the Department, “that the enormous birth rate between 1880 and 1893 still shows its effect in the present German army, for all of these individuals are now between 21 and 34 years old, and therefore constitute the flower of the fighting force. With the decline in the birth rate, and especially since Berlin was passed by London in 1893, it must have been clear to the Kaiser that the prospects for a continuation of an overwhelmingly large army were becoming dimmed.” In 1913, the birth rate of New York was 26 per 1,000 of population; of London, 23; of Berlin, 20; of Paris, 17; and of Brussels, 16.—*Medical Record*.

WOUNDS IN MODERN WARFARE.

Military operations now under way in Europe upon such a tremendous scale, arouse interest in the subject of gunshot wounds, and in the probable loss which will be sustained by the combatants. The increase in range, the rapidity and accuracy of fire developed in modern military firearms, supplemented by the relative increase in the strength of field artillery, will have an important bearing upon the character of the wounds and the number of casualties. Experience in recent wars has demonstrated the character of the injuries produced by modern military firearms. The European powers have all adopted rifles with similar ballistic properties. The bullet is jacketed, of small calibre, varying from 6.5 mm. to 8 mm. (0.255 to 0.315 inch), and weighs from 150 to 220 grams. It is either ogival or pointed in shape, and has an initial velocity of from 2,00 to 2,700 feet a second. The pointed, or "spitz ball," has been adopted by England, Germany, Turkey, and the United States. The wounds inflicted are therefore of entirely different character from those inflicted by the rifle in use several decades ago. This weapon had a low velocity and carried a soft leaden bullet of large calibre.

The effects produced upon the tissues by projectiles depend upon the velocity with which the bullet impinges, its size, and the resistance encountered; the energy expended is directly proportionate to the velocity with which it strikes. If the resistance encountered is slight, as in soft tissues, the damage will be equally slight, while with a high velocity and great resistance, the damage will be relatively great. Explosive effect, that is, the effect that would be produced by the action of an explosive within the tissues, is not frequently met with on the battlefield, since it occurs only at the short range, say under 300 or 400 yards, when the bullet is moving at a high rate and when the resistance encountered in the tissues is great, as in bones and encapsulated organs, and in cavities filled with liquid or semi-liquid masses, such as the skull, stomach, heart, etc.

Experience in the Russo-Japanese and Balkan wars has demonstrated that at the greater ranges perforations of the abdomen, chest, and skull, may take place with astonishingly slight effects. This statement must be modified so far as the pointed bullet is concerned, since this bullet has its centre of gravity near its base and is usually "set up" on meeting with slight resistance, thus forcing its way through the tissues in its length instead of in its diameter. In the Balkan war the comminution produced in bones by the pointed bullet was found to be greater than that produced by the ogival shaped bullet. Injuries to the dia-

physes of the long bones are usually accompanied by great splintering and comminution. In the epiphyses of the long bones and in cancellous bones, the injury is more likely to be a perforation. Wounds of the soft parts inflicted by the modern rifle bullet and protected from infection by the prompt application of the first aid dressing, are usually trivial in character, and men so wounded are generally fit for duty at the end of two or three weeks, even when the lungs have been perforated.

Fatal primary hemorrhage occurs much more frequently than in earlier wars, because the small calibre jacketed bullet is more likely to sever vessels, while the large calibre bullet, moving with lower velocity, affords time for the vessel to be pushed away from its course. It has been estimated that eighty-five per cent. of the deaths upon the battlefield in modern warfare are due to hemorrhage. Secondary hemorrhage, which in former wars was of such common occurrence, nowadays rarely occurs, while traumatic aneurysms is much more frequent.

Amputations are much less frequently found necessary, and then only where there is extensive destruction of the limb, as in wounds by large shell fragments, or injury to bloodvessels completely arresting the circulation. During our civil war military surgeons considered that in all wounds of the larger joints amputation was indicated. Wounds inflicted by the modern rifle bullet, if properly protected against infection, never require amputation unless the circulation is arrested. In injuries to bones, even with the greatest comminution, if no infection ensues, repair usually will be very good, provided efficient fixation is employed; such, at least, was the experience of surgeons in the Balkan war. Machine guns use the rifle ammunition and the wounds inflicted by them are identical in character with those inflicted by other small arms.

The wounds caused by shrapnel bullets differ from those caused by the rifle bullet in that they are accompanied by greater contusion and involve a greater amount of tissue, shrapnel bullets being of greater size and having a much lower velocity. The shrapnel bullet of the three-inch field gun of the United States is made of lead and antimony, has a diameter of one-half inch, and weighs 167 grains; there are 250 bullets to each case. The velocity of the bullet at the end of its longest range, about 6,500 yards, is 865 feet, which is sufficiently great to kill a man or a horse. Shrapnel wounds are frequently multiple, and almost invariably suppurate, since they are very apt to carry foreign material from the clothing into the wound. Grenades produce injuries similar to those made by fragments of shells, and were used in action at close quarters by the Japanese in the Russo-Japanese war, often with fright-

ful effect. Wounds produced by them are usually multiple, often extensive, and may be caused by pieces of the casing as well as by the explosive action of the charge. At times, limbs may be shattered or completely torn away. Wounds produced by bombs and mines are similar to those produced by grenades. The great amount of contusion that is present in these injuries likewise increases their liability to suppuration. Shell wounds are produced by fragments of the bursting shell, which vary considerably in size and shape. Such wounds are always lacerated and may vary from a simple contused incision to a complete disruption of tissues. Like shrapnel wounds they are prone to suppurate.

Roughly speaking, battle casualties in recent wars have varied from ten per cent, to twenty per cent. of the number engaged. The ratio of killed and wounded has been about one to four. Of the casualties, from 65 to 80 per cent. were caused by rifle fire, and from 20 to 30 per cent, by artillery fire, chiefly shrapnel. Bayonet and sabre wounds apparently have been of rather infrequent occurrence, since little mention of them is made in reports. During our civil war, 90 per cent. of the total wounds recorded were caused by small arms, while the injuries from artillery amounted to but 9.87 per cent. of the total wounds.—*New York Medical Journal*.

ARMY SANITATION.

Sir William Osler a short time ago issued a warning to the British troops. Among other things he said:

“It was formerly said that an army marched on its belly; now it is marched on brains. Bullets are less fatal in war than bacilli. Where one slew a thousand the other slew tens of thousands. Twenty-two thousand lives were lost in the Boer War. Of these 1,800 were by bullets and 14,000 by bacilli. I appeal to each individual soldier to use intelligent co-operation to combat this more deadly enemy. Dysentery, pneumonia and enteric were the three great scourges.

“Only by boiling all water can dysentery be prevented. To stave off pneumonia don't neglect coughs and colds. The most fatal enemy, however, is enteric or typhoid fever. There were 57,684 cases in the Boer War, 8,022 proving fatal, especially from consequent action of flies and dust. Enteric killed more British soldiers than Boer bullets. It is urged that vaccination against typhoid be carried out. Among the unvaccinated in France the rate was 68 per thousand, and only one-fifth of one per cent. among the vaccinated. Inconvenience to the soldier from vaccination only lasted 24 hours.

“With a million in the field their efficiency can be increased one-third if we prevent enteric, as we can.”

PERSONAL AND NEWS ITEMS

Ontario.

Dr. A. A. Fletcher, son of Prof. John Fletcher, of Toronto, arrived home some time ago. He was studying in Germany when the war broke out, and had quite an exciting time in making his exit from the country. He saw the German torpedo boats busily engaged in laying mines.

The Fellows of the Toronto Academy of Medicine have agreed to give free medical attendance to the families of volunteers in such cases as might require the same.

Miss Margaret Thirsk, formerly of Cobourg Hospital, and recently of Toronto General Hospital, has been appointed superintendent of Bruce County Hospital, Walkerton, and has already entered on her duties.

The Toronto Academy of Medicine donated \$1,000 to the Patriotic Fund of Toronto and York.

Dr. G. B. Archer, medical missionary, who is in Toronto on furlough from India, is being detained from returning to his work owing to the uncertainty of the passage during the war.

Toronto Women's Patriotic League requests all women in Toronto, who are working for the sick and wounded at the war, to send a list of all the articles that can be ready by September 8, to Dr. Margaret Patterson, at the headquarters, 559 Sherbourne Street, in order that, if the list of requirements furnished by the Red Cross Society is not completed the gifts may be supplemented.

Dr. and Mrs. Thos. Kerr, Toronto, with their daughter, Dorothy, the Misses Kerr and Mr. Jack Kerr, are holidaying at Point-au-Baril.

Dr. and Mrs. Murray McFarlane, Toronto, have returned from Camp Minnesing in the Algonquin Park.

The Canadian Women's Hospital Fund according to last accounts has reached the handsome sum of \$250,000. They started out to raise \$100,000. This was accepted in the following terms: "This generous gift has been accepted by the Admiralty with deep gratitude. The new hospital will be supplementary to the Royal Naval Hospital at Haslar, and will be known as the Canadian Women's Hospital."

Dr. G. G. Nasmith of Toronto, will go to Europe with the first Canadian contingent to fight germs, not the Germans. This permission was granted by the Board of Control yesterday on receipt of a letter from Col. the Hon. Sam. Hughes, Minister of Militia, requesting the further services of Toronto's laboratory specialist.

During the absence of Dr. A. J. MacKenzie of Toronto, Dr. W. Oldright will be in the office, corner Carlton Street and Homewood Avenue, from 2 to 3 p.m. daily, or by appointment.

Dr. W. H. Ellis, so long known as an eminent practical chemist, has been appointed Dean of the School of Practical Science. Dr. Ellis graduated in medicine, but preferred to follow up his chemical work. For many years he has been at the head of the department of applied chemistry in the University of Toronto.

Dr. F. C. Macdonald, of Midland, left on 15th September for the front. He is a member of the staff of the Royal Army Medical Corps, and sailed from New York for London. He is a South African veteran, having served on the same gun with his brother, Dr. W. J. Macdonald, of St. Catharines, in "C" Company, making the march to Mafeking, and was with Baden-Powell at Rustenberg. During his second year he was surgeon on General Smith Dorrien's brigade.

Sir William Meredith has been re-elected chancellor of the University of Toronto by acclamation. He has held the office with marked distinction for many years.

Drs. William Burt, H. J. Mamilton, Augusta S. Gullen and C. J. O. Hastings have been elected by acclamation to the senate of the University of Toronto, as representatives in medicine.

Dr. B. L. Riordon left an estate of \$26,800 to his widow as sole beneficiary.

Nearly one thousand nurses volunteered to go with the Canadian contingent, of whom about one hundred were chosen. Forty of these had training with the army medical corps. It is proposed to have two bas hospitals and two other hospitals of 200 beds each, and a clearing hospital. There will be 32 nurses in each of the larger hospitals.

Dr. R. D. Rudolf, of Toronto, has been appointed as physician in charge of the base hospital of the Canadian contingent.

The staffs of the Toronto hospitals have suffered considerably through the war. The nurses and doctors who have been called away with the Canadian contingent from the Hospital for Sick Children are: Drs. P. B. Menzies and D. G. Robertson, Miss Myra Goodeve and Miss Helen Fowlds; from the General Hospital, Drs. A. K. Haywood, Perry Goldsmith, Cooper Cole, J. M. Stewart, McKillip and H. H. Burnham; from Grace Hospital, Drs. W. L. C. McBeth, E. B. Hardy, D. W. McPherson and R. S. Pentecost; from St. Michael's Hospital are: Drs. Alex. Mackenzie, Wallace Scott and H. B. Jeffs.

Major D. A. Clark, 400 Jarvis Street, Toronto, potentate of Rameses Temple, A.A.O.N.M.S., Toronto, was present with the Canadian soldiers at Valcartier, being medical officer for the 3rd Artillery Brigade.

Dr. Clark has the distinction of being the first medical officer to be appointed to the overseas force. The members of the Rameses Temple presented Dr. Clark with a very handsome solid gold wrist watch and a suitable address expressing their wishes for his success and a speedy return.

Dr. S. P. Ford, who has practised in Norwood for 50 years, was banquetted by his neighboring practitioners and presented with an address.

Dr. Walter Wright, of Toronto, is doing post-graduate work at Moorfield's Hospital, London.

Dr. Chester Brown, formerly of Toronto, has been appointed assistant medical officer and bacteriologist at the William Head Quarantine Station, B. C.

Dr. W. E. Gallie, of Toronto, has been elected a member of the American Orthopaedic Association.

Dr. H. A. Bruce, of Toronto, was elected first vice-president of the Clinical Congress of Surgeons, which met recently in London.

Dr. Harvey Clare, for some time connected with the Toronto Hospital for the Insane, has been appointed medical director of the Reception Hospital, Toronto, for suspected cases of mental derangement.

Quebec.

Dr. H. S. Beland, for some time a member of Sir Wilfrid Laurier's Cabinet, was in Belgium on his wedding trip when the war broke out. He offered his services as a medical officer to Belgium and was at once accepted and placed in charge of a responsible medical service. It is understood he will be attached to the Canadian Army Medical Corps with the first Canadian contingent.

Final figures concerning the medical examinations at Valcartier have been given out by Col. Dr. Shillington, who had charge of them. He announced, before returning to Ottawa, that 31,385 men had been examined, and of these 28,315 had been found fit for active service.

The St. Justine Hospital for Children, in Montreal, was recently opened. It has three public wards, a private ward, and a dispensary.

The Bruchesi Institute, at Montreal, treated last year 3,285 patients ill with tuberculosis.

The Victorian Order of Nurses in Montreal gave attention to 12,942 patients. The nurses made 128,546 calls. The nurses also give instructions to mothers on the care of infants.

Maritime Provinces.

Dr. Wilfred Grenfell writes from St. Anthony, Newfoundland, to Dr. Primrose, of the faculty of medicine of the University of Toronto, asking for a doctor to succeed Dr. Phelps at Pilley's Island. He states that he wants "a man of some individuality and Christian spirit, and one who loves the people rather than himself. We cannot afford to accept a selfish man."

The Sanatorium for Tuberculosis at Kentville, N.S., is doing good work. The 9th annual report shows that 38 patients were admitted during the year. A fee of \$5 per week is charged. A good percentage of the cases were discharged as apparently cured.

Western Provinces.

It is rumored that Hon. Dr. Roche, Minister of the Interior, will retire from the Federal Cabinet on account of ill health. It has also been stated that Hon. Dr. Roche might become Minister of Health, if a separate department should be created.

The work on the Fort Qu'Appelle sanitarium for tuberculosis has been suspended for lack of funds. The building is to cost \$225,000, and about \$150,000 has been expended.

The Saskatchewan Medical Association held a very successful meeting at Saskatoon on 18th, 19th and 20th August.

An important addition is being made to the Hospital for the Insane at Battleford.

In Saskatchewan a regulation has been issued that paper drinking cups, at a cost not exceeding one cent each, must be kept on all trains. Individual towels must also be supplied in all public places.

From Abroad.

The Admiralty has preferred to accept the modified offer of the women of Canada to provide and maintain a naval hospital rather than a hospital ship. The new hospital will be supplementary to the Royal Navy Hospital at Portsmouth, and will be named the Canadian Women's Hospital.

The Duke of Devonshire has lent Devonshire House, a famous palatial old mansion in Piccadilly, for the headquarters of the British Red Cross Society.

Among the Red Cross nurses at the Eastern Railway Station, Paris, when wounded soldiers came from Peronne and Guise, were Mme.

Verola, cousin of the Emperor of Russia, her daughter, Countess Mornoff, and Princess Ghika. Many society women were present and prepared to take care of the wounded soldiers.

The Canadians in London have undertaken to raise \$100,000 for a hospital of 100 beds. The Canadian War Contingent Association, assisted by the Canadian Masonic Lodge, has the matter in hand. The Canadian hospital scheme has received the approval of the War Office.

Miss Alena Losee, New York, formerly of Picton, is in charge of a thousand American nurses who have gone to France. Miss Losee is favorably known in Prince Edward county.

Hon. W. T. White, Minister of Finance, has received a letter from Sir Charles Tupper with a cheque for \$1,000 to the Canadian Patriotic Fund. The veteran Canadian statesman also wrote: "Four of my grandsons will be in his Majesty's service and I need not tell you how proud I am of the manner in which Canada has responded at this supreme moment to the call of the Empire."

Smallpox is prevalent in many parts of Albania. The refugees are suffering severely, as they are homeless and have no proper care.

Dr. Alexis Carrel, of the Rockefeller Institute, New York, who is in charge of the hospital at Lyons, reports that the French wounded are doing well, and that they are very well treated at the front, and arrive at the hospitals without fever.

Dr. George E. de Schweinitz has resigned his position of ophthalmologist to Philadelphia General Hospital.

It has been learned that the benefactions of the late Lord Strathcona were not all included in his will. The late High Commissioner during his lifetime set aside the sum of \$25,000 to found an institution for lepers in England, the money to be used in the discretion of Mr. John Burns, the then president of the Local Government Board, and Sir Arthur Downes, of that department. The money has been applied toward the establishment and upkeep of a leper settlement in one of the eastern countries.

Sir William Osler has been elected foreign associate of the Academy of Medicine, Paris.

Sir Rickman Godlee has inaugurated a movement for an association of surgeons in Britain similar to the one in America.

Sir Charles Tupper, M.D., a well-known Canadian, and at present in England, has recently celebrated his 93rd birthday.

The American Red Cross Society has fitted up a hospital ship for service in Europe.

Surgeon-General Sir Anthony Home, V.C., a distinguished medical

officer on the retired list, died 9th August at the age of 87. He saw much service in India, China, Ashantee, etc.

Dr. Walter Acton, a Crimean surgeon, died at the age of 86, about three weeks ago.

The United States Internal Revenue Commissioner has issued a list of medical preparations containing alcohol that are not sufficiently medicated to prevent their use as beverages. They will have to be sold by persons having liquor licenses.

A statue of Dr. Edward Adrian Wilson, who perished in the Antarctic with Captain Scott in March, 1912, has recently been unveiled at Cheltenham, England, Dr. Wilson's birthplace.

The death of Prof. Paul Reclus, of the department of clinical surgery of the University of Paris, France, was reported on July 29th. Dr. Reclus, who was in his 68th year, was also attending surgeon at the Hotel-Dieu, Paris, an officer of the Legion of Honor and a member of the French Academy of Medicine.

Report from New Orleans, La., states that on August 16, 17 and 18 three new human cases of bubonic plague were reported in that city, making a total of 20 since the outbreak of the infection there on June 27th.

The American Red Cross on August 15th sent out its first call for nurses to join the relief expeditions which it is preparing to send to Europe. Great Britain, France and Russia, through the American Embassies in those countries, have already formally accepted the offers of surgeons, nurses, surgical equipment and hospital supplies from the Red Cross. One of the Red Cross units will also be sent to Servia.

The Pasadena Sanatorium in South Pasadena, Cal., was destroyed by fire on July 25th. The sixty patients in the institution were removed without mishap. It is estimated that the loss was about \$30,000.

One of the echoes of the European war here was the request received by the New York City Health Department from the Vienna Serum Institute, for fifty liters of tetanus antitoxin. The Health Department will have the serum prepared and forward it through the Austrian Consul.

Dr. James D. Kennedy, of the firm of "Drs. K. and K.," of Detroit, was recently fined \$5.00 for circulating obscene literature in advertising matter.

Dr. W. J. Cooke, of Sudbury, who has been studying in a London hospital and taken a diploma, finding his services not wanted by the War Office, sailed Saturday as assistant surgeon on the Mauretania.

CORRESPONDENCE

OBSTETRIC PRACTICE.

To the Editor of The Canada Lancet:

Dear Sir,—I have read very carefully an article by Prof. Watson on the use and abuse of forceps in midwifery. He gives some excellent advice and procedures. I think I can help some to make things clearer still by giving you a few sketches from my practice during my long career.

First of all I commenced the study of medicine with Dr. George Park, of Simcoe, in my nineteenth year. He was a student of old Dr. John Rolph (formerly of Toronto). From him I received an excellent training, but at that time we had no fluid extracts, pellets or pills, the students had these to make and the doctors to help in any way they could. In this present month of August, 1914, seventy-one years ago, I attended my first case of confinement. I was then just twenty-three years old. After this I attended old Columbia College, in New York city, where I graduated in 1845. Then I went to McGill, Montreal, and back here in this village, where I stuck up my shingle in May, 1846. In 1847 or 1848 I was called to a very hard-working woman in confinement. I saw this same woman raking and binding rye at a rate of five acres a day not more than three months before her confinement. For some little time after my arrival I was alarmed by the severity of her pains, I feared there would be rupture of the uterus, yet after waiting and watching for some hours I came to the conclusion that the expulsive efforts were almost exclusively by the abdominal muscles and very little by the uterine. This terrible racking pain continued for about twenty-one or twenty-three hours, when a boy weighing eighteen and a half pounds was born. The bones of his head were rigid and unyielding. Any application of forceps in this case would have been an abuse, unless just at the very last when they, were of no use. You can imagine my astonishment the next day when I called to find this woman up washing her big boy. She seemed lively and not at all the worse for the terrible ordeal through which she had just passed.

Some eight or ten years after this I was called to another case of confinement. Her husband was a sawmill man, and she took the same diet as the men: fat pork, potatoes, bread, butter, applesauce, etc. (By the way, this was exactly the same diet used by the mother of the 18½-pound boy). This woman for some reason became almost helpless soon after pregnancy took place, but her appetite remained good. She ate and grew stouter and stouter still until she was a shapeless bundle

without having seen her knees for months. Her confinement when it did occur was a lingering tedious affair, lasting five or six days. (It was the custom here to charge no more than five dollars, whether you travelled ten rods or ten miles, and whether you remained ten minutes or a week). This woman's pains were almost entirely uterine. Forceps might have been useful here in terminating the third stage, but it was my invariable rule never to interfere so long as the woman could manage by herself. It must be an impossible delivery before I would interfere. I have never used forceps more than two or three times, and I have never lost more than two or three women in confinement. Some thirty or thirty-five years ago I saw a letter written by a missionary returned from China in which he stated that the Chinese women went out in the rice fields to work, would give birth to their child, and immediately go on with their work as though nothing had occurred. Considering this as a fact, I thought it must be due to rice as a diet. I at once began to recommend rice cooked in water alone, and fruit, preferably apples, either raw or cooked, to pregnant women at a diet. I soon discovered that women who had given birth to eight and ten-pound children would produce a baby of about five pounds and the bones of the head yielding and compressible and the confinement very soon over.

During this time my patient, who had not seen her knees for months before her confinement, had lost her husband and after waiting ten years married again to a widower with a family of three or four girls. She had become pregnant again, and as before, helpless. I at once put her on a generous diet of rice and fruit, with forced exercise of one-half to three-quarters of an hour three times a day. When I was called I hurried to her side and was kept less than an hour before a girl baby was born that weighed less than five pounds. She was strong and lively and could have got up the next day if she had so wished, instead of being obliged to remain in bed five or six weeks after her five to six-day confinement. This child less than five pounds in weight grew up to a woman larger and stronger than any of her half-dozen half-sisters. From my observations I am of the opinion that the children born from rice and fruit-fed mothers are stronger and healthier and ten or fifteen per cent. more of them would be alive at the end of the first year. The difference in the effect on the hard-working woman, like her of the rye-binding 18½-pound boy's mother getting up and washing her child next day, and that of the Chinese woman in the rice field mentioned by the missionary, and of the widow who became helpless while her confinement lingered on five or six days then being obliged to remain in bed five or six weeks. The point here is that every

woman crippled so that she is unable to exercise, stomach-sick women, or women unable to exercise from any cause, or the naturally lazy woman, or her sister, the rest-cure woman, who does not believe in exercise, and at the same time those of them indulging in a heavy diet are the ones to suffer in the end. There must be continued daily exercise to get up strong after confinement, with a rice and fruit diet to produce a small child.

I will now refer to a third case, that of a naturally strong and healthy woman of about twenty years of age. Soon after her pregnancy occurred she got sick at the stomach, would vomit and vomit, even the smell of cooking would make her vomit. In answer to my question of why she did not apply for medical aid, she told me that she thought there was no help for her, that she had just got to bear her troubles as best she could. This state of things continued all through her pregnancy. I was not called until she thought her time was overdue eight or ten days. Then she was a most pitiable sight to behold. Almost helpless, nearly starved to death, with an enormous abdominal distention. I made my preparations for raising the posts of the bed against the wall four or five inches, then procuring a tub with a capacity of 12 to 15 gallons, placed her across the bed with a foot on a chair on each side of the tub, and arranged the sheets so that all the discharge would go into the tub. Then I began trying to rupture the membranes. This I could not do with my fingers. I was obliged to use a bistoury. The membranes were elastic as rubber and apparently tough as leather. The child did not exceed three pounds. There was no hemorrhage, but fully 10 or 12 gallons in the tub. I have noticed a good many varieties of anesthetics recommended in midwifery, but the very first one of all that was discovered by the old Scotch professor, Simpson, chloroform, in my opinion is still the best of all. If given early it may do harm, but near the end it will relieve the mother of the hardest and worst pains of all. Ever since its first use I have always carried a small bottle of chloroform when visiting a woman in confinement and found the woman herself is the one to administer it. Double up a handkerchief and place in her hand, then drop ten or fifteen drops of chloroform on it, with instructions to inhale to slight drowsiness, but never to sleepiness, so that she did not know everything going on about her. I have never met one who did not carry this out better than I could have given it to her.

I think it would be a good proposition for our common country that some means should be taken to have all pregnant women educated in a way to fit them to become mothers with the least difficulty and the best chances of success, both for themselves and their offspring. I have

seen estimates made valuing a native-born Canadian child at one year old worth to his country from one to two thousand dollars. Considering this at the lowest estimate of one thousand dollars, there would be a credit to the rice and fruit-fed mothers of millions every year. If this was done there are very few pregnant women but would follow the directions to the letter and the saving of child life would be enormous.

Yours respectfully,

ALFRED BOWLBY.

Waterford, Norfolk County, Ont.

OBITUARY

W. L. GABOURY.

Dr. W. L. Gaboury, a practitioner of Pembroke, Ont., while driving across the railway track his buggy was struck by a train. He was instantly killed. He was the son of Dr. Gaboury, of Plantagenet, Ont., and graduated from Queen's University in 1912.

HENRY G. FARISH.

Dr. Farish died at Liverpool, N.S., in his 89th year. He was the son of Dr. H. G. Farish, and was born in Yarmouth. He had been a resident of Liverpool for 64 years. He retired from practice a few years ago.

LESTER R. FISLEY.

Dr. Fisley died at his home in Calgary. He had been in poor health for some months.

W. M. KEYES.

Dr. Keyes, of Georgeville, Que., died there. He had lived and practised there for many years.

ARTHUR W. GROVER.

Dr. Grover lived and practised in Dresden, Ont., where he died. He was compelled to retire some time ago on account of ill-health.

ARTHUR VAILLANCOURT.

Arthur Vaillancourt, of Waterloo, Que., died there in his 39th year. He was born in the country of Lotbinière. He was educated at Laval University. He leaves a widow and three children.

JOSEPH A. CHARETTE.

Dr. Jos. A. Charette, of Montreal, was killed on 18th September while returning to his home from the trial of Bourret, Beauchamp and Foucault for the murder of Constable Bourdon. The doctor was one of the leading witnesses for the Crown in the trial. His death resulted from an accident to a motor car, driven by Joseph Girard, who, along with Alphonse Deguire, an occupant of the car, received injuries that are thought not to be serious. The machine smashed into a fence, turned turtle and crushed Dr. Charette beneath it.

BRUCE L. RIORDON.

Dr. Riordan, of Toronto, died on 29th August. Dr. Riordan was born in 1859 on 17th March. His father settled at Port Hope, where the doctor was born and where he received his early education. His medical education was obtained at McGill, where he graduated when 21 years of age. Subsequently he graduated from the University of Toronto. For two years he acted as a ship's surgeon on the Allan Line. He settled in Toronto in 1881 and became one of the surgeons for the Grand Trunk Railway. He held at various time honorable positions in medical societies. He was on the consulting staff of the General Hospital and was Dean of Grace Hospital staff at the time of his death. He was at one time president of the International Society of Railway Surgeons. He married a daughter of the late Dr. James Thorburn. His widow and son survive him.

J. R. RUTHERFORD.

Dr. John R. Rutherford, 74 years old, a practitioner at Aurora, Ont., for 35 years, and one of the best known men in that town, died recently of pneumonia, at the home of his daughter, Mrs. Richardson, 229 Ouellette Avenue, Windsor, whom he came to visit a few weeks ago. He is survived by two sons, who live in British Columbia, and Mrs. Richardson. The body was taken to Aurora for burial.

J. M. SHAW.

Dr. J. M. Shaw, a well-known physician of Leeds county, died suddenly on 22nd September, at his home in Lansdowne Village.



BOOK REVIEWS

SEROLOGY OF NERVOUS AND MENTAL DISEASES.

By D. M. Kaplan, M.D., Director of Clinical and Research Laboratories of the Neurological Institute, New York City. Octavo of 346 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1914. Cloth, \$3.50 net. The J. F. Hartz Company, Toronto, Canadian agents.

This volume deals with a subject on which there is very little literature in book form, though a considerable amount in the form of journal articles. It was with the view of meeting this want that the author undertook the preparation of this work. The first portion of the book deals with technology. Under this heading the author discusses lumbar puncture, the properties of spinal fluid, and Wassermann reactions. The second section takes up serology in nervous and mental diseases of non-luetic etiology. Here we have discussed diseases of the brain, spinal cord, nerves, and miscellaneous nervous afflictions. The author enters very fully and carefully into the changes found in the spinal fluid in these diseases. The third section deals with the serology of nervous and mental diseases of luetic origin. In this section there is a full examination into the spinal fluid of tabes dorsalis, cerebrospinal syphilis, and general paralysis. The last section takes up the therapeutics of salvarsan. This section is of special value, as it deals with a practical topic. It throws much light upon the proper method of using salvarsan, the preparation of the drug, the care of the patient both before and after the injections, and the complications. The author is deserving of the thanks of the medical profession for the painstaking and scientific manner in which he has performed a very difficult task. We can recommend this work and feel that it will prove of much service to those who consult its pages.

A TEXT-BOOK OF MEDICAL DIAGNOSIS.

By James M. Anders, M.D., Professor of the Theory and Practice of Medicine and of Clinical Medicine, Medico-Chirurgical College, of Philadelphia, and L. Napoleon Boston, M.D., Professor of Physical Diagnosis, Medico-Chirurgical College, Philadelphia. Second edition, thoroughly revised. Octavo of 1,248 pages, 500 illustrations, some in colors. Philadelphia and London: W. B. Saunders Company, 1914. Cloth, \$6.00 net. The J. F. Hartz Company, Toronto, Canadian agents.

This really splendid work on medical diagnosis now appears in its second edition. This edition has been in preparation for the past two years, and contains the latest advances in physical and chemical diagnosis. Among some of the specially new matter may be mentioned

electrocar, diagrams, extrasystole, auricular fibrillation, sinus irregularity, succussion sounds audible over the abdomen, albuminous sputum, cobra-venom reaction in syphilis, the tick in transmitting relapsing fever, Rumpell-Leed phenomena in scarlet fever, sweating and its significance, trichinella spiralis in the blood, MacEwen's sign in epidemic meningitis, Prendergast's reaction for typhoid fever, fatty emboli, papillary reaction, drug eruptions, nitrogen content of the blood, respiratory movements in hiccup, colloidal nitrogen in the urine, and initial eruptions in measles. Many valuable clinical tables have been added on bloody sputum, dyspnea, hemorrhage from the mouth, abdominal enlargement, vomiting, ascites, splenic enlargement, hematuria, and bacteriuria. Every system of the body is gone over with great care and thoroughness. Those who are familiar with the first edition will fully appreciate what is meant when it is said that this edition is a marked improvement upon it, perfect as it was. We most heartily congratulate the authors upon the results of their labors. This is one of the best volumes that can find a place in any bookcase. It is full, accurate and clear, and the illustrations are numerous and of high merit.

THE PRACTICE OF SURGERY.

By James G. Mumford, M.D., Lecturer on Surgery in Harvard University. Second edition, thoroughly revised. Octavo volume of 1,032 pages, with 683 illustrations. Philadelphia and London: W. B. Saunders Company, 1914. Cloth, \$7.00; half morocco, \$8.50. The J. F. Hartz Company, Toronto, Canadian agents.

Dr. James Gregory Mumford has already made a name for himself as a writer on surgical subjects. The first edition of this work was well received, as was its due. The book has a number of redeeming features. In the first place it is reliable in its teachings. The surgeon may safely follow what he finds in this volume. In the next place the author expresses himself in clear language, so that there are no ambiguities. In the last place the volume is not too large. This latter feature has been attained by a careful condensation and terseness in expression. The aim of the author is to write a work on the *Practice of Surgery*. This, of course, makes the volume assume a practical form, and the author states that in its preparation he has kept his own experience before his mind. This makes the work all the more valuable. The surgeon who has a thorough knowledge of surgical literature and has also had a long and large experience of his own is in a doubly good position to prepare for the guidance of the medical profession a sound work on the *Practice of Surgery*. The numerous illustrations add much to the value of the book. These are produced very well because the paper is of such ex-

cellent quality. Turn to any portion of the volume one pleases and a thorough lucidity is found. This work will prove attractive to the expert surgeon, and indispensable to the man in general practice who must be ready for surgical cases, as these are bound to come his way.

DISEASES OF BONES AND JOINTS.

By Leonard W. Ely, M.D., Associate Professor of Surgery, Leland Stanford Junior University, San Francisco, Cal. Sextodecimo, 220 pages, 94 illustrations. New York: Surgery Publishing Co. Price, cloth, \$2.00.

The unusual interest now manifested by the profession in acute and chronic arthritis, as well as other forms of bone and joint diseases, makes this book particularly timely.

Prof. Ely is particularly well equipped from experience to present an authoritative work, having specialized in this particular branch of surgery for years.

This book is intended primarily for the general practitioner, but instead of furnishing that long suffering and very important person with a mass of details, and with many methods of treatment from which he may choose, the book lays down broad general principles, with the evidence upon which they are based, and then shows how these principles may be applied.

In a brief terse way it presents the Anatomy, Physiology and Pathology of Bones and Joints, Acute and Chronic Arthritis of various types, Ankylosis, Diseases of the Shafts, Acute Osteomyelitis, Chronic Inflammations in the Bone Shafts, New Growths in Bone, etc.

The profuse photo-micrographs with other illustrations aid materially in placing up to the eye of the reader the contents of the book and the marginal side-heads, printed in contrasting colors, permits of ready reference.

It is a book which will be much appreciated by the general practitioner and can be read with the assurance that it presents valuable instructions from an authoritative source upon a subject where much light is needed.

GUIDING PRINCIPLES IN SURGICAL PRACTICE.

By Frederick-Emil Neef, B.S., M.L., M.D., Adjunct Professor of Gynaecology, Fordham University School of Medicine, New York City. Sextodecimo, 180 pages. New York: Surgery Publishing Co. Price, cloth, \$1.50.

The author answers herein some of the questions which present themselves to the general practitioner and surgeon, particularly in the

beginning of his career, during the period in which he formulates for himself the rules that are likely to direct him in his future work.

The viewpoint is based on clinical studies in the operating room and at the bedside of the patient. The book covers the practical points in the preparation of the patient for an operation, the arrangement of the operating room, the important relations between the surgeon and his anesthetist, the assistant, the family physician, the nurse during the course of the operation, also the after care of the case.

Other chapters in the book cover such important considerations as sterile washes and wound dressings, sterilization of utensils and instruments for the operation. The surgeon's hands. Wound healing and scar formation, asepsis, suture material, anaesthesia, incision, the course of the operation, care of the patient after operation, the treatment of unclean wounds, in fact, within this book of 180 pages will be found those very necessary essentials that guide in the successful handling of operative work.

The mechanical features of the book are superb, presenting throughout marginal headings in contrasting ink, facilitating most ready reference.

NORRIS ON BLOOD-PRESSURE.

Blood Pressure: Its Clinical Applications. By George W. Norris, A.B., M.D., Assistant Professor of Medicine in the University of Pennsylvania; Visiting Physician to the Pennsylvania Hospital; Assistant Visiting Physician to the University Hospital; Fellow of the College of Physicians of Philadelphia. Octavo, 372 pages, with 98 engravings and 1 colored plate. Philadelphia and New York: Lea & Febiger, publishers. Cloth, \$3.00 net.

The importance of blood-pressure in diagnosis, prognosis and treatment is becoming more widely recognized every day, and with this recognition has come the creation of a literature devoted to this special field. The latest contribution to this literature is that of Dr. Norris. He has presented his subject in condensed and practical form, and as definitely as the present state of our knowledge permits. Both the experimental and clinical data which have been available have been included, for it is the combination of these two that the physician must rely upon when handling his cases. The author's method of discussing each part of the subject is such that his book is a well-balanced presentation of the latest scientific information regarding blood-pressure and its clinical applications. It is probably the most complete and authoritative work in English on this new and extremely important topic. The illustrations are well chosen and help to an easy understanding of the text.

As one examines the pages of this book it becomes more and more apparent that the author has had an extensive clinical experience and has made good use of it. He draws extensively from the field of actual observation. The result is that he has given to the reader a very valuable contribution on blood-pressure. As this is one of the newer claimants for attention it would be well to study such a book as this.

BALLENGER ON THE NOSE, THROAT AND EAR.

A Treatise on Diseases of the Nose, Throat and Ear. By William Lincoln Ballenger, M.D., Professor of Laryngology, Rhinology and Otolaryngology in the College of Physicians and Surgeons, Chicago. New (4th) edition, thoroughly revised. Octavo, 1080 pages, with 536 engravings, most original (and 33 plates. Philadelphia and New York: Lea & Febiger, 1914. Cloth, \$5.50 net.

Four large editions in six years is a record of very unusual achievement. An examination of the contents of this work will disclose the reasons for its enviable popularity among students, practising physicians and specialists. Every line of the text and every one of the five hundred and thirty-six illustrations bear evidence to the enormous amount of work, care, and expenditure bestowed upon this book by both author and publishers. In this respect it is almost unique in medical literature. In this new edition the important feature will be found in its chapters on the labyrinth, the new matter on which amounts to over one hundred pages. Great labor has been bestowed in marshalling the facts and formulating them for teaching purposes. Thirteen original colored plates now illustrate the physiological and pathological manifestations of nystagmus. A careful study of these alone will suffice to convey a clear idea of the subject. Twelve drawings illustrate the Newmann and the Hinsberg labyrinth operations. Among other new matters may be mentioned the full description of Mosher's fronto-ethmoid operation, with five drawings, showing each step. Mosher's technique is a distinct advance in the surgery of the sinuses. Autogenous vaccines in the treatment of hay fever are given place, though this remedy has not yet fully proved its value. The section on Functional Tests of Hearing has been rewritten. Otosclerosis has been extensively revised and brought fully to date. Haynes' operation on the cisterna magna is fully described, and five drawings illustrate the technique. Vaccine therapy has been revised, and the His Leukocyte-extract therapy is given in detail. It forms a distinct advance in the treatment of certain forms of infectious diseases, especially of the nasal sinuses and meninges. Meningitis has been largely rewritten, with much new material. The section on Abscess of the Brain has been revised by Dr. Howard Charles Ballenger. The use of salvarsan in the treatment of syphilis of the

brain and auditory nerve is described with great fulness. It forms an important addition to this edition. Dr. George McBeam's theory of the causation of paracismus Willisii is given in full. In a word, every line of the book has been revised, all obsolete matter has been eliminated, and much new text has been incorporated, with many new illustrations and plates, all of which were drawn by the author. The volume is one hundred pages larger than the previous edition and there are about thirty more illustrations in the text as well as eleven new plates.

This work needs no introduction now, as it has passed the stage calling for the ordinary form of review. Dr. Ballenger's work is regarded as an authoritative standard. It is no longer a claimant for attention, but has become a recognized guide.

HARRINGTON'S PRACTICAL HYGIENE.

A Manual of Practical Hygiene. For Students, Physicians and Health Officers. By Charles Harrington, M.D., late Professor of Hygiene in the Medical School of Harvard University. Fifth edition, revised and enlarged by Mark W. Richardson, M.D., Secretary to the State Board of Health of Massachusetts in collaboration with the following officials connected with the Massachusetts State Board of Health: W. H. Clark, Chief Chemist; X. H. Goodnough, Chief Engineer; William C. Hanson, M.D., Assistant to the Secretary; Hermann C. Lythgoe, Chief Analyst of Food and Drug Department, and George H. Martin, formerly Secretary to the Massachusetts State Board of Education. Octavo, 933 pages, with 125 engravings and 24 plates in colors and monochrome. Philadelphia and New York: Lea & Febiger, publishers. Cloth, \$5.00 net.

The ever increasing importance and the broadening scope of hygiene are going hand in hand with the great strides which are constantly being made in our knowledge of the subjects concerned with preventive medicine. It is no longer possible for one man to have first-hand knowledge of all the parts of this vast field. To the end therefore that Harrington's Hygiene, in its new edition, might offer the latest information of high authority on every phase of its department, the editor has secured the collaboration of the experts associated with him in the work of the Massachusetts State Board of Health. This latest edition, therefore, is thoroughly representative, and to the smallest details, of this board which has long been noted for the high character of its laboratory investigations and its public health administration. Many of the chapters have been practically rewritten and in each case this has been done by a gentleman who has made a specialty of the topic under discussion. The revision has been extremely thorough throughout, and the new edition contains one hundred pages more than the previous one, as well as twelve additional plates.

The subject of hygiene has taken a prominent place in medical science. This volume covers the ground of preventive medicine in a

very thorough manner, and should find many readers. It has gone through five editions now, and has been made as perfect as it is possible to make a book. It may be accepted as a safe exponent of the best teachings on hygiene.

COAKLEY'S LARYNGOLOGY.

A Manual of Diseases of the Nose and Throat. By Cornelius G. Coakley, M.D., Clinical Professor of Laryngology in the College of Physicians and Surgeons, Columbia University, New York. New (5th) edition, 12mo, 615 pages, with 139 engravings and 7 colored plates. Philadelphia and New York: Lea & Febiger, publishers, 1914. Cloth, \$2.75 net.

This work has long been recognized as one of the most practical and useful manuals of laryngology in the English language. It touches upon the pathology, simplifies and abbreviates the diagnosis, and emphasizes those methods of treatment which are most practical. Its statements are brief and clear, and its illustrations convey valuable supplementary information. This book gives quickly and easily the practical working points indispensable in the everyday routine of the busy physician. Its teaching quality, as well as its simplicity, are among its attractions, for it is a favorite text for undergraduate students. With the publication of this new edition, the fifth, Coakley's Laryngology is again before the profession in revised form. It is pre-eminently suited for the general practitioner, as he can here find all he requires and in compact form. The directions for treatment are explicit, and the methods of operation satisfactorily stated. This work by Dr. Coakley is a well-tested one and has come through many years of trial and five editions, with steadily increasing favor. It can be recommended with confidence.

BRAUN'S LOCAL ANESTHESIA.

Local Anesthesia: Its Scientific Basis and Practical Use. By Professor Dr. Heinrich Braun, Obermedizinalrat and Director of the Kgl. Hospital at Zwickau, Germany. Translated and edited by Percy Shields, M.D., A.C.S., Cincinnati, Ohio, from the third revised German edition. Octavo, 399 pages, with 215 illustrations in black and colors. Philadelphia and New York: Lea & Febiger, publishers, 1914. Cloth, \$4.25 net.

Braun is, without question, the world's greatest authority on local anesthetics, and it is his work, especially in the perfection of technique, which has made possible the successful use of local anesthetics in general surgery and the surgical specialties. In this book the vague, erratic and unsatisfactory efforts which have been made in this field for many years are systematized, and a logical procedure, based upon scientific facts and having an exact and undeviating technique, is of-

ferred. The development of the various local anesthetic methods is demonstrated objectively, so that the reader will be able to make practical use of local anesthetics. This has been accomplished by descriptions of many operations performed under local anesthesia, with the aid of numerous illustrations, many of which are photographs taken during these operations. There is no doubt that brilliant results are being obtained almost daily with infiltration and conduction anesthesia, and the use of general anesthetics is being correspondingly reduced. Leaving the many other advantages of local anesthesia out of consideration, the total absence of mortality and injury to the tissues should give it a permanent and important place in surgery. Up to the present time the various surgical text-books have given but little attention to local anesthesia, and the monographs have concerned themselves with special and individual methods. This work, therefore, may be regarded as the first and only one of high authority which covers the whole subject completely and places the entire present knowledge thereof at the disposal of the profession. In the portion of the book dealing with the specialties the author has been aided by specialists in their respective fields. The illustrations are numerous, many are in colors, and many have been drawn by Professor Braun himself.

It is well within the memory of the present generation of medical men when cocaine came into use; indeed, it is only about 25 years ago. In addition to cocaine, the author goes fully into the action of tropococaine, eucaine, holocaine, aneson, akoin, stovain, alypin, novocaine, the orthoform group, and a number of others. The work is of a highly scientific order of merit.

KNOWLES ON DISEASES OF THE SKIN.

Diseases of the Skin, Including the Acute Eruptive Fevers. By Frank Crozer Knowles, M.D., Instructor in Dermatology in the University of Pennsylvania; Clinical Professor of Dermatology, Women's Medical College of Pennsylvania; Fellow of the College of Physicians of Philadelphia, etc. Octavo, 546 pages, with 199 engravings and 14 plates. Philadelphia and New York: Lea & Febiger, publishers, 1914. Cloth, \$4.00 net.

Probably the most striking feature of this new work is its splendid series of large and clear illustrations, nearly all of which are original, and most of which are photographs of the author's own cases. For its illustrations alone, the book should have a place in the library of every doctor who treats dermal affections. The work is unusually complete in that it covers every eruption of the skin and contiguous mucous membranes, and includes not only the exanthemata but also the acute eruptive fevers that are constantly or occasionally accompanied by a cutaneous outbreak. Every practical point in treatment is emphasized, and

nothing is left to guesswork or is written in mere outline, as is too often the case in dermatological books. The treatment is given as if the author were giving full instructions to a patient in the office, which kind of presentation is most helpful to the student or practitioner. The sections on diagnosis are just as carefully constructed, and in addition valuable aid for purposes of differentiation will be found in the illustrations. It is difficult to see how the careful reader of this work could fail to obtain uniformly good results in the practice of cutaneous medicine.

A new book on diseases of the skin calls for some attention, as there are many excellent works already on this subject. The present one bids fair to take a place with the best of these, and become a very popular one. For the practitioner who wishes help on the problems of dermatology there are many advantages to be found in this book. It is thorough and not too bulky.

DISEASES OF THE EYE.

A Manual of the Diseases of the Eye for Students and General Practitioners. By Charles H. May, M.D., Chief of Clinic and Instructor in Ophthalmology, College of Physicians and Surgeons, Medical Department, Columbia University, New York; Attending Ophthalmic Surgeon, Mount Sinai Hospital, New York; Consulting Ophthalmologist to Bellevue Hospital, etc., etc. Eighth edition, revised, with 377 original illustrations, including 22 plates, with 71 colored figures. New York: William Wood and Company, 1914. Price, \$2.00.

This is a well-trying work. Edition after edition has been called for, and still it becomes more appreciated as time goes on. That the author has written a good book is borne out by the universal favor with which it has been received. Generation after generation of students have been taught from this text-book, and have gone forth to join the ranks of the profession, feeling confidence in themselves so far as diseases of the eye are concerned, because they had learned what Dr. May had to say on these diseases. There can be no doubt about the fact that this is a very superior book of medium size. It gives what the student and general practitioner ought to know, and gives it in the very best form. The first edition appeared fourteen years ago, and now we have the eighth. Nothing more need be said.

NEW JERSEY BOARD OF HEALTH.

Thirty-seventh Annual Report of the State of New Jersey, 1913, and Report of the Bureau of Vital Statistics, Patterson, N.J. News Printing Co., State Printers, 1914.

The present issue is up to the high standard of former years, and gives a great deal of valuable information on health topics. It will be read with interest by all who are engaged in sanitary science, hygiene and preventive medicine.

MISCELLANEOUS

ACTION OF THE TORONTO ACADEMY OF MEDICINE.

At a special meeting of the Council of the Toronto Academy of Medicine it was moved by Dr. W. H. B. Aikins, seconded by Dr. W. A. Young:

(1) That the Council of the Toronto Academy of Medicine, speaking for the whole membership, respectfully recommends as a patriotic duty that the Fellows of the Academy undertake without charge the professional care of the needy dependents of any men serving with the allied armies during the war now going on.

(2) That this service be understood as supplementing the ordinary agencies for the medical care of the sick poor.

(3) That the Council ventures to express the hope that some similar action may be taken by the profession as a whole throughout the country, thus following the example set by the profession throughout the Mother Country.

(4) That Dr. J. T. Fotheringham act as chairman of a special committee ad hoc and represent the Council of the Academy with power to select a committee.

ELECTION FOR MEDICAL COUNCIL, COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO.

An election will be held to elect representatives in the Medical Council of the College of Physicians and Surgeons of Ontario on the first day of December, 1914. Nominations will be received up to November 13th, 1914, addressed to the returning officer for the division in which the voter resides.

ONTARIO MEDICAL ASSOCIATION.

The next meeting of the Ontario Medical Association will be held in Peterboro in May, 1915. Arrangements are now being made to have this annual meeting in conjunction with the Medical Health Officers' Association, so that the attendance will be large and members will be sure of reduced fares on the railroads. The following is a list of the committees:

President—D. J. Gibb Wishart, Toronto.

COMMITTEES.

Arrangements—T. W. H. Young, chairman; N. H. Sutton, secre-

tary; J. H. Eastwood, D. C. King, B. E. Kelly, all of Peterboro; R. H. Bonnycastle, Campbellford; H. A. Turner, Millbrook; W. A. Ross, Barrie; J. Holdercroft, Havelock, and W. G. Collison, Lindsay.

Papers and Business—H. J. Hamilton, Toronto, chairman; G. S. Cameron, Peterboro, vice-chairman; Geo. B. Strathy, Toronto, secretary; A. W. McPherson, Peterboro, local secretary; T. N. Greer, J. A. Morgan, J. V. Callivan, J. M. McCulloch, D. N. Carmichael, all of Peterboro, and the crairmen and secretaries of the Sections, as follows:

Surgery—C. L. Starr, Toronto, chairman; F. P. McNulty, local chairman; A. Moorhead, Toronto, secretary; E. V. Frederick, Peterboro, local secretary.

Medicine—A. R. Gordon, Toronto, chairman; F. C. Neal, Peterboro, local chairman; Geo. S. Strathy, Toronto, secretary; L. S. Hammond, Peterboro, local secretary.

Obstetrics and Gynaecology—W. D. Scott, Peterboro, chairman; A. Moir, Peterboro, secretary.

Eye, Ear, Throat and Nose—N. D. Buchanan, Peterboro, chairman; W. W. McKinley, Port Hope, secretary.

Credentials—W. K. Colbeck, Welland, crairman; J. W. S. McCullough, Toronto; S. H. McCoy, Toronto; T. N. Greer, Peterboro; A. G. Hore, Markham; D. N. Carmichael, Peterboro.

Public Health—W. E. Olmstead, Niagara Falls, chairman; G. M. Davis, Welland; C. J. O. Hastings, Toronto; Lorne Drum, Ottawa; D. M. Anderson, Toronto; Geo. D. Porter, Toronto.

Publication—W. A. Young, Toronto, chairman; J. Ferguson, Toronto; J. T. Fotheringham, Toronto; R. W. Powell, Ottawa.

By-laws—J. H. McGarry, Niagara Falls, chairman; J. Malloch, Toronto; W. T. Connell, Kingston; C. P. Lusk, Toronto; A. R. Gordon, Toronto; B. C. Bell, Brantford.

Ethics—J. L. Bradley, Creemore, chairman; J. D. Ivey, Cobourg; E. T. Kellam, Niagara Falls; S. Johnston, Toronto; C. H. Bird, Gananoque; W. T. Parke, Woodstock; R. S. Hoig, Oshawa.

Executive—The President, Secretary, and Treasurer, ex officio; G. S. Cameron, Peterboro; R. R. Wallace, Hamilton.

Neurology—J. H. Elliott, Toronto, chairman; W. H. Cameron, Conniston; Lorne Robertson, Stratford.

Audit—J. A. Amyot, Toronto, chairman; G. Boyd, Toronto; J. M. Rogers, Ingersoll; E. E. Harvey, Norwich; A. McKinnon, Guelph; C. Meyers, Toronto; F. N. G. Starr, Toronto; R. J. Wilson, Toronto; D. E. Mundell, Kingston; F. Williams, Bracebridge.

General Secretary—F. Arnold Clarkson, Toronto.

Local Secretary—J. B. Mann, Peterboro.

McGILL GRADUATES AND THE WAR SITUATION.

The following letter has been sent to every McGill graduate:

At a time like the present, when the destiny of the Empire is at

stake, McGill University and its graduates should come forward and do everything in their power to help the common cause. The individual graduate probably does not fully realize the influence the graduates as a whole have in Canadian affairs. Over 5,000 educated men, holding important positions all over the Dominion and elsewhere, are a tremendous power and influence, particularly if their efforts are concentrated on certain fixed objects.

It was felt by the executive of the Graduates' Society and by the committee in charge of the reunion, which it had been proposed to hold in the fall of 1915, that in the present crisis in the Empire, something should be done; and it was decided to write a letter to every graduate asking him to use all his influence towards patriotic ends.

In order to make our influence felt in a definite way, it was thought that a fund should be started to which every graduate of the University would contribute. The contribution of each individual would be for the nominal amount of one dollar, which would represent his patriotic vote and the signification of his intention to do everything possible to assist Canada in the responsibility and duty created by the war.

The vote of the McGill graduates will be deposited in cash form to the credit of the Canadian National Patriotic Fund.

You are therefore invited to fill in and return the accompanying cheque form, which will be cashed at par, or to enclose one dollar in some other form.

An immediate response is necessary if this action is to have all the effect that is hoped for from it.

It may be that some letters have not reached their destination. Remittances should be addressed to Mr. Geo. C. McDonald, 179 St. James Street, Montreal.

For the Executive,
 JOHN L. TODD,
 President
 WILLIAM STEWART,
 Secretary.

ALIENISTS AND NEUROLOGISTS OF UNITED STATES.

At the third annual meeting of the alienists and neurologists of the United States, held under the auspices of the Chicago Medical Society, for the purpose of discussing mental diseases in their various phases, July 13th to 17th, 1914.

The Committee on the Prevention of Insanity reported the following resolutions, which were unanimously adopted:

Whereas, it is well recognized by alienists and neurologists the world over that certain major factors are the chief causes of physical conditions accompanied by mental derangement and deficiency, and

Whereas, these major causes are largely, if not wholly, controllable and eradicable, and

Whereas, these major causes are alcoholism, habit-producing drugs, venereal diseases, work in unsanitary and unhygienic surroundings, and hereditary influence, including the immigration of the physical and mentally unfit;

Therefore, be it resolved:

First: That we recommend to the proper state authorities, the absolute control of the sale of alcohol until such time as actual prohibition be enacted.

Second: That the sale of all habit-inducing drugs be strictly regulated in all States of the Union.

Third: That municipal or state control of venereal diseases be established, with proper treatment for indigent patients, to the end that the spread of syphilis and gonorrhoea be prevented.

Fourth: That proper special hospitals for the care and treatment of alcoholism and drug addictions be established.

Fifth: That municipal, state and national inspection of labor conditions be regularly maintained and child labor abolished.

Sixth: That no known defective dangerous to himself and to others, should be permitted to have unrestricted liberty.

Seventh: That adequate teaching of the principles of hereditary and sex life be initiated and fostered in the home, with the view to its introduction into the curricula of schools—above the grammar grades, this instruction to be given to the sexes separately.

Eighth: That the various States pass reasonable and universal marriage laws, that will be reciprocal, in preventing the marriage of the physical and mental unfit.

Ninth: That a psychopathic laboratory be connected with the criminal courts, common schools, railroads, transportation companies and public service utilities, responsible for the actual safety of the general public, should have their employees regularly examined as to their physical and mental fitness.

Tenth: That, inasmuch as state, country and city public health institutions should have as their superintendents men of highest qualifications, who may devote their best efforts to their tasks, we recommend that all such positions be subject to civil service examinations.

Eleventh: That in addition to the above, we recommend a nationwide campaign of education conducted through the public press, university and medical schools, boards of health, state, county and city boards of education, women's clubs and all other proper educational mediums, upon the true significance of the development—physical, mental and moral—of the individuals and the race, and finally, we recommend that a committee be appointed to promote the enactment of the above resolutions.

The Committee on Alcoholism as a Causative Factor of Insanity reported the following resolutions, which were unanimously adopted:

Whereas, in the opinion of the meeting of alienists and neurologists of the United States in convention assembled, it has been definitely established that alcohol, when taken into the system, acts as a definite poison to the brain and other tissues; and

Whereas, the effects of this poison are directly or indirectly responsible for a large proportion of the insane, epileptics, feeble-minded, and other forms of mental, moral and physical degeneracy; and

Whereas, many hospitals for the insane and other public institutions are now compelled to admit and care for a multitude of inebriates; and

Whereas, many States have already established separate colonies for the treatment and re-education of such inebriates, with great benefit to the individuals and to the commonwealths;

Therefore, be it resolved that we, unqualifiedly, condemn the use of alcoholic beverages and recommend that the various State Legislatures take steps to eliminate such use; and be it further

Resolved, that we recommend the general establishment by all States and Territories of special colonies or hospitals for the care of inebriates; and

Resolved, that organized medicine should initiate and carry on a systematic persistent propaganda for the education of the public regarding the deleterious effects of alcohol; and

Be it further resolved, that the medical profession should take the lead in securing adequate legislation to the ends herein specified.

The Committee on Syphilis as a Causative Factor of Insanity reported the following resolutions, which were unanimously adopted:

Whereas, syphilis is responsible for a large percentage of all insanity and mental deficiency,

Be it resolved that:

First: Health Departments (municipal and state) should be equipped to make laboratory examinations for venereal diseases.

Second: All hospitals for the insane should be equipped to make laboratory examinations for venereal diseases.

Third: Hospitals and dispensaries for the treatment of venereal diseases should be provided.

Fourth: Physicians should be compelled by law to report cases of venereal diseases, as is now done in other contagious diseases.

Fifth: Applications for marriage should be required to furnish health certificates.

Sixth: Lectures and bulletins should be offered freely to the public regarding venereal diseases.

Seventh: Newspapers should be requested to use their best influence to educate the people concerning venereal diseases.

Eighth: Sex hygiene should be taught in the public schools, above grammar grades, to the sexes separately.

THE QUEEN'S CANADIAN HOSPITAL.

Sir William Osler is named as physician-in-chief of the Queen's Canadian Military Hospital, which is to be established in London by the Canadian War Contingent Association.

The services of these doctors who have been doing post graduate work in London have been accepted: Drs. Alan Currie, of Halifax; Norman Wallace, of Guelph; W. A. Kennedy, of Kingston, and Howard Harrison, of Toronto.

Among the nurses engaged are: Misses L. B. Bryce, Flora Pyke and F. B. Mitchell, of the Toronto General Hospital; Muriel Galt and G. L. Baynes, of Montreal General Hospital; Flora Wylie and Gertrude Squire, Royal Victoria Hospital, Montreal. The latter attended the Duchess of Connaught in her recent illness. Several other nurses are expected shortly from Montreal, they being sent by the Women's Association.

Sir Arthur Markham has placed a furnished house near Folkstone at the association's disposal as a convalescent home, having also installed an X-ray apparatus and loaned an ambulance and two cars. Dr. William Fox, of Grosvenor Street, has lent the association another motor ambulance.

Dr. Donald Armour, son of the late Chief Justice Armour, of Ontario, will be at the head of the surgical service.

A well-equipped private hospital has been purchased. Towards this Canada Lodge of Freemasons has donated £1,000, and it is hoped that Freemasons in Canada will contribute liberally. Dr. Pelletier is asking the Quebec Government to make a grant.

There was some difficulty in arranging with the nurses formerly in charge of the private hospital, as they are not willing to make way for the Canadian nurses. The result was that the whole work will have to be carried on at Folkestone, and the hospital in London given up.

MEDICAL PREPARATIONS

A MOUTH WASH IN FEVER CASES.

In all fever cases where the tongue is coated, the lips dry and cracked, and the teeth covered with sordes, the use of some cooling and soothing mouth wash would seem to be indicated.

Glyco-Thymoline in a 20 per cent. solution with cold water fills this want perfectly. Its frequent use is grateful to the patient and at the same time a great factor in relieving the condition.