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Original Articles

SOME RESULTS OF CORRESPONDENCE WITH MEDICAL EXAMINERS.*

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A few weeks ago I received a letter from our worthy chairman, requesting me to read a paper at this session and send him the name of same. I replied that I would endeavor to prepare a short one and gave him the title of the paper. He sent me a note thanking me for my promise, with the remark: "You have chosen a large subject."

I fully realize that the subject is a large one, but I propose only touching on certain points which have in my experience struck me very forcibly. I have no doubt all of you have had the same experience, more especially those who have been Medical Examiner-in-Chief for some years. My excuse, however, for taking up your time is to place on record some of the practical results which we all have obtained by corresponding with our local examiners.

I am sure all of you have from time to time received very caustic answers from certain local examiners in reply to letters asking for further information about applicants. Some of these cutting communications are evidently intended to make one conclude that the society has made a mistake in placing you in the important position you hold and that the writer would undoubtedly have been the proper man.

* Read before Medical Section National Fraternal Congress, 27th August, 1900, Boston, Mass.

Other communications imply that you are questioning the local examiner's honesty or their capability of properly examining an applicant, and indignantly repudiate the same, stating that their honesty was never before questioned and that they have been examiners for years for insurance companies and societies (enumerating a list of the same) and this is the first time they have ever received such an insulting communication.

Then, again, there is another class of physicians who are much grieved at you asking for a further examination, as they consider they did all that was necessary in the first place. They are sure nothing further can be elicited on the lines you suggest.

Another class send a reply to the effect that they absolutely refuse to make a further investigation, as the fee is too ridiculously small.

I might give further instances where the local examiners consider the Examiner-in-Chief is giving them extra trouble without sufficient cause, but the above will suffice.

In reference to the first class, it is most unfortunate that the respective societies have not recognized their ability and given them positions of higher trust.

In reference to the second class, it must unfortunately be admitted that we have dishonest or unsafe examiners, and also examiners who are incapable of making a proper examination, notwithstanding the fact that they are examiners for many insurance companies and societies.

I would strongly recommend the third class to carefully analyze the cases I am about to report in this paper. These ought to convince the ordinary mind that further investigation has been the means of excluding many unsafe risks which would otherwise have been accepted.

I agree with the fourth class that the fee allowed by the various societies is too small, but surely that is not the chief object in accepting the position of examiner. No matter if the fee is \$1.00 or \$10.00, the physician in accepting the position should be prepared to do his duty and do faithful work under the contract.

I have been Medical Examiner-in-Chief for the society which I represent for the past nineteen years, during which time I have reviewed nearly 300,000 medical examination papers, and have been in correspondence with several thousand local examiners and I am happy to state that I have received very few caustic or complaining letters. In fact the vast majority of the replies are cheerfully given, further examinations and investigations are readily made, and in very many instances I have been thanked by the local examiners in asking them to further investigate the case of the applicant on the lines I suggest. Surely the large experience one has had over so many years ought to have some practical results. Does it not make him a specialist on the subject? From

his large experience does he not arrive at conclusions which it is impossible for the local examiners to do? Are not these conclusions practical and valuable ones in determining what is a safe insurance risk? And if an Examiner-in-Chief has made a study of his specialty, he surely ought to be able to give valuable instructions to local examiners, and any communications from him should be received at least with respect.

I do not consider that I am an unreasonable individual, and I can assure the local examiners I do not write because I have nothing else to do, for after reviewing 100 to 200 papers in a day I am not keen to dictate letters in order to annoy the local examiners. The fact is that one, after the many years he has been engaged in reviewing examination papers, is educated to read between the lines and not to take everything set forth in the papers as the truth and nothing but the truth. Again, the busy practitioner may not have time to carefully weigh the answer to certain questions that they merit; or, again, he may not see the importance of them the same as a specialist in life insurance work will do. I know many of the letters I write and the answers thereto add nothing further to the knowledge of the risk, only removing doubt about answers to certain questions.

Without delaying you further I shall now enumerate a number of cases, showing the result of further investigation. In doing so I hope I will not tax your patience to weariness.

An applicant recommended as a *first-class risk*, aged thirty-four, but his mother died of consumption, and he himself had pneumonia three years previously, lasting five weeks. I wrote for further particulars, and the doctor replied: "I recommend him as a *first-class risk* from the fact that he successfully recovered from his attack of pneumonia three years previous, and that since then he has had no tendency to further lung trouble," and he further adds: "I questioned again the applicant about this attack and about his mother's death." He states that none of his mother's relatives ever had tubercular disease, and "I still feel that if there was a predisposition to tubercular disease, the applicant would have succumbed at the time he had pneumonia, and I still consider the applicant a *safe risk*." However, he adds: "I consulted the physician who attended the applicant at the time he had pneumonia, and the physician stated that he (the applicant) expectorated, during the attack, considerable pus and that since that time the applicant, under the advice of his physician, has spent the winters in California."

An applicant recommended as a *first-class risk*, he had one brother who died of pneumonia, after an illness of four weeks, and another brother dead, cause of death, "Don't know." I wrote the Court Physician, asking if it were not possible to find out cause of death of brother marked "Don't know," and also if he were satisfied

the other brother died purely of pneumonia, and that there was no tubercular trouble. He replied: "On investigation I find that the first brother died of tubercular disease and that the one reported as dying of pneumonia possibly had tubercular disease also," and the doctor further added, "I cannot now recommend his acceptance."

An applicant was recommended as a first-class risk, but owing to his slight build, mother's death from pleurisy and death of four sisters, I wrote for further information about his family history, and also as to whether the slight build as a family characteristic. The examining physician replied: "From subsequent information and present condition of applicant, I wish to say that I do not now recommend him for insurance."

An applicant recommended as a first-class risk, but stated that his mother died at fifty-three years of age, cause of death "not known," and a sister from anemia. I wrote the examining physician to investigate further as to the cause of death of these two and he replied: "I am satisfied after investigation that they died of consumption, and I cannot recommend the risk."

An applicant recommended as a first-class risk, aged thirty-three, stated that his mother died in child-birth. I wrote the examining physician, asking if the father of the applicant could not answer more definitely as to the cause of death of mother, and also if the mother's brothers and sisters were living and in good health. He replied: "The mother and one of her brothers died of consumption," and the doctor added, "I cannot now recommend his acceptance."

An applicant, aged nineteen, recommended as a first-class risk, stated that one brother died of pneumonia, another of hemorrhage of the nose and a sister of inflammation of the brain. On inquiry I found that the brother died of pneumonia after an illness of five months. The brother who died of hemorrhage of the nose had bled from throat and nose for the previous six months and had not extra good health. The brothers and sisters living, all in good health, except the youngest sister, whose health was only fair. Family history on mother's side was good; on the father's side, however, one uncle was found to have died of chronic myelitis, another of cancer, two sisters and one brother of consumption. The doctor adds: "These extra questions bring out quite a different history; the applicant, however, had to hunt to find out all this and did not know it himself," and he added, "I cannot now recommend him."

An applicant recommended as a first-class risk stated that he had a brother who died of pneumonia, another of bilious fever and two sisters of inflammation of the brain. I wrote for particulars about these deaths and the examining physician replied: "I have made diligent inquiry of those who know the applicant's

people and they tell me that his brothers and sisters died of consumption. He misrepresented and lied to me straight. I questioned him closely in regard to consumption in his family."

An applicant recommended as a first-class risk, slight build and his father died at the age of forty-nine after an illness of seven months. I wrote for particulars and found that an uncle on father's side died of consumption and an aunt had epilepsy, also that two of his mother's sisters died of consumption. With this additional information the applicant, being only twenty-seven years of age, was rejected.

An applicant recommended as a first-class risk, stated to have had one brother who died of inflammation of the lungs and another of laryngitis. I wrote for further particulars about the deaths of these two brothers and the doctor replied that after investigation he found that they had both died of phthisis and advised the applicant's rejection.

An applicant was recommended as a first-class risk, uncle had died of consumption, he himself was of slight build and had a sore throat a short time previous, lasting a month. I was suspicious that the sore throat might mean more than some acute trouble and asked the doctor to give me a further opinion about the throat and also to take the applicant's temperature. He replied that the throat appeared perfectly healthy, but on two or three examinations with the thermometer he found the temperature 99, and wished to withdraw his recommendation.

An applicant recommended as a first-class risk states that he has an ordinary sore throat each winter. I wrote the doctor for further particulars. He replied one month after the date the applicant had been examined. "He is not now in good health, is suffering with a deep-seated cold. I am sure he will be a sickly man and an undesirable member for any Order."

An applicant was recommended as a first-class risk in February, 1897, he had pneumonia in February, 1897 and reported as being ill for two weeks. He was also under weight. In reply to a letter the doctor informed me that he found the pneumonia had lasted for several months and though at present apparently a sound man, he would give it as his opinion that the applicant was not a good risk.

An applicant recommended as a first-class risk, but stated that he had had asthma, but no symptoms of the trouble whatever for the past seven years. I asked the doctor to inquire more closely into the history of the asthma and also to examine heart and pulse after active exercise. He not only found that the applicant had had asthma within the last two or three years, but also that the heart was in an unsatisfactory condition, although no murmur, yet somewhat irregular.

An applicant recommended as a first-class risk, with no history

of consumption or insanity admitted in the examination paper. On further inquiry in reference to family history, I found that his mother had suffered from melancholia for three years, that an uncle on mother's side was insane, that his father, who was stated in the examination paper to have died from inflammation of the bowels, was scrofulous, that the glands and different parts of the body were often swollen and the doctor added that he must now withdraw his recommendation of the applicant.

An applicant recommended as a first-class risk, but the family history did not appear satisfactory and I wrote the doctor to obtain further particulars, to which he replied: "I took pains to find out from his friends what kind of a man he was and all about him and from my inquiries I find that I cannot recommend him as a safe risk. Of course when I first examined him I took him as I found him, as he was a total stranger to me, but I find it different and cannot now recommend him."

An applicant recommended as a first-class risk, whose father was reported to have died of pneumonia after an illness of two weeks and it was stated that his previous health was good. On further investigation the doctor informed me that the father's health had not been good for some time and that two of the father's sisters had died of consumption. In the examination paper he stated that none of his relatives ever had consumption.

An applicant was recommended as a first-class risk, but he stated that his brother died of pneumonia and I noticed the pulse was quick, running up to 95. I wrote for further particulars and the doctor informed me, on investigation, that he found that the brother had tuberculosis and that after active exercise the applicant suffered considerably from shortness of breath and that he now could only recommend him as a poor risk.

An applicant recommended as a first-class risk and who stated in his examination paper that there was never any tubercular history in the family. I wrote for further information because he stated that his father died from pleurisy. The doctor informed me that after careful inquiry he found that not only the father, but that two of the father's sisters also, died of consumption.

An applicant recommended as a first-class risk, who had been rejected by an insurance company on account of rapid heart. I wrote the examining physician to examine heart and pulse after active exercise and he replied: "His pulse after active exercise is very rapid and somewhat irregular, running from 96 to 140 per minute and I also find that he is subject to bad headaches, which he claims are due to overwork and I am also suspicious of some heart murmur."

An applicant recommended as a first-class risk, but pulse was quick, running up to 94, and he also was on the stout side. I wrote the examining physician to examine heart and pulse after active

exercise and let me know the results. He replied: "Will say that I gave him as good a paper as I possibly could make. I have not re-examined him for obvious reasons, namely, that I have since learned that he is a hard drinker, is intoxicated frequently, that he was not honest in his answers to me and I cannot now recommend him."

An applicant reported as a good risk, not first-class on account of three aunts and an uncle having died of consumption, but he was forty-five years of age and this history should not have had so very much weight, but his pulse was slow and I wrote the doctor to examine heart and pulse after active exercise. He replied: "I have had him run up a flight of stairs and find quite a pronounced bruit immediately following systole of heart, with vigorous impact of apex against chest wall. I therefore must now withdraw my recommendation."

An applicant recommended as a first-class risk, pulse rather quick, 91 per minute. I asked the doctor to examine heart and pulse after active exercise. The reply was: "After running up and down a flight of stairs, upon examining heart I detected a murmur with the second sound, loudest at base and distinctly heard at both sides of sternum."

An applicant recommended as a first-class risk, but with pulse rather quick, running up to 95. I wrote asking the doctor to examine heart and pulse after active exercise. The reply was: "After running up two flights of stairs the pulse did not seem much more frequent, but the action of the heart was labored. I could discover no murmur. I should suspect some dilatation of the heart."

An applicant recommended as a first-class risk, with a sound heart, had had sub-acute rheumatism for three months, two years previous to examination. I wrote the doctor, asking him to examine heart and pulse after active exercise and he replied: "I examined the applicant as requested; just after exercise found a murmur, extending towards the base of heart, quite distinctly, pulse rapid and somewhat irregular."

An applicant recommended as a first-class risk, but pulse rather quick, running up to 90 and the applicant had rheumatism in '92 for three weeks. I wrote the doctor to examine heart and pulse after active exercise and his reply was: "There are abnormal sounds of the heart, which no doubt account for the rapid rate of pulse; this seems to have escaped me at the first examination."

An applicant recommended as a first-class risk, had two attacks of inflammatory rheumatism six years previously. I asked the doctor to examine the heart after active exercise. He replied about three weeks after the first examination of the applicant, as follows: "A week after the examination was made this man was taken ill; I examined his heart as directed and found him in ill

health. I would not recommend him now, as his heart is in a very bad condition."

An applicant recommended as a first-class risk, but pulse was very quick, running up to 98. I wrote the examining physician, asking him to first count the pulse when the applicant was quiet and then examine the heart and pulse after active exercise. On examination after the exercise he found a distinct murmur at the base of the heart, produced by roughness of aortic valves. The doctor added: "This examination after exercise would seem to justify your suspicion. I am of the opinion that the aortic valves are not entirely sound. On my former examination I took the applicant's pulse at the close of the examination instead of, as usual, at the beginning, having discovered no abnormality in the heart sounds. I attributed this rapidity to the excitement due to the overhauling I had given him."

An applicant is reported to have been rejected when making application for the position of fireman on account of heart trouble. He was recommended to us by our local examiner as a first-class risk with no heart trouble whatever. I wrote the doctor to examine his heart after active exercise. He replied as follows: "I will recall the applicant and follow your instructions, but I firmly believe he should not have been rejected on the grounds of heart disease. It is true he was rejected once when applying for position as fireman for this cause, but on my examination I found no heart difficulty and so reported. Besides this, he has since that rejection been accepted by several companies, and is now making application to admittance to the firemen again. However, as you suggest, I will recall him and report results as soon as possible." Eight days later the doctor writes: "As per instructions I recalled the applicant and examined him carefully. I found after violent exercise a murmur with the first sound of the heart. I desire, therefore, to modify my first report by saying that I do not think him insurable and do not recommend him for membership in the I.O.F."

An applicant recommended as a first-class risk, excepting a very slight irregularity of pulse, which the doctor attributed to excitement caused by the examination. I asked him to examine heart and pulse after active exercise. He replied: "After the applicant ran up two flights of stairs the pulse was ninety per minute and intermitted twelve times in a minute. There were no abnormal sounds."

An applicant recommended as a first-class risk, with a sound heart, admits having palpitation of the heart occasionally. I wrote the doctor to examine heart after active exercise and he replied: "After the applicant ran up two flights of stairs, I found quite a turbulent action of the heart and on immediate examination found a rather indistinct pulmonary regurgitant murmur and a tricuspid regurgitant murmur."

An applicant recommended as a first-class risk, but pulse was intermittent and I wrote asking the doctor to examine heart and pulse after active exercise. He replied : " Applicant has a mitral regurgitant murmur."

An applicant recommended as a first-class risk by the doctor, had an attack of inflammatory rheumatism previously and was rejected by another society. I wrote the doctor asking him to make an examination of the heart after active exercise, and he replied that he found a distinct murmur and could no longer recommend him. In the original paper he found no heart trouble whatever.

An applicant recommended by the local examiner as a first-class risk and the only point reported against him was that there was a slight irregularity of the heart. I asked the doctor to examine the heart after active exercise. He replied that he found mitral regurgitation.

An applicant recommended as a good risk, not first-class, because he had had an attack of asthma lasting two months three years previously. He was also of slight build. I wrote for further particulars and the doctor replied : " I regret to be obliged to ask you to reject this applicant. I made close investigation and I have the proof that he is drinking hard at times, viz. : three times a month. Most probably the asthma he suffered from previously was caused by alcoholic abuse."

An applicant recommended as a first-class risk, complained of pain in the back and the specific gravity of urine was very low, 1010. In a reply from the doctor to a letter from himself he says : " In regard to the applicant will say that he has been very sick for the last month from pneumonia complicated with Bright's disease, so he might as well be considered N.G. He has been complaining for some time with kidney trouble and I do not think we can run any risk with him ; he is still sick." This letter was written about six weeks after the applicant was first examined.

An applicant represented as a good risk, but specific gravity of the urine only 1002 and no albumen. I wrote the doctor asking him to make another examination of the urine and he stated as follows : " I find the specific gravity 1005 and a decided presence of albumen." Possibly a proper examination was not made in the first place.

An applicant recommended as a first-class risk, he was overweight, height being 5 ft. 8 in., and weight 205 lbs. I wrote the doctor asking if the extra weight was due to muscular development or fat and if he could explain the cause of the excessive weight. He replied : " The extra weight is due to fat and that is due to the use of intoxicating liquors." The applicant himself stated that he was quite temperate and never was intoxicated.

An applicant recommended as a first-class risk, but he stated

in his personal history that he was subject to dizziness, due to "biliousness." I wrote for further particulars and the doctor replied that he had these bilious attacks quite frequently and on further inquiry stated: "I cannot recommend him, as I find his habits are not the best."

An applicant recommended as a first-class risk stated that he had convulsions when about six months old and that they troubled him until he was ten years of age. I wrote for further particulars and the local examiner informed me that he never saw the applicant before examination and believed his statements to be true, but had learned that the applicant had convulsions up to eighteen years of age and he did not consider him a safe risk.

An applicant recommended as a first-class risk, but he stated he had been rejected by the New York Life because at that time he was suffering from a tapeworm. He also stated that two years previously he had had an attack of inflammation of the bowels. On investigation the local examiner informed me that the applicant was still suffering from tapeworm and that the attack of inflammation of the bowels was appendicitis.

An applicant recommended as a first class risk, but stated in his personal history that he had varicose veins. I also noticed that he was very tall, 6 ft. 3 ins., and of light weight. I asked the local examiner if the veins amounted to much. He replied that he had not examined them, but was satisfied that they were very slight. Owing to these veins, and owing to his very slight build, I decided to reject him. Shortly afterwards the applicant called upon me; I asked him to let me see his legs and I found them in very bad condition, especially the right one. I do not think I ever saw a worse case of varicose veins and I also discovered that there had been ulcers on two or three different occasions. I found the pulse weak and he certainly had not a healthy appearance.

All the above applicants were rejected.

From the above cases we might conclude that the local examiners concerned were new at the work or careless, but I know in several instances the examiners were experienced men, who had examined for insurance companies and societies for years. My conclusion is, when there is a reasonable doubt, to write for further particulars or have, as it were, a consultation with the local examiner.

Reports of Societies

TORONTO CLINICAL SOCIETY.

The adjourned meeting of the Toronto Clinical Society was held in St. George's Hall on the evening of the 14th of November, the President, Dr. W. H. B. Aikens, in the chair.

A CASE OF POST-HEMIPLEGIC MOTOR APHASIA—WITH EXHIBITION OF PATIENT.

Dr. W. H. PEPLER—The condition occurred in a man aged forty-two years, who complained of intermittent attacks of aphasia following right hemiplegia. The family history was particularly free from nervous diseases. The patient has always enjoyed good health until 1891, when he was suddenly attacked with severe headache lasting for a couple of weeks, followed by weakness of right arm and leg and difficulty in speech. There was no paralysis of facial muscles and no loss of consciousness. In a couple of days he improved and in a week he was able to work and use his arm a little. Speech also gradually improved. He returned to work in a month's time, and remained well for two years, when he had another attack. At that time he remained in the hospital three weeks, perfectly insensible. At the end of that time he regained consciousness and left. There was no paralysis at that attack. Following that, about six months after, he had a series of attacks of temporary insanity, lasting from two days to two weeks at a time, and six months to eight months lapsing between attacks. For the last two years, these seizures have altered in character, being ushered in with fulness in the right frontal region. During these attacks he cannot speak voluntarily nor answer any questions. He cannot repeat words and cannot read aloud nor write; can see objects and people. In most of the attacks he uses "dead propositions," *i.e.*, oaths, and unintelligible gibberish. He has tried to continue his work during these attacks. These attacks are very frequent, varying from one to eight in twenty-four hours and lasting a minute or less. If attacked during the night they always waken him up. The patient is of good muscular development, although the general expression of face is somewhat dull. Hearing is acute and vision good. The patellar reflex is slightly exaggerated; pupils react well. There is no paralysis remaining now, but there is slight rigidity of right leg. Walking is defective. He cannot turn round quickly with ease. The urine is normal in quality and quantity. The patient has been taking iodide of potash and is now taking a drachm three times a day. No doubt the case was either originally a hemorrhage or a

thrombus into the first or second branches of the middle cerebral, with some injury to the posterior part of the third left frontal convolution.

DR. MEYERS, in discussing the case, thought he would be inclined to class it with pure motor aphasia, or it probably might be a form of petit mal.

Dr. G. S. RYERSON subsequently examined the patient and gives the following report: Homonymous hemianopia present and concentric contraction of both fields of vision. Ophthalmoscopic examination reveals partial atrophy of both optic nerves. Vision nearly normal in seeing portions of fields. Bery states the lesion in such cases is in the cortex of the occipital lobe, though it may also occur in the optic tract.

TRAUMATIC PARALYSIS OF THE RIGHT RECURRENT LARYNGEAL NERVE.

DR. H. E. TREMAYNE, Lambton Mills, who was present by invitation, read the report of this case and presented the patient, a boy aged fifteen years. The family history was unknown. The father was a laborer, and had suffered from rheumatism; the mother was healthy. One sister was a deaf mute. The patient was undernourished and emaciated, pupils dilated, thyreoid gland enlarged; somewhat short of breath. Had diphtheria eight years ago; tonsillitis, typhoid fever and rheumatism. Has always been troubled with cough in the winter time. About ten weeks ago, while going up a lift, his neck was jammed and following that his voice became very hoarse, with slight tenderness on the right of the right sternomastoid muscle. The skin was not broken anywhere. When first seen by Dr. Tremayne he was complaining of cough. On examination his heart appeared normal. Vocal resonance is increased on the right side. Examination of the throat showed that the right cord was immovable.

DR. RYERSON examined the patient and said that the whole of that side of the larynx was immovable and that there was complete paralysis, but the arytenoid on that side moves. He instanced a similar case in a South African soldier who was shot through the neck, in whom it was a matter of wonder how it had escaped the arteries.

DR. PETERS said that the presentation of this case recalled one he had seen with Dr. Thistle, a case of exophthalmic goitre with a large cyst situated on the right side and close to the nerve. The paralysis which followed after operation for removal of the cyst was probably the result of scar tissue pressing upon the nerve fibres, although it was not complete paralysis.

TUBERCULAR DISEASE OF THE TUBES WITH ACUTE PERITONEAL INFECTION.

DR. H. A. BRUCE—This process is usually primary in the tubes although in a few instances the tubes may be involved secondary

to the peritoneum. Dr. Bruce recited some of the anatomical and clinical features of the disease. The case reported by him occurred in a woman twenty-six years of age, who had always been healthy and doing heavy work at service, during which time she was suddenly taken with pain. At first the temperature was 102 and the pulse 110. The abdomen rapidly filled with fluid, which was greatly extended with well-marked ascites. Nothing could be felt through the abdominal wall on account of distension. There was no disease in the lungs or in other organs. The diagnosis was tubercular peritonitis or malignant disease. On opening the abdomen it was found filled with dark greenish fluid of which several quarts were removed. There were no small tubercles to be seen or felt. The peritoneal surface was red or soft and looked like granulation tissue. The tubes were removed and subsequently examined microscopically by Dr. Goldie and pronounced tuberculous. Speaking of the treatment of this disease, Dr. Bruce quoted Treves, who had reported three hundred cases treated by abdominal section, who is of the opinion that good prospects of cure can be promised in from 60 to 80 per cent. of cases operated on. He has secured the best results when the fluid has been simply extracted.

DR. PRIMROSE spoke about the permanency of cure. He had observed in his own experience that not infrequently symptoms recurred even after prolonged intervals. He thought that very frequently the cures were not permanent.

DR. W. B. THISTLE emphasized the necessity of giving larger doses of creosote in both surgical and medical cases of tuberculosis. He thought the surgeons particularly neglected this branch of the treatment. If larger doses, say from 30 to 40 minims three times a day were employed, he thought there would be more permanency to the cures. His method of administering these large doses was in capsule form with bismuth. In support of this he quotes from an article in the *British Medical Journal*, where drachm doses of creosote had been given three times a day, and also where several patients had taken 100 minims three times a day.

(1) ALOPECIA UNIVERSALIS. (2) ATAXIC PARAPLEGIA.

DR. GRAHAM CHAMBERS presented both patients and read notes of the respective cases. (1) Alopecia Universalis.—The patient was a female of twenty years of age. She said that her hair began to fall out in patches when she was five years of age. From this first attack she completely recovered. At the age of twelve she again began to become bald in patches, and since that date has never been free from the disease. The patient was admitted to St. Michael's Hospital in March, 1898. At that date the lesions had the appearance of those of the common form of alopecia areata. She was treated by local applications of chrysarobin, trikresol, carbolic acid, etc., and tonics internally. The condition of her

scalp improved for two or three months, but it then gradually grew worse. The hair fell out not only from the scalp but also from the eyelids, eyebrows and from all parts of the body surface and she is at the present time devoid of hair except two hairs on the anterior part of the scalp. While in the hospital in 1898, she was treated by Dr. Roseburgh for interstitial keratitis. (2) A case of Ataxic Paraplegia.—A young girl, aged seventeen years, was admitted to St. Michael's Hospital on June 1st, 1900. Family history negative except that her only sister, when fifteen years of age, had curvature of the spine, from which she completely recovered. Patient had measles when five years old. Menstruation commenced at the age of fourteen, but since has been very irregular. In March last, the cellar of the house where patient worked was flooded with water, and she not knowing that she was menstruating took off her shoes and stockings and waded through the water, which came up to her knees. Two days after she complained of feeling tired and that her left leg felt so heavy that she could scarcely lift it. About a month after the disease extended to the right leg, and it was about this date when the patient was first examined by Dr. Chambers. She then complained of numbness and heaviness in the legs, but suffered no pain in the legs or back. Patellar jerk is increased. Both ankle clonus and knee clonus present in the left leg; tibial reflex present. Romberg's sign is present; and patient complained that she had to support herself against the wall while washing her face. Since that date the patient has become gradually worse and sensory symptoms have developed. Patient cannot distinguish hot from cold on the plantar surfaces of the feet and on the sides of the ankle joints. Several patches of the skin between the ankles and the knees are anesthetic. Sense of locality is disturbed; field of vision normal in both eyes; pupils react to light; retina and optic nerves healthy. The sphincters of the bladder and rectum normal. Patient is now unable to walk without aid.

DR. THISTLE discussed the latter case and concurred in the diagnosis of Dr. Chambers. In the case of alopecia, he thought that the loss of the eyebrows meant syphilis.

DR. MEYERS also discussed the latter case.

DR. LESLIE spoke of a similar case of alopecia, where a girl was quite bald for a year and a half. Her hair has come back better than before.

HYDATID CYST OF THE PANCREAS.

DR. GEORGE A. PETERS reported this case, which occurred in the practice of Dr. McKinnon, of Guelph, and upon which Dr. Peters was asked to operate. It occurred in a young man, Spanish by birth, a resident of the Argentine Republic, who in May of 1900 came under the care of Dr. McKinnon. For two or three years the patient had suffered from attacks of pain obscurely located in

the stomach and bowels, and latterly had his appendix removed, at which time a tumor could be felt in the left hypochondriac region, which at times was the seat of great pain. The cyst was aspirated and twenty ounces of limpid fluid of specific gravity 1.013 withdrawn. Much relief was experienced but the cyst slowly filled, and the temperature and pulse showing that a septic process was proceeding it was decided to operate. On examination a rounded tumor could be felt below the ribs on the left side, about midway between the nipple and sternal lines. Its relation to the pancreas were determined by stomach resonance above the tumor and between it and liver as well. Between the spleen, kidney and tumor resonance was also present. The operation was done from behind, the incision being made along the margin of the erector spinæ, three inches long. Considerable difficulty was experienced in its removal, owing to the toughness of the walls. An examination of the fluid shows numerous daughter cysts with their attached embryos, as well as many separate hooklets. The specimens were exhibited by Dr. Peters and the hooklets were well seen under the microscope. A search of the literature so far by Dr. Peters, reveals no other reported case of hydatid cyst of the pancreas.

In discussing the case, Dr. Bruce thought that it might possibly have been connected with the liver, as these are extremely common.

Replying to this, Dr. Peters stated that stomach resonance was distinctly to be made out all along the line between the liver and this tumor, and such being the case, he could not see how any one could make it out to be a tumor of the left lobe of the liver.

Special Selections

CEREBRAL HEMORRHAGE.—A CLINICAL LECTURE.*

BY D. R. BROWER, M.D., CHICAGO,

Professor of Diseases of the Nervous System in the Woman's Medical College; Professor of Mental Diseases in Rush Medical College, etc.

I found in the office of the hospital this very interesting patient, and the boy's father has kindly consented to his being shown to you. He is seven years of age, is very bright, and has a marvellous memory. When eleven months old, while sitting in an ordinary high chair, such as is used by children, he threw himself backward out of the chair, and struck the floor with great violence. He cried considerably after the accident. The nurse picked him up, took him out in his carriage, and after he had been out of doors a short time he had a convulsion. The convulsions followed one another in rapid succession, and he had a large number of them. The convulsions continued for two or three days. With the disappearance of the convulsions, consciousness returned. He was found to be paralyzed on the right side. You observe he does not raise the toes of the right foot, and there is some remaining paralysis of the right leg. The legs are about the same size; there is no wasting of the muscles. The arms are apparently of the same size. There is a pronounced dragging of the toes of the right foot as he walks, which is not so with those of the left. With the dynamometer in the left hand he throws it with the greatest ease around to 40, of the outer circle, while with the right he has difficulty in throwing it to 30, of the outer circle. In the second attempt he throws it to 50, in the outer circle, with the left hand, while with the right it is the same as in the first attempt. We can put it down that the relation of the two hands is as 30 to 50, or as 3 to 5. Something occurred at the time of the fall to produce the convulsion, and it has been followed by paralysis. As I have previously said, there is no wasting of the muscles, and the convulsions must have been cerebral. I have no doubt that the case is one of cerebral hemorrhage. Where was the hemorrhage? That is an interesting point to determine. He continued for four or five years to have convulsions, losing consciousness, but the convulsions were limited to the right side. The left side is not paralyzed. The convulsions he had immediately after the fall were also one-sided,

* Delivered at the Cook County Hospital.

so that it would seem reasonable to locate the hemorrhagic focus in the motor territory in the opposite side, or to regard the hemorrhage as meningeal, and not as having occurred where cerebral hemorrhage more frequently is found—in the neighborhood of the corporis striata ophthalmicus of the basal ganglia. The probability is, owing to the fact that there was a source of irritation on the opposite side of the brain sufficient to produce convulsive movements on the paralyzed side, that there was a cortical hemorrhage either of the vessels of the dura mater or of the vessels of the pia mater. I think we are not unreasonable in saying that the hemorrhage that produced the paralysis was a cortical one. I do not say it is the vessels of the dura mater or pia mater. It may have been one or the other.

There is another interesting feature about the child's case, and that is two years ago the convulsive seizures disappeared. You know that epileptiform attacks are of two kinds, the *grand mal* and *petit mal*. For some reason or other, two years ago the grand mal seizures stopped. At present, once a week, sometimes more frequently, he has the petit mal form of the disease. It is very unusual for the grand mal attacks to stop and the petit mal attacks to begin. The reverse is common. A child will have petit mal attacks for a long time, and after a while will have grand mal attacks.

The attacks are momentary, during which he grinds his teeth for a second or two, and the loss of consciousness is not sufficiently prolonged to allow him to fall. There is a little twitching of the facial muscles, but the setting of the teeth and the movement of the muscles of the lips are transitory, rapidly disappearing. It may be possible that the hemorrhage took place in the cortical territory when he was a little child eleven months old. At one time there must have been a great deal of irritation there, when he had the grand mal attacks. Now there is less irritation, and he simply has the petit mal seizures.

His father wants to know what is the best thing to do for him. If my theory of the boy's case is correct—and I think there is a great deal to be said in favor of it—the thing to do is to stimulate absorption so as to remove what remains of the hemorrhagic focus, and for that purpose I would give him iodide of potassium, and in order to control the explosive effort on part of the cells of the brain that produce the petit mal attacks, I would give him the bromides. A combination of the iodides and bromides would be the treatment indicated in his case.

Another thing: I am one of those who believe that we can send a galvanic current through the brain. It is disputed by

some, but my personal observations lead me to believe we can do it, and we can bring about changes in the nutrition of the brain by passing a galvanic current through the head. I would apply one large electrode over the motor territory, and the other large one on the other side, passing the current transversely through the brain, and to stimulate the vaso-motor apparatus of the brain send a current also from the forehead to the nape of the neck, the negative pole placed over the supposed seat of the lesion, and the positive on the opposite side (two large electrodes). If the combined treatment did not stop the petit mal seizures, I should have a surgeon trephine a portion of the skull over the motor territories, at least for exploratory purposes, which can be done without any particular injury to the boy. Under the antiseptic surgery of to-day there is not as much danger in opening the skull as there was when I began to practice medicine in cutting off the first joint of the finger. This child's head could be explored and it might result in some permanent good. There is in his case something which I regard as encouraging, from the fact that the grand mal seizures have disappeared and the petit mal seizures have taken their place. As the child grows older the pathological process deepens, and the petit mal becomes grand mal. To find the reverse of the case is extremely unusual. We will put him upon the treatment I have outlined and see what the outcome is. If it does not relieve him, his father should by all means have his skull trephined.

The next patient we present to you is sixty-five years of age. His father died of bronchitis. He was born in England. He uses alcohol and tobacco. He says he has had several attacks of bronchitis. While walking upstairs yesterday morning he noticed weakness in his legs, which grew worse until he had absolutely no use of his left leg and only partial use of his left arm. The patient's general nutrition is fairly good. At the present time he is unable to move the left leg, but the left arm he moves just a little. The tongue is protruded in the median line; pupils are equal, and equally respond to light. The patellar-tendon reflex is exaggerated on the left side. There are many coarse rales over the entire chest; heart feeble; no murmurs demonstrable.

This man has hemiplegia just as the boy has, but here it occurs in one sixty-five years of age with no history of an accident. The man was addicted to alcohol. What produced the paralysis in this case? Those of you who did not fully make out the degeneration of blood vessels in the three cases that we had before you on a previous occasion will have an instructive

study of arterial degeneration in this case. It is nearly as far advanced as it was in the case of the old man you saw at that time. This degeneration of blood vessels is noticeable in both the radials and is well marked also in the femorals.

Let us see what the difference on the two sides is in power. He throws the indicator of the dynamometer with the left hand to 45, on the outer circle, while with the right he throws it around to 55. Now, what has produced the paralysis? Hemiplegia from spinal disease is extremely uncommon; hemiplegia from degeneration of nerves is also uncommon. A neuritis that would affect the two sides in this way would be exceedingly uncommon. So I think we can safely say that the lesion in this man's case is in the brain, whatever it is. A very large proportion of all the cases of hemiplegia follows hemorrhage, so that we may say that the probabilities are in favor of hemorrhage simply because hemorrhage is the usual cause; but we have another reason for saying that this case is one of hemorrhage. Take the causes of cerebral apoplexy. One is hemorrhage, by which a blood vessel ruptures, and the other two causes are from plugging of a blood vessel. In brief, we have cerebral hemorrhage, cerebral embolism, and cerebral thrombosis. Which of the three is probably the lesion here? A plugging of a vessel in the brain by the process known as embolism, that is, by a clot brought from a distant point, is an uncommon thing in persons as old as this patient, because the embolus usually comes from the heart. A patient has rheumatism, and as a consequence of the rheumatism has an endocarditis and polypoid deposits upon the valves of the heart, some of these growths, whipped away by the blood stream, travel and lodge in the brain. These emboli leave the heart and constitute the process of embolism, and almost invariably travel into the left middle cerebral artery. So far as embolism is concerned the location is right; but this man has no valvular disease of the heart, and he has reached a time of life when acute articular rheumatism is very uncommon. If a person reaches the age of 35 without an attack of rheumatism, he is not rheumatic. This man's age is against the embolic theory. Taking his age and the condition of the heart into consideration, I think we can safely throw out embolism.

How about thrombosis? His health previous to the attack, apart from bronchitis, was good. No trouble with the head; no dizziness. Thrombosis is usually caused by endarteritis. Endarteritis is frequently syphilitic. As syphilis is a disease that is usually contracted in early life, endarteritis is a condition usually found in early life. He may have endarteritis from other causes,

from interstitial nephritis, for example; but uranalysis excludes this. An endarteritis has some such history as this: The interior coat of a blood vessel becomes roughened, the fibrin from the blood becomes deposited there and shuts up the vessel temporarily, then the patient has a little impairment of function, a sense of numbness or of weakness that passes away and recurs after a time. He will have a good deal of disturbance in the way of dizziness at all times, and a good deal of headache from the disturbance of the circulation in the brain that results from a partial occlusion of blood vessels by the thrombotic process. Thrombosis is rarely confined to a particular territory; many points of the brain are attacked at once. The patient's previous good health, the absence of any well-defined cerebral symptoms prior to this paralytic stroke, throws out the thrombotic theory, so that the probabilities are that the lesion in the brain that produced the hemiplegia was hemorrhage. There is a very marked degeneration of the blood vessels; they are like pipe stems, will break very easily. The blood vessels in the brain that have undergone degeneration, will break much more readily than other blood vessels about the body, because the cerebral blood vessels are not supported by the brain tissue as blood vessels are generally. In the brain each blood vessel is surrounded by a peri-vascular space. The presence of this peri-vascular space takes away the support the brain tissue might give it, so that when degeneration occurs to a certain extent hemorrhage usually takes place first in the brain. So that, take the man's age, history, and the pipe-stem character of his arteries, the probabilities are altogether in favor of his paralysis being the result of hemorrhage.

There is no particular difference in the treatment of acute softening from embolism or thrombosis and destruction of the brain by the hemorrhagic process.

Another interesting feature about this man's case is the method of its onset. He did not lose his consciousness. He had that form of onset that has been called *simple*. Most of the cases of cerebral hemorrhage come on in the form of apoplectic seizures. If standing, the patient falls, becomes unconscious, passes into a state of profound coma from which he cannot be aroused by ordinary methods. The respiration is peculiar. With each expiration the cheeks are puffed out, but after each inspiration they are drawn up and the flopping in and upon the teeth gives a peculiar quality to the respiration that belongs to apoplexy, whether it is due to hemorrhage, embolism or thrombosis. The temperature is sub-normal during the comatose state; it frequently falls as low as 96 1-2 degrees. As a rule, during the

apoplectic fit, the head is turned to one side, the conjugate deviation of the head and eyes. It is almost impossible to get the head back into the median line, it being turned away from the paralyzed side. The conjugate deviation of the head and eyes is a very important thing from a diagnostic standpoint. You can usually make out in the midst of the coma a little difference in the muscular tonus of the two sides. The laity have a wonderful amount of confidence in a person who can look into the future; and if you can say positively that this man has apoplexy and is going to be paralyzed and it turns out to be so, your reputation is fixed forever in that house. Your prognosis will give you a great deal more reputation than a diagnosis.

Again, as onset may be epileptiform, the man loses consciousness and falls. This indicates a more serious hemorrhage, usually.

The most practical point is: What shall we do for the patient? Called to see a patient in an apoplectic or ordinary seizure, the first thing to do is to make a *diagnosis*. The coma of apoplexy is very like that of alcoholic coma. The coma of uremia is very much the same, as is also the coma of diabetes. Every now and then the hysterical coma is difficult to differentiate from the other conditions that have been mentioned. Alcoholic coma—the ordinary comatose state that produces respiration something like that of cerebral hemorrhage—is never profound unless there are some complications in the case. I saw stated as a new thing an old way of differentiating alcoholic coma. This method has been used in this hospital ever since it (the hospital) started, and has been handed down from one interne to another. Pressure over the supra-orbital foramen in alcoholic coma will cause a man to come to immediately.

An eminent physician of this city had a seizure, was picked up and said to be drunk. A doctor who saw him kept him down town in a quiet place for twenty-four hours, waiting for the so-called intoxication to pass off. It was twenty-four hours before the doctor found out that the distinguished physician was not drunk, but paralyzed. It was apoplectic coma and not the intoxication of alcohol. Unfortunately for the doctor he had gone out for a night's work attending obstetrical cases and was tired out. He had, however, taken a drink of whisky to fortify himself for the work before him. After his obstetric work was over, on his way home he fell down in an apoplectic fit, and the good doctor who found him with a strong odor about his breath simply said he was "dead drunk." Therefore, remember that this simple expedient will enable you to differentiate alcoholic coma.

The coma of uremia is very much like that of cerebral embolism and thrombosis. There is no easy way to differentiate it. If you take the urine and examine it you may have reason to suppose the case is uremic coma, but there are one or two points that will help you out. I told you that the temperature in the coma of apoplexy was subnormal, and if you have conjugate deviation of the head and subnormal temperature, then you know that it is not uremic poisoning; that it is not opium or diabetic coma.

This coma is a condition in which you can do very little for the patient. A purgative should be administered as soon as possible to relieve the intra-cranial pressure. In the comatose state you can drop onto the patient's tongue one or two drops of croton oil, and if arterial tension is exceedingly high, it is not a bad thing to draw blood. You may, therefore, apply leeches to the temple, behind the ear, or you can draw blood from the arm. When consciousness returns, when the blood pressure is high, the administration of aconite is a good thing, using it every few minutes until the high tension of the pulse is diminished. Shut out the light and keep away the friends. Sometimes there is retention of urine; catheterize the patient in such cases. For the next few days he will complain of headache and be restless, which you can relieve best by the administration of moderate doses of the bromides. Later along, if there is no inflammatory disturbance, Nature undertakes to shut off the area of acute softening from the balance of the territory of the brain by encapsulating or surrounding it with connective tissue. Whether it be an area of acute softening from embolism, thrombosis, or a hemorrhagic focus, in either case Nature encapsulates it. This process is accompanied by fever, sometimes restlessness and delirium. You give a purgative and then the bromide. When you get beyond the inflammatory condition, a week or two after the accident, it is time then to begin to think of means to restore power. You may from the beginning of the case resort to moderate massage. Later on, you may begin the use of electricity, and believing that the galvanic current has alterative properties, promotes absorption, stimulates function and improves nutrition, I should send the galvanic current through the patient's head and exercise the muscles of the paralyzed side by the faradic current. In paralysis from brain disease there is no wasting of the muscles except what comes from disuse, so the faradic current will readily cause response. Then comes the general nutrition of the patient, whatever builds him up benefits him in this particular direction, and should be given. Elimination by the kidneys and bowels should be carefully attended to, and tonics,

such as iron, quinine and strychnia, with small doses of iodide of potassium and the mild use of laxatives, is the general constitutional treatment indicated in this case. The patient must be instructed from the beginning to exercise all the possible will power he possesses on the paralyzed muscles. In the course of three or four months in a certain number of cases you will find contractions coming on. This man perfectly straightens out his fingers. After awhile he will begin to have contractions, the fingers will be drawn in so that he cannot possibly extend them. There will also be more or less permanent flexion of the elbow. Rigidity first comes on in the hand, and later you will find it in the foot. When this comes on you know that there has commenced, and travelled a good ways, a degeneration at the hemorrhagic focus or at the area of softening down through the internal capsule through the crus cerebri, the pons, and from the middle into the lateral territories of the spinal cord. You know that you have a secondary lateral sclerosis in consequence of a descending degeneration that began in the hemorrhagic focus or the area of softening, as the case might be; and the further important fact that you have accomplished all that is possible for the restoration of the patient, and it is a good thing for you to tell the patient or his friends that there is no need for the further use of treatment so far as the restoration of power is concerned. There will never be any further improvement in power. Of course, they may get tired of you and go to some other doctor, but very soon you will get the benefit of your correct and honest prognostication.

This man has a degeneration of blood vessels. I believe that something can be done to prevent the rapid progression of this degeneration. It is remarkable that he could have so much degeneration at 65 years of age. The atheromatous degeneration of blood vessels I believe can be diminished in rapidity of progress by the line of treatment proposed by Professor Bartholow, which consists in the internal administration of alkalies and alteratives, the carbonate of ammonium and the iodide of ammonium. They increase the alkalinity of the blood and promote elimination. Along with these may be given malt and the hypophosphites. You must impress upon the patient the importance of keeping himself free from excitement; he must not indulge in alcoholics and the luxuries of the table. He must lead a very quiet and peaceful life, avoiding all causes that tend to increase the blood pressure of the brain. By so doing, something can be done towards preventing the recurrence of hemorrhage in these cases as well as in others where there is such a marked degeneration of blood vessels.—*The Clinical Review.*

ON THE PHARMACOPÉIAL RECOGNITION OF DIPHThERIA ANTITOXIN.*

BY JOSEPH W. ENGLAND.

There is no fact in clinical medicine more clearly established than that the human body has within it natural resources for combatting disease processes and effects. But these resources have their limitations in the same individual at a given time, and in different individuals at different times, and become progressively weaker after the limit has been reached and passed. The inadequacy, in some cases, of the natural resources to successfully combat disease conditions is well known, but it is particularly obvious in certain infectious diseases (*e.g.*, diphtheria, small-pox, tetanus, septicemia, etc.), where the bacteria causing the disease multiply with almost unthinkable rapidity, and the decomposition products (toxins) are so large in quantity and so virulent in character that they tax the system to its utmost to eliminate them, or, this failing, they cause death.

Within the last five years, however, there has been placed upon the market medicinal products which, injected into a body infected with certain diseases, have the property of strengthening the natural resources to combat conditions arising from the disease. These products are called "Antitoxins" or "Serums," and their use the "Serum Treatment."

In their preparation, the natural processes that take place *inside* of the human body in its fight to overcome infection and its effects are duplicated *outside* of the human body, that is, in the serum of animals. An "antitoxin," therefore, is a modified serum (properly purified) which has the property of combating infectious diseases and their effects in the same manner as that possessed by the human body itself.

In the preparation of small-pox vaccine, the micro-organism of small-pox is developed in calves, and is then transferred to the patient, who elaborates in his own body, from the organism, the antitoxin necessary to confer immunity.

Diphtheria antitoxin acts in the human body probably by chemically destroying the poisonous products of the bacteria causing the infection. It exhibits, also, a physiological action, supplying to the body the same elements that the body develops to protect itself against the poisonous bacterial invasion.

*Read before the meeting of the American Pharmaceutical Association, held in Richmond, Va., May, 1900.

The true nature of the active principle of diphtheria antitoxin is an unsolved problem. It may be an organic substance, an organized product, or an enzyme or soluble ferment (which are proteid or nucleo-proteid in chemical character). The small dose of antitoxin, its rapidity of action, and its profound influence upon the human system, would suggest that it might be enzymic in character, although there is no positive evidence to sustain this theory. The power of some enzymes for work is almost unlimited. A sample of invertase which had inverted 100,000 times its own weight of cane sugar was found by O'Sullivan and Thompson to be still active. ("Soluble Ferments and Fermentations," p. 120, J. Reynolds Green.)

The preparation of antitoxins is of interest. That of diphtheria antitoxin is typical of the others, and is as follows: A culture of diphtheria bacilli is grown upon Loeffler's solidified blood serum, and the colonies grown are transplanted into faintly alkaline bouillon (in flasks) and kept at a uniform temperature of 37 degrees C. The bacilli rapidly multiply and produce large quantities of a highly poisonous product of toxin (diphtheria toxin), after which the bacilli are destroyed by the addition of 1 per cent. trikresol, and their dead bodies are removed by filtration.

The toxicity of the toxin, or rather its antagonism to antitoxin, is found by injecting it into guinea-pigs, the standard of strength being such that 0.01 to 0.1 cc. should kill the control animal in from 24 to 36 hours. The antitoxin is then prepared by injecting the toxin into horses, which are used because they are most easily handled, and because they yield large quantities or a serum that is less irritating in its effects upon the human system than that of other animals. Further, horses are naturally immune to diphtheria, and this immunity is greatly strengthened by the toxin treatment. Disease-free animals only are employed, the mallein test being used to detect glanders, and the tuberculin test for tuberculosis.

The first injection of the toxin is about 1 cc., and it is repeated every 5 to 8 days in gradually increasing amounts. The limit of toleration is generally reached in from 9 to 12 weeks, when as much as 300 cc. may be borne. As soon as the injection of large amounts of toxin into the horse causes but a slight rise of temperature, trial bleedings are made, and the product is tested. If the test proves satisfactory the horse is bled quite freely, the blood being collected in sterile bottles and cooled for about a day. The serum is removed from the coagulum with a pipette, and preserved by the addition of 0.4 per cent of trikresol. The serum

is then standardized. The standardization is expressed in immunizing units. An immunizing unit is ten times the quantity of serum that is necessary to save from death a 300-gram guinea-pig that has received ten times its minimum fatal dose of toxin (determined by a series of experiments upon average animals per gram of body weight).

This test is very accurate. Where, for example, 9 units of antitoxin have failed to save the life of a certain guinea-pig, 10 units of the same antitoxin have saved the life of an animal of the same family, weight, etc.

This finished antitoxin is placed in glass tubes, which should contain a fixed number of units to each cc., ranging from 250 to 500 units. The most useful strength is 500 units to each cc. The immunizing dose is from 300 to 500 units, the curative dose from 2,000 to 10,000 units. The glass tubes are hermetically sealed. The antitoxin retains its strength for six months or longer. The trikresol present makes the serum slightly fluorescent, but does not precipitate any active principle. So long as there has been no septic change in the preparation (and this can be absolutely prevented with trikresol), there need be no fear of overdosing.

In fact, wonderful as has been the reduction of the mortality of diphtheria with the antitoxin treatment, it would have been still more pronounced had the fact been earlier recognized that the *time* to give diphtheria antitoxin is as early as possible in the infection, before large quantities of the toxins have been formed, and that the *dose* should be as large as the exigencies of each particular case will permit. It is better by far to give a larger dose than is apparently necessary than to err in the direction of a too small dose. When ferric hydrate is given as an antidote in arsenical poisoning, no one would think of giving just enough of it to neutralize the amount of arsenic actually taken: an excess is always employed to make the assurance of antidoting doubly sure. Similarly, when it is wished to arrest the effects of rapidly multiplying bacteria, an excess of antitoxin should always be used, and, if necessary, repeated in from six to eight hours.

A word now with reference to the preservation of diphtheria antitoxin. It should not be kept on the upper shelves of the store, where there may be excessive heat or gaseous fumes. In the Philadelphia Hospital the writer used for the purpose of storage a dust-proof drawer in a part of the drug store remote from direct heat, and about equal distance between floor and ceiling. The results were entirely satisfactory.

Jacobi has said: "The principal question to be raised in reference to any modifications in cases of serious disease, is its life-saving power." Measured by this standard there is, now, absolutely no doubt as to the life-saving power of diphtheria antitoxin, and great as has been the reduction in mortality by its use (from about 40 per cent. to 18 per cent., and this with about only 60 per cent. of the diphtheria cases being treated with antitoxin) the reduction can be made still greater in the future, when its use becomes more general and the importance of early treatment becomes more generally recognized.

The manufacturers of the country have now a standard "unit of strength" which they have agreed to follow, and tests for identity and purity can be readily framed. The question arises at this point as to whether or not the time has come when official recognition should be accorded diphtheria antitoxin. Here is a remedy that has saved thousands of lives, and if safeguarded by appropriate tests in the Pharmacopeia—tests which should fix a proper standard for identity, purity and strength—may save many more lives, relatively. As the case now stands, while manufacturers recognize a "standard unit of strength," there is no general agreement as to the number of immunizing units that each cc. shall contain, nor is there any guarantee that manufacturers hereafter engaging in the making of antitoxin will accept the standard of the present manufacturers, and follow it.

A large number of states have food and drug laws, and these latter, as a rule, recognize the U. S. Pharmacopeia as the official standard in the matter of medicinal products. If antitoxin were officially recognized, its standard of strength could be controlled in these states surely, and in the others most probably. The criticism may be made that antitoxin cannot be officially recognized with tests for identity, purity and strength, because the Pharmacopeial Convention held in Washington last week directed in its general instructions to the Committee on Revision, that:

"The committee is instructed to append assay processes to as many of the potent drugs and preparations made therefrom as may be found possible, provided that the processes of assays are reasonably simple (both as to methods and apparatus required) and lead to fairly uniform results in different hands. As regards the products of such assays, tests of identity and purity should be added wherever feasible. Physiological strength should not be introduced by the committee."

A casual reading of this declaration would imply that diphtheria antitoxin is not admissible into the Pharmacopeia, because an official recognition would be valueless unless supplemented

by tests for determining strength; and with antitoxin these are made physiologically. But a more careful reading of the paragraph would seem to indicate that the requirement that no physiological test for determining strength should be introduced was intended to apply only to vegetable drugs and preparations made therefrom, and that the matter of antitoxin (which has no preparations made therefrom) was not thought of. As the force of a law rests in its intent, the Committee on Revision can, the writer believes, decide that "Antitoxin" is not included in the scope of the resolutions above, and that it could be officially recognized and have tests prescribed for it.

The preparation of serum products in this country has developed into a most important industry. Not only are the domestic needs supplied, but the domestic products are shipped to all parts of the world, which indicates that they are surely winning their way in popular favor against the older French and German makes. This has been brought about by the higher concentrations of the American antitoxin, and the improved methods used in its preparation.

Should not the American antitoxin be now recognized by the American or United States Pharmacopeia, and become the standard for the world to follow?

MR. SAYRE: I hope the discussion on this paper will have a certain direction. I think it a very important one, indeed, and the paper does not appear to be intended to influence the Revision Committee direct, but designed to influence this Association, to bring the influence of the Association to bear on the Committee of Revision. I believe that in accepting this paper we should do it in a cordial manner, and in order to make this proposition effective I move that a committee be appointed to confer with the manufacturers and bacteriologists and therapists, with the view of ascertaining the feasibility of introducing antitoxin serum into the United States Pharmacopeia. I also move that the paper be received and take the usual course.

The motion of Mr. Sayre provoked considerable discussion, participated in by Messrs. Oldberg, Mayo, Hallberg, Eccles, Sayre and Beal, and having been seconded by Mr. Prescott, with the proviso that the committee to be appointed shall report next year, it was put to a vote and carried.

APPENDICITIS IN ITS RELATION TO INSURANCE.*

BY E. FRANCIS MORRILL, M.D.

Through the courtesy of your chairman I have been requested to present to your honorable body some thoughts on the sequences of appendicitis from the point of view of Medico-Insurance.

Though our medical literature on the subject of appendicitis has been enriched by monographs from the pens of our ablest thinkers and writers, it is quite silent on the ultimate effect on the life history of the survivor of this popular disease and to the profession lucrative.

Along some lines I have been embarrassed by wealth of information obtainable, but in other fields the virgin soil has scarce been turned.

Despite the acknowledged mendacity of figures, I have selected statistics from a few reports, which, though not convincing, are at least suggestive. I have no theories to expand, no convictions to expound, but approach the subject with you to better understand its significance in our work.

The first question which presents itself on reviewing an application in which a history of appendicitis is found is, "Did the physician make a correct diagnosis?" If not, would the conditions which simulate this disease justify rejection?

Of one hundred cases investigated by Robert Morris an error of diagnosis was found in seven. These seven presented either cancerous or tubercular lesions in this ileo-cecal region. Of 181 cases recorded by Maurice Richardson there occurred eight errors of diagnosis. Of these, four were conditions arising from adhesion bands. Two cases of malignant disease. Two were cases of specific infection. John B. Murphy in a report of 141 cases—girls, five cases of mistaken diagnosis: one perforating round ulcer of stomach; two extra nephritic renal calculi; one rupture of psoas abscess; one gangrene of M. M. of colon.

The possibility of these conditions being present would make us guarded in our final disposal of the application.

The fact of the attack being established, the probability of ultimate recovery presents itself. And here we must make a very artificial distinction—one based on treatment.

Should we recommend an applicant for insurance who gives a history of one attack of appendicitis treated medically?

How long a time should elapse before we may consider such an applicant safely insurable?

*Read before Medical Section National Fraternal Congress.

Should we recommend an applicant for insurance who has had more than one attack?

Rotter, of St. Hedwig Hospital, who reports twenty-four cases of recurrence, states that the second attack is most commonly within a year after initial seizure, though not rarely during second year from apparent recovery—seldom after two years.

Charles J. Whalen in a recent monograph reports statistics on 6,500 cases found in medical literature, among which there were 1,483 cases of recurrent appendicitis, making 29 per cent. of the number treated.

Of the forty-six recurrent cases reported by Maurice Richardson, twelve had had one attack; three had had two attacks; nineteen had had three attacks; twelve had had several attacks.

Maurice Richardson and G. W. Brewster in their study of 256 relapsing cases, finds that years of immunity do not give security. In several of the worst cases the initial attack was in childhood.

John B. Murphy, in a report of twenty-seven recurrent cases treated medically, cites the number of attacks as ranging from one to twenty and covering a period of months or years.

Rutherford Morrison, in the *Edinburgh Journal*, gives the interval of attacks found in his researches as from one week to thirty-six years, and that many cases diagnosed as appendicitis and treated medically, die as a result of tuberculosis and cancer of the ileo-cecal region, these conditions often resulting in appendicitis.

Robert I. Morris presents a report of one hundred cases diagnosed as appendicitis. Of these sixty-six proved to be cases of recurrent appendicitis, four were tubercular, one ovarian tumor and one cancer.

A most careful study of thirty-four cases from Brocas' clinic, covering a period of from five to fifteen years after treatment, finds nineteen cases treated medically. Of these five returned for operation on account of recurrence; thirteen recovered absolutely—so far as the history of fifteen years would indicate. This means a recurrence in 25 per cent. The *Medical Standard* of this year estimates the chances against recurrence as three to one.

There seems to be a general unanimity that recurrence obtains in from 25 per cent. to 30 per cent. of all cases which recover when treated medically.

These reports are only few among the many, but are most significant. We must conclude that two attacks reject, and that at least three years should elapse after an initial attack before the applicant would be safely insurable, and that the possibility of other conditions simulating the disease should make us most guarded in our recommendation.

In approaching the cases treated surgically, we again are confronted by a distinction of treatment. Was there simply a drainage of the abscess cavity or a radical operation performed?

So universally condemned is the drainage treatment that I have not thought necessary to quote authorities. The recurrence of an attack as a result of some overlooked point of infection seems almost certain.

The removal of the appendix with any necrotic tissue and careful cleansing of the cavity proves the only safe procedure. The sequelæ of this operative treatment would present themselves as follows :

(1) Lesions induced by the anesthetic; (2) Lowered vitality resulting from shock; (3) Fecal fistulæ; (4) Hernia; (5) Adhesion bands; (6) Recurrence of symptoms.

1. The morbid processes set up by the irritation of the anesthetic are too well known to need even passing mention here.

2. The resultant shock is much less from a laparotomy than from the amputation of a limb or disturbance of any large nerve trunk and would appear to have no influence in the future life history of an otherwise healthy individual.

3. Fecal fistulæ, while annoying, offer no menace to life, and almost invariably close without operative interference.

In only two cases of many reported were fistulæ persistent.

4. Hernia is the most constant evil associated with the sequelæ of operative cases. The most careful dissections and satisfactory progress may result in hernia. This condition, in most of the reports, developed during the first three years. The percentage of cases was unobtainable.

Inasmuch as our blanks provide for this condition, irrespective of cause, it should not debar from insurance, unless it is of such a character that a properly fitting truss cannot be applied. The same rules which govern hernia cases should obtain here.

5. Of adhesion bands, which complicate these cases in after years, I find scant mention. That they do exist, and rarely present symptoms is sure.

In questioning a number of surgeons they cited a few cases where these bands caused obstruction and produced symptoms, much resembling appendicitis, but this condition is practically ignored in medical literature.

6. The question of ultimate recovery is as yet an undeveloped one. The surgeon is content to relieve the existing conditions without future care for the case unless he returns for operation. There are very few reports tabulated otherwise than deaths and recoveries.

Of the 181 operative cases of Maurice Richardson, two died of secondary abscess some time after apparent recovery; one made an apparent recovery and died eighteen months later of malignant disease of ileo-cecal region.

Of 151 cases reported by him since August, 1894, all recovered permanently but two; one developed tuberculosis and one malignant disease of the whole ileo-cecal region.

Permanent recovery would seem well assured, but there is a broad field here for further investigation.

In summarizing I would suggest:

1st. That acute appendicitis has a recurrence of from 25 per cent. to 30 per cent.

2nd. That such recurrence is usually within the first three years.

3rd. That cases treated by removal of appendix are safely insurable two years from date of recovery.

4th. That all other cases should be regarded with suspicion, and that the possibility of a tubercular or malignant disease in the ileocecal region should be kept in mind.—*Medical Examiner*.

SOME NOTES ON THE USE OF MERCURÖL: A NEW REMEDY IN URETERITIS.*

BY RAMÓN GUIERAS, M.D.,

Professor of Genito-Urinary Surgery in the Post-Graduate Medical College of New York. Lecturer on Genito-Urinary Surgery in the University of the City of New York.

The author states that he has thoroughly tried mercuröl in his clinic, and from his experience has drawn certain conclusions which he presents in this paper. After describing the chemical nature of mercuröl he states that he found the weaker solutions had little effect and the stronger solutions were at first irritating. He finally concluded that the average strength best borne by the patient is ten grains to the ounce, or approximately two per cent. After having reached this conclusion he had the histories of one hundred cases recorded, in thirty-three of which an examination for the gonococcus was made, revealing its presence in thirty cases. In the remaining sixty-seven cases a clinical diagnosis was depended upon, since the writer considers the experienced eye competent to recognize the disease. In one extremely interesting case no gonococcus could be found in the urethral discharge, although gonococci were present in that of some venereal ulcers on the glands.

In these cases a 2 per cent. solution of mercuröl was ordered, which the patients were directed to inject three times a day, after micturition; the injection to be held within the urethra for five minutes at each operation. The clinical reports of the cases show that frequently in two days after beginning the use of mercuröl, gonococci could no longer be found in the discharge.

The author discusses at some length the value of the term "practically cured," and sums up his argument by saying that to draw conclusions of value we should consider only cases that have

* Abstracted from the *Lancet*, London, England, September 22nd, 1900.

been under treatment for three or more weeks, omitting those making but a few visits. On this basis he eliminates all but sixty-five cases from his report and tabulates these as follows :

Ten cases were cured in four weeks, or 15 per cent. ; fifteen cases were cured in six weeks, or 23 per cent. ; twenty cases were practically cured, as there was no discharge, though there were some shreds in the urine at the end of from four to eight weeks, 30 per cent.

One of the most valuable observations that the writer has made is the fact that only two cases suffered from complications, one having developed gonorrheal rheumatism and the other epididymitis. He states that this fact in itself would tend to argue much in favor of the use of mercuriol, for where is there any other solution or mixture which does not show a greater percentage of complications? When we consider that many writers claim that epididymitis occurs in 20 per cent. of all cases of urethritis, the rate of 1 per cent. reported in this series of cases argues much in favor of mercuriol as a harmless, yet efficient injection.

Another interesting feature is that in only one of the one hundred cases was there any marked posterior urethritis. Therefore it would seem that mercuriol quickly destroys the gonococcus, lessens the severity of the inflammation, and tends to prevent the development of complications. From a comparative study of the different methods of treating gonorrhoea the author concludes that treatment with mercuriol is an advance beyond the older methods with balsamics and astringent injections.

DRUG STANDARDIZATION.

What right has any firm, whose business is to furnish the physician with his principal weapons, to place upon the market pharmaceutical preparations of unknown medicinal value? Should we not expect, yes, even demand, that the producer of fluid extracts make his products conform to some standard of excellence—that he shall indicate what effects his fluid extracts may be expected to have ere he sends them forth from his laboratory?

It has been shown that even drugs selected with care vary most extraordinarily in their percentage of active principles. Witness, for example, this statement by the editor of a leading pharmaceutical journal* who knows whereof he speaks :

“Professor Puckner assayed nineteen samples of belladonna leaves, procured, mind you, from dealers who were told that only the best was wanted, and that purchase would depend upon the results of assay. He found these nineteen samples to range in

* Bulletin of Pharmacy, January, 1899.

alkaloidal content from .01 to .51 per cent! The strongest sample fifty-one times as strong at the weakest."

The most careful treatment of such drugs, with the choicest menstrua, and by the most approved processes, will yield preparations that may be fair to look upon, but in medicinal value they will vary just as much as the crude drugs from which they are made. The compensatory remedy for this unfortunate condition is standardization—chemical standardization when practicable, and when that method is inadmissible, as it often is, physiological standardization. It has been found that certain important drugs cannot be assayed chemically, as their medicinal virtues reside in unstable bodies, and these are readily decomposed in the analytical processes. For this reason the strength of such powerful and useful drugs as digitalis, aconite, convallaria, strophanthus, ergot, cannabis indica, and many others, cannot be determined satisfactorily 'by the analytical chemist. However the problem which proved to be an insurmountable difficulty to the chemist, was solved by the pharmacologist with ease. He tests upon living animals all drugs that cannot be assayed chemically. Dogs, rabbits, fowls and guinea-pigs receive doses of the preparations under examination. Accurate observations of their physiologic effects are made, variations are noted and corrected, until the preparations correspond in medicinal strength with the adopted standard extracts.

Formerly the physician was obliged to make his own physiologic tests of ergot, digitalis and so on ; not upon dogs and guinea-pigs, however, but upon his patients. The old way was to begin with small doses of powerful drugs and then to push them until the desired effect was produced. The new way is a much better one ; it is safer for the patient, more satisfactory to the physician, and it is more scientific. Prompt results are assured, for the physician knows just how much fluid extract of ergot, aconite or cannabis indica he need include in his initial dose to secure a definite result.

The name of the greatest pharmaceutical manufacturing house in this country is so closely linked with the phrase, "drug standardization," that the mere mention of one suggests the other. Parke, Davis & Co. began years ago to manufacture a full line of standardized fluid extracts that are guaranteed to be of definite and uniform strength. More recently they devised and perfected methods for standardizing physiologically those important drugs that are incapable of analysis by chemical processes. Parke, Davis & Co. have done a great deal for the medical profession and for humanity, and standardization, more especially physiological standardization, is one of their greatest achievements.

INTERMITTENT PULSE IN LIFE INSURANCE EXAMINATION.

Recently a young man who had waited in the office a half hour for examination was found with palpitation, and a pulse of ninety, irregular and intermittent, says *Atlanta Journal-Record*. Assuming that his waiting has in a measure quieted the action of the heart, which was likely to reject, and thinking that a little exercise would bring out more clearly the real condition, he was quietly asked to do an errand a few blocks distant while a patient received attention. On his return the writer was surprised to find no palpitation and a pulse of eighty-two, regular and free from intermission. However, on auscultation mitral insufficiency was detected.

Eleven years ago the writer examined a man of thirty-five, whose pulse, on different sittings, skipped a beat at frequent but irregular intervals. He was reported "a good risk, free from organic heart disease, notwithstanding that his nervous and digestive symptoms are somewhat impaired." He was rejected at the home office, and for a number of years spent much time examining his own pulse, and in consulting travelling doctors. Nevertheless, he still lives, and has continued his work in the wood department of a furniture works, and is to-day in better health than when refused insurance. What disposition shall the examiner make of similar and allied cases? Have not many of them been unnecessarily rejected?

Levan. A Treatise on Medical Examinations for Life Insurance, says: "That alteration in the rhythm of the heart, which produces a distinct intermission in its action, whilst frequently found even in healthy persons, suggests, nevertheless, a diseased condition of the valves or orifices, although it may often be difficult to explain the precise cause."

The majority of companies instruct their examiners that an irregular or intermittent pulse should reject. One of the strong companies of to-day in their "Instructions to Medical Examiners," issued more than twelve years ago, says, "An intermittent pulse is not of itself sufficient cause for rejection, as it is sometimes found in the healthy. But an irregular or intermittent pulse must ever be taken with suspicion of some grave disorder, either in the heart and great blood-vessels, or in the economy at large. It is sufficient alone to justify rejection."

Osler, Practice of Medicine, third edition, under the heading Arrhythmia, says: "An intermission occurs when one or more beats of the heart are dropped. Irregularity is the condition when the beats are unequal in volume and force, or follow each

other at unequal distances." . . . "The causes of these various disturbances of rhythm are thus classified by G. Baumgarten :

"1. Those due to central (cerebral) causes, either organic disease, as in hemorrhage or concussion ; more commonly psychical influences.

"2. Reflex influences, such as produce the cardiac irregularity in dyspepsia and diseases of the liver, lungs and kidneys.

"3. Toxic influences ; tobacco, coffee and tea are common causes of arrhythmia. Various drugs, such as digitalis, belladonna and aconite, may also induce it.

"4. Changes in the heart itself: (a) In the cardiac ganglia. Fatty, pigmentary and sclerotic changes have been described in cases of this sort and may have an important influence in producing disturbances in the rhythm ; but as yet we do not know their exact significance. They may be present in cases which have not presented arrhythmia. (b) Mural changes are common in conditions of this kind. Simple dilatation, fatty degeneration and sclerosis are most commonly present, the two latter usually associated with sclerosis of the coronary arteries.

"The significance of arrhythmia is not always easy to determine. Simple irregular action of the heart may persist for years. The late Chancellor Ferrier, of McGill University, a man of unusual bodily and mental vigor, who died at the age of eighty-seven, had an extremely irregular pulse for almost fifty years of his life. One or two other instances have come under my notice of persons in good health, without arterial or cardiac disease, in whom the heart's action was persistently irregular."

Pepper states that "irregularity of the pulse may be noted for years without any disturbance of the patient's health. In other cases this symptom is of ominous significance. The prognosis is to be based upon the cause of the cardiac arrhythmia. On the whole, the outlook is more grave in any form of myocardial or valvular disease in which arrhythmia occurs than when the condition is absent."

It would appear that the examiner should exercise great care to exclude any nervous excitement, make a thorough examination, and report just what he finds, giving his opinion as to the cause of abnormalities and the character of the risk. Then let the home office make their decision. The following extract from a recent edition of "Suggestions to the Medical Examiners," of an old and prominent company, are well worth reading by every examiner : "The medical examiner should have constantly in mind two important differences in mental attitude between the patient and the applicant for insurance. In the first place, many, especially at their first examination, or among the younger applicants, are extremely nervous ; the idea that the examination may reveal some hidden ailment so takes possession of their minds as to disturb consider-

ably the nervous equilibrium—to induce, as it were, a mild degree of shock. In such cases the pulse may be found extremely rapid or intermittent; there is apt to be pallor or muscular tremor. The picture is one of nervous debility or a want of normal bodily vigor. Whenever an examiner meets with this condition he should be able by tactful handling, to reassure the applicant, and to re-establish the normal nervous balance; at any rate, he should make due allowance in his report for the disturbed mental state of his subject.

“As to the other difference to which we have referred, when he consults his physician the patient endeavors to describe every detail of the disease of which he complains. He conceals nothing. His mental attitude is one of unreserved co-operation. When he is a candidate for life insurance, the case is very different; his memory for details is less acute; his state of mind is one of antagonism. He believes himself to be a good risk, and his bias of mind in that direction is so strong as—no doubt unconsciously—to color his entire history. On this account a medical history for life insurance is a very different matter from that which is obtained from a patient. The patient assists his physician—the applicant for insurance does not assist the examiner. It requires time for any physician to adjust himself to this difference in mental attitude. The skilled medical examiner has learned this lesson.”—*Medical Examiner and Practitioner*.

PINK EYE.*

BY W. CHEATHAM, M.D., LOUISVILLE, KY.

Pathologically this is a contagious muco-purulent conjunctivitis depending upon a bacillus, demonstrated by Weeks, of New York, confirmed by Morax and others, by whom the disease has been reproduced by inoculation of sound eyes. I use the name “pink eye,” as it is so well known, and offer this short paper upon the subject as the disease is now quite prevalent. When properly managed it is of short duration, but when improperly managed other more serious diseases, such as phlyctenular conjunctivitis or even keratitis, may supervene. The first symptom is usually that of a sensation of a foreign body in the eye, with hyperemia of the conjunctiva and some gluing of lids; in from one to three days the disease is usually at its height; if mild, there will be some con-

* Read before the Southern Kentucky Medical Association, Glasgow, Ky., April 18th, 1900.

jection of even the ocular conjunctiva, with increased secretion which is now muco-purulent. My experience has been in these cases that the secretion will escape in lumps at the inner canthus and be found in the inferior cul-de-sac in rolls, not liable to get into the lashes and mat them together.

Again, the disease may be still more violent, such as in a case I have on hand now in the person of a young lady, who about five days ago had a sensation of having gotten something in her left eye; the disease progressed very rapidly, so when I saw her the third day there was great congestion of the eyeball, with one phlyctenule at the junction of cornea and sclera, some edema of lids, muco-purulent secretion very great, with fear of light and considerable pain; in such a case there are frequently small sub-conjunctival hemorrhages. This is, of course, an extreme case.

As I stated before, the cause of the disease is a bacillus first discovered by Weeks and confirmed by Hansell, Kartulis and Morax. Others in different sections of the country have found the pneumococcus; Gasparini was the first to find that the diplococcus of Frankel and the micrococcus pasteurii of Sternberg would produce a conjunctivitis of a muco-purulent character. This has also been confirmed by others. Morax has found a diplo-bacillus which he considers the pathogenic factor in subacute conjunctivitis, which is contagious. I have, during this epidemic, had many of my cases of pink eye have at the same time tonsillitis much resembling that form known as follicular.

Treatment.—The mild cases need but little care; the eyes must be kept clean; the patient's surroundings as perfect as possible; dust and smoke are harmful. The eyes should be bathed in borac acid, gr. x, to aqua ℥ i; if the lids glue, use on them during the sleeping hours, acid boric, gr. xv; vaseline, ℥ ss; this can be used in the eyes also with much benefit. In the second class of cases when the inflammation is more severe and all symptoms increase, in which even the corneal epithelium may be disturbed, the acute stage had better be managed as that of the case just spoken of; to the treatment might be added the application of cold or hot cloths, whichever give the most comfort, or hot water bath to the eye. After the acute stage has passed, or even before if there is much pain and fear of light, I use atropia sulph., gr. i; aquæ, ℥ ss, in the eye morning, noon, and night. I give the patient a bath to be used in an eye cup—acid boric, soda boras, sodium chlor., āā ℥ ss; dest. ext. hamamelis, ℥ ii; aquæ, ℥ xiii. Use this four times a day. If the discharge still persists, use protargol, 1 per cent. sol., to be dropped into the eye four times a day. In the severe cases referred to the pain was so great that I ordered atropia sulph., gr. i; acid boric, gr. iv; cocaine, muriate, three per cent. sol., ℥ ss, to be dropped into the eye four times a day. When the great irritation now in this eye subsides, I shall order an oint-

ment of hydrarg. oxid flav., gr. iii; vaseline, ℥ ss, to be used in the eye once per day. Zinc sulph. is highly recommended in this form of inflammation, also a lead wash, which is dangerous if there is any abrasion of the corneal epithelium. Boric acid solution alone will cure a majority of the cases of pink eye if used early. The tendency of the practitioner of medicine in these cases is to commence the use too soon of an astringent. This is quite liable to lead to corneal involvement or convert the disease into phlyctenular inflammation; the disease being contagious, instructions must be given as to other people using the same towels or basins and handkerchiefs, that the bedrooms must be well ventilated, etc. The patient should avoid bright light, use of eyes, avoid smoke, heat and dust. Sometimes the use of quinine internally or some of the salicylates, the latter especially in those cases in which the tonsils are involved, are indicated. Existing errors of refraction and catarrh of the nose should be corrected, also some constitutional dyscrasias, especially rheumatism, malaria and gout, or any thing else which may cause hyperemia of the conjunctiva, as this condition furnishes a good soil for the germ proven to produce pink eye. This being so, feeding in relapsing cases must be of some consequence, as I believe rheumatism and gout originate in the intestinal canal in a large majority of instances.—*Louisville Journal of Medicine and Surgery.*

THIOL (potassium guaiacol-sulphonate) has been made the subject of a series of investigations by Dr. Wilhelm Schulhof, of Budapest, at the Budapest Polyclinic (*Klin. Therap. Woch.*, VII., pp. 778) who sums up his conclusions regarding the remedy as follows: Thiocol may be recommended in all those cases in which creosote has heretofore been given, as it possesses the useful properties of the creosote preparations in an increased degree, because by means of it more guaiacol may be introduced into the system than can be done by creosote, and without the repugnant taste and odor or the irritating action of the latter. A certain connection between the gain in weight and the increase in appetite could in some cases be seen unquestionably. No unpleasant by-effects, disturbances of digestion or diarrhea, were observed even in advanced cases of the disease wherein no improvement could be expected. In most cases the therapeutic object of the treatment—increased nutrition—could be obtained, and conditions were thus reached which could enable a cure to be consummated.

DOMINION MEDICAL MONTHLY

Issued Nov. 26th, 1900.
P. H. Bayce, M.A., M.D., Secretary.

MONTHLY REPORT.

Issued by the Provincial Board of Health of Ontario for October, 1900. Showing the deaths from all causes and from Contagious Diseases in the Province, as reported to the Registrar-General by the Division Registrars throughout the Province.

YEAR.	MONTH.	Total population of Province 2,283,182	Total municipalities of Province 777.	Total deaths reported from all causes.	Rate per 1,000 from all causes.	Scarlatina.	Rate per 1,000	Diphtheria.	Rate per 1,000	Meadles.	Rate per 1,000	Whooping cough.	Rate per 1,000	Typhoid.	Rate per 1,000	Tuberculosis (Consumption).	Rate per 1,000
1900....	October....	2,214,150 97%	710 92%	2,050	11.1	8	0.04	44	0.2	2	0.01	10	0.05	120	0.6	160	0.9
1900....	Sept.....	2,270,150 99%	715 92%	2,490	13.1	3	0.01	42	0.2	2	0.01	20	0.1	58	0.3	172	0.9
1900....	August....	2,271,800 99%	708 98%	2,371	12.5	8	0.04	31	0.1	1	0.005	14	0.7	44	0.2	180	0.9

YEAR.	MONTH.	Total population reporting.	Total municipalities reporting.	Total deaths reported.	Rate per 1,000 from all causes.	Scarlatina.	Rate per 1,000	Diphtheria.	Rate per 1,000	Meadles.	Rate per 1,000	Whooping cough.	Rate per 1,000	Typhoid.	Rate per 1,000	Tuberculosis.	Rate per 1,000
1899....	October....	2,275,000 99%	740 95%	1,940	10.2	8	0.04	34	0.2	4	0.02	7	0.04	88	0.5	194	1.0
1899....	Sept.....	2,265,308 99%	738 95%	1,967	10.3	10	0.05	21	0.1	0	0	8	0.04	55	0.3	190	1.0
1899....	August....	2,265,246 99%	700 94%	2,088	11.4	8	0.04	25	0.1	5	0.03	16	0.09	55	0.3	172	0.9

N.B.—Division Registrars will please make their returns on or before the 5th of each month, thus enabling the Department to have the monthly report compiled much earlier than heretofore.

Computed by G. B. Lindsay, First Clerk.

DOMINION MEDICAL MONTHLY

AND ONTARIO MEDICAL JOURNAL

EDITOR:

BEATTIE NESBITT, B.A., M.D., F.C.S.

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No. 6.

THE VALUE OF MEDICAL JOURNALS.

The value of medical journals rests with the medical profession. It is on the profession they rely for original articles and for case reports, and on the results of original research and observation. Then the reports of national and local medical societies are items of interest, which the societies in this country do very little towards placing before the profession. Some journals live and fatten on these societies, or rather on the papers read at these societies; and if it were not for them, their columns would be ragged and bare. There is a burden of responsibility resting on the profession in the making of good medical journalism, which the profession evidently does not properly appreciate. So often do we hear the remark concerning such and such a journal: "What good is it?" "That's no good!" and similar denunciations—and this often by men who do not try to make a journal better. The most practical and interesting things in medical journalism to-day are "conspicuous by their absence." We refer to case reports, not of rare yet interesting diseases, but reports which would teach betterment in the common every-day practice; and of articles, editorials or otherwise, which would make towards a better condition of things in the profession generally. Who amongst the thousands in the country who would like to see conditions bettered in the profession of medicine in the Dominion, are doing anything in that direction? The editors may be striving to do that here and there now and again, but with scant encouragement from the great mass of the profession. The great bulk of our journals are filled with selected articles and abridgments of original articles from other journals—one living on the other in this respect—and also on abstracts which have been selected wholesale and of very little importance to the every-day

general practitioner. Would not reports of experiences and observations in different cases be infinitely better and more profitable than these rough-and-ready abstracts which all too often owe their protracted life to a pair of scissors—and yet editors are expected to provide edible knowledge for these epicures who never run with the fox, but always hunt with the hounds. What, then, is the value of a local medical journal? We notice that many of them have extensive staffs of editors who never edit, or who never even contribute a paper or a case report, except through the *éclat* of a meeting of one of our great medical societies, to say nothing of writing an editorial under their own signature. Is such an editorial staff valuable to a journal? This question readily answers itself. Would it not enhance the value of a journal if the editorial pages were increased and articles appeared each month by each or say most of the staff, expressing personal views on given subjects of current interest, under their own signatures, than by a jumble of abstracts taken from other journals and copied over and over again? Strike out the abstracts and the selected articles from our local journals, and there would be scarcely enough to light a decent fire. Editors who authorize their names on journals should give us some of their thoughts on those editorial pages. The profession at large looks for it and it is their right to expect it. Then let the profession at large do their share, fair and proportionate, in the way of case reports, and local medical journalism will take a step upward which will be for the good of all concerned. The profession should help in this way to dry up the milch cow of the local journal—"the weekly," which every progressive man ought to have and read, and of which this continent as well as England produces good ones. Then with news items which are news items, and not the every-day movements of the doctors who happen to live where the journal is published, we might hope to make in Canada a medical journalism worthy of the name. Let the profession and the staffs combine to accomplish this good.

MEDICAL DEFENCE UNIONS.

Some time ago we called attention to the importance of the formation of these unions throughout Canada; and we have been pleased to note that the Canadian Medical Association took the matter up in earnest at the Ottawa meeting. Word comes from the Eastern Townships that the medical men of the St. Francis District Medical Association are taking the initiative in the matter of organizing a Defence Association and will shortly seek endorsement from the National Association. It strikes us very forcibly that this is the proper way to organize medical defence. Medical societies all over the Dominion should at once take the matter up

and in their local spheres establish subordinate societies and then request that the Canadian Medical Association establish what we might now call, for want of a better term, a "Grand" or "Supreme" Medical Defence Association. The local societies, which were then affiliated with the "Grand" or "Supreme" body, could collect the fees for such purposes, and the "Grand" body could administer them. There seems to be no reason why medical men could not organize in this way just as other organizations have done in the past; and we should think that the onus of organization should rest with the respective presidents and secretaries, with their executive officers, of the local societies. The time has arrived in the history of the medical profession in this country, when our societies can well afford to spend one or two evenings at least during their short sessions in discussing "business"—time which in the end will prove to have been well spent, and which will turn out advantageously to the profession at large and to the individual members as well. As a profession, we are altogether too humanitarian. Our meetings are all "shop." In our desire to perfect ourselves in the scientific aspect, in order that our patients may reap the benefit, we neglect ourselves, all of which is now striking home with a vengeance. A little less of scientific matter, a little less of rare cases, interesting as they may be, a little less of what is ordinarily denominated of practical importance, and more of finance and "business" will result in pulling the profession out of the slough into which it is rapidly sinking. At this juncture a responsibility rests upon the presidents of our local societies, to see to it that their offices are not altogether a cloak of honor and popularity among their fellow-members, but that there actually is some responsibility resting upon them in accepting these offices at the hands of their confrères. What is being done in this direction amongst medical men in the progressive cities of the Dominion? Are they to be set the example by those rural members of our body, who may perhaps not feel so keenly the disabilities under which we try to earn our daily bread? Why hesitate in this work of organization which is pushing itself upon us? We hope this appeal to the presidents of local medical societies will set them thinking and acting at once.

ORGANIZATION.

There is no more important subject before the medical profession to-day than the question of organization upon practical "business" principles. Too long have we drifted on the wave of "ethics" and "professionalism." We must now insist on our rights in the community. We must protect ourselves and our families. Medical organization on business lines is a prominent and pre-dominant and ever-growing question in the Republic to the south

of us, so why should we rest idly on our oars and permit hospital trusts, dispensaries, fraternal societies and "dead beats" who are able to pay, kick and puck us around like an ordinary every-day football or hockey plaything. Especially is this earnestly required in city practice, where competition is keen, where hospitals, dispensaries, and lodges flourish as the green bay tree, and the number of people who deem it inadvisable and unnecessary to pay for their doctor's service are too numerous to mention. In this matter, who should take the initiative? We would respectfully invite the attention of our representatives on the Medical Council of the Province, and the presidents of our local medical societies to this, as occupying positions of confidence and honor from their fellow practitioners, and who, if they desire to mark the incumbency of their respective offices by taking steps to create a lasting and permanent organization of this character, will be placing themselves under great obligation to their confrères and of immense and vital moment to the profession of medicine. The plain and unvarnished truth of all this is that in the neglect or wilful disregard of physicians' accounts and the attempts to obtain skill in the performance of important operations, is simply an evidence of the great amount of dishonesty rife in the land and a further evidence of respectable rogues in lace and fine linen who are constantly busy in the attempt to obtain goods under false pretences; for it is nothing more than the smallest and meanest bit of petty larceny to get surgeons to operate on people able to pay, but who are disguised in the fine lace and silk of paupers. An instance in point is worth recording—and there is no surgeon who cannot name these by the dozens. A farmer brings his wife to a Toronto hospital and puts her in an ordinary \$2.80 per week bed. That farmer is in many instances a rich man. He owns a good farm of one hundred, two hundred, or perhaps three hundred acres, with a large quantity of stock, but he cannot afford to pay a surgeon for operating on his wife, and so places her under the charitable hands of some foolish surgeon. In the city, on the other hand, people must have all the enjoyments of life: the theatres, a piano, and the best of clothes, whilst the doctor's bill goes unpaid. It is probably harsh on religion to say that the failure to inculcate honesty is the fountain of all this evil, but disregard for the truth and disregard for the right is constant and ever-growing. It is perfectly astonishing, but leading lawyers and leading business men, as well as the entire laity, are seized of the belief that the surgeons and physicians who give their time and their skill to the actually and the seemingly poor in our hospitals are being recompensed for their trouble and their time by either the trustees of the hospitals, the municipality or the local government. When this is the universal belief, a popular vote might be got to make it a reality. When a pauper goes into a hospital, he should go there in the widest sense of the

term as the ward of the municipality who sends him there, and his hospital maintenance, as well as his physician's attendance, should be paid by the municipality. Since the charitableness of the physician and the surgeon has been so much abused in this particular, surely is it not high time for physicians to cease working for nothing. We get no credit for it from the great mass of the people, who imagine we are paid for it, so why continue to sail any longer under false colors? Organization is bound to come—it must come. In this important matter let the young and the old physician stand firmly together, and let us enter into our rightful heritage. It is time to cease working for nothing for anybody. It is time to throw off this cloak of unappreciated charity and philanthropy. Hospitals are no longer charitable institutions. They are to-day used as much for the rich as for the poor. Just the same, it is not charity to the poor man to doctor him for \$1.00 a year, because the poor man is often able but unwilling to pay properly for his doctor's attendance. Before another moon goes around, we hope some of our present society officials in authority will take this matter up properly on the broad and general lines of common business principles.

ANYONE who witnesses the blanching effect of suprarenal extract upon the conjunctiva for the first time is impressed with the great possibilities in store for this agent in the treatment of diseases of certain mucous membranes, and especially hay fever. The chief hindrance to its convenient use heretofore has been the necessity imposed upon the physician of preparing fresh solutions. Messrs. Parke, Davis & Co., with commendable enterprise, have recently brought out a fine extract of fresh suprarenal gland, which is known commercially as "Suprarenal Liquid with Chloretone." This preparation is in several respects unique; it is vastly superior to extemporized solutions of the dried gland, since it has been shown that in the drying process the adrenal loses much of its virtue; it is permanent and, therefore, always ready for use in emergencies or in the daily routine of the office. It is interesting to note that the permanence of this preparation is attained by the addition of that remarkable drug, chloretone, which in addition to its hypnotic property, is also a valuable antiseptic, and a local anesthetic as well. The local anesthetic effect of chloretone (which is entirely free from the dangerous properties of cocaine) and the powerful vaso-motor action of fresh suprarenal extract are skilfully combined in this new remedial compound. We predict it will soon come to be recognized as a veritable *sine qua non* in the treatment of hay fever and diseases of the nose, throat and eye.

News Items.

OTTAWA is to build a new contagious disease hospital.

SCARLET fever is very prevalent in the city of Montreal.

AN outbreak of small-pox is reported from Nanaimo, B.C.

THE smoke nuisance is to be dealt with within a short time by both Toronto and Montreal.

A HOSPITAL in connection with the Woman's Medical College is contemplated for Toronto.

THE many friends of Dr. Adam Wright will be glad to learn that he is recovering from his very severe illness.

THE last outbreak of small-pox in Montreal, of which there was twenty-three cases, cost that city \$11,679.59.

CANADA not having adopted the "Free-Mash-Tun" principle, there is no fear of poisoning from drinking Canadian beer.

THERE were an unusually large number of deaths from typhoid fever throughout Ontario during the month of November.

Dr. W. H. ANDERSON, a graduate of Toronto University, will succeed Dr. Higgins at the Williamshead Quarantine Station.

Dr. J. W. WALKER, Macdonald Professor of Chemistry at McGill, will deliver the annual convocation lecture at McGill on January 10th.

MONTREAL is contemplating the erection of a new civic hospital on the pavilion plan. It will be governed by a Board of nine governors.

FOR hazing one of the professors, the second year medical students of McGill have been threatened with expulsion unless they make public apology in a body.

Dr. MONTIZAMBERT has been successful in tracing the cause of the outbreak of small-pox in the Yukon last summer. It was brought in by a man from Seattle.

THE Dominion Cattle Breeders' Association will endeavor to have the law changed relating to the tuberculin test. The Hon. John Dryden states that he believes the test to be a fraud and a humbug.

FRUITFUL indeed is the valley of the Lake St. John. A woman there has given birth to eleven children in seven years; triplets once, twins twice, and the balance in the regular quantity. Five of these were born inside of eleven months, viz. : the triplets and one pair of twins.

Physicians' Library.

Annual and Analytical Cyclopedia of Practical Medicine. By CHARLES E. DE M. SAJOUS, M.D., and one hundred Associate Editors, Assisted by Corresponding Editors, Collaborators and Correspondents. Illustrated. Volume V. Philadelphia, New York and Chicago: The F. A. Davis Company. 1900.

Volume V. of this excellent cyclopedia fully sustains the expectations and reputation of those which have preceded it. Amongst other and many good things it embraces a comprehensive and unusually able article on pleurisy by that distinguished clinician, Alexander McPhedran, of Toronto, a fact alone which will commend this volume to the many graduates of Toronto Medical School who had the advantage of Professor McPhedran's knowledge and experience as exemplified at the clinics at the Toronto General Hospital. It is said that probably the ablest article on Cholelithiasis in existence is that in a previous volume by the late Dr. James Elliott Graham, of Toronto; and that in volume V., which is to appear shortly, will be found the last written article by Dr. Graham on typhoid fever. These three alone will be almost sufficient to commend the entire work to Canadians. The entire cyclopedia so far is a splendid system of medicine and of great practical importance. We have used it constantly in practice, and often wonder how we ever got along without it. It is indeed a great help in general practice. If the volume still to be issued, No. VI., is as good as all the previous ones, it will comprise a system that very few indeed will be able to find fault with.

Twentieth Century Practice. An International Encyclopedia of Modern Medical Science. By Leading Authorities of Europe and America. Edited by THOMAS L. STEDMAN, M.D., New York City. In twenty volumes. Volume XX. "Tuberculosis, Yellow Fever, and Miscellaneous. General Index." New York · William Wood & Company. 1900.

Volume XX. completes one of the greatest systems of medicine ever issued to the medical profession. This elaborate production

will long stand as a monument to the faithful and indefatigable energy of its Editor, Dr. Thomas L. Stedman, of New York City, who in spite of many disabilities owing to sickness, death, and other causes, carried out the original conception of this great masterpiece to a successful and brilliant conclusion. The present and last volume, No. XX., contains an elaborate and modern article on that paramount subject in medicine at the present day, Tuberculosis, by Dr. August Jerome Lartigau, of New York, and to say that he has given us a comprehensive and brilliant article on this great subject seems but scant praise for its production. In the article on Yellow Fever, by our distinguished countryman, now resident in New York, Dr. Wolfred Nelson, a graduate of McGill University and Bishop's College, Montreal, and who, we believe, was the first student to enrol himself in medicine at Bishop's, appears a splendid description of our own Quarantine Station on Grosse Isle. The balance of the volume deals with poisoning by snake venom, mushroom poisoning, diseases of the uvula, soft palate, and faucial pillars and neural and mental defects in childhood. The general index embraces the balance of Volume XX., running from page 603 to 906. Amongst the great productions of William Wood & Company, the "Twentieth Century Practice of Medicine" must stand in the front rank. It will be sufficient to add that no medical library will be complete without it.

A Practical Treatise on Genito-Urinary and Venereal Diseases and Syphilis. By ROBERT W. TAYLOR, A.M., M.D., Clinical Professor of Venereal Diseases at the College of Physicians and Surgeons, Columbia University, New York; Surgeon to Bellevue Hospital, and Consulting Surgeon to City (Charity) Hospital, New York. Second edition, thoroughly revised, with 138 illustrations and 27 plates in colors and monotone. New York and Philadelphia: Lea Brothers & Company. 1900.

That the author of this excellent work has succeeded in presenting to the profession a compact, clear and concise treatise, both practical and up to-date, no one who carefully examines its 700-odd pages can for one moment doubt. Elaborate descriptions of rare and anomalous conditions of the genito-urinary system are conspicuous by their absence; so also are operations and methods in treatment which have long since been relegated to the pages of history. All this enhances the value of the work to the practical man, who cannot well afford to do without this really valuable book. Nor is anything of value left out, but everything is dealt with in a manner which will commend itself to all. Particularly has due and proper attention been paid to the different operations

on the genito-urinary system ; and especially in all matters relating to treatment—which after all is the part which will commend itself to the practitioner—the author has presented this department in a form easy of comprehension as well as in an authoritative manner. On gonorrhœa and syphilis much care and attention has been bestowed, embracing in a comprehensive form all the different and diversified phases of these two diseases. Of the illustrations, the colored ones are admirable, the monotonous excellent, and the others the best that could possibly be executed. All these latter add greatly to the text and contribute in no small measure to making Taylor's "Genito-Urinary and Venereal Diseases" a book worthy of a place in every medical library. After a careful and painstaking examination of the entire volume, the DOMINION MEDICAL MONTHLY can heartily recommend it to its readers.

Practical Ureanalysis and Urinary Diagnosis. A Manual for the use of Physicians, Surgeons, and Students. By CHARLES W. PURDY, LL.D., M.D., Queen's University, Fellow of the Royal College of Physicians and Surgeons, Kingston, Canada ; Professor of Clinical Medicine at the Chicago Post-Graduate Medical School. Author of "Bright's Disease and Allied Affections of the Kidneys" ; also of "Diabetes: Its Causes, Symptoms, and Treatment." Fifth Revised and Enlarged Edition. With numerous illustrations, including Photo-engravings, Colored Plates, and Tables for estimating total solids from Specific Gravity, Chlorides, Phosphates, Sulphates, Albumin, Reaction of Proteids, Sugar, etc., in Urine. 6 x 9 inches. Pages xvi-406. Extra cloth, \$3, net. F. A. Davis Company, Publishers, 1914-16 Cherry Street, Philadelphia.

This is the fifth revised and enlarged edition of this easily leader in this department of medicine ; and it can readily be understood how acceptable it has been to the profession in the past, when it is known that it is only a little over two years ago since the fourth edition appeared. The author is a Canadian, a graduate of Queen's, Kingston, and the whole profession of Canada, and Queen's in particular, should be proud of this production from the pen and brains of this distinguished son of the Dominion. The authoritative style in which it is written, especially commends it, and while that style is clear and easily comprehended, that fact does not render the book any the less thorough, but adds to its worth. There is no book which has given the reviewer more satisfaction in its careful perusal and examination for some time than Purdy's "Ureanalysis." It is sufficient to say that no one can afford to be without this book ; and it will soon be

found on its possession that it has repaid many times over the money expended in its purchase. The F. A. Davis Company are to be congratulated on its production and at having such a treasure to offer the medical profession throughout Canada.

Warner's New Therapeutic Reference Book. The present edition of this handy little volume includes the addition of many new and valuable features, so many in fact as to make it almost a new book in its entirety. Warner's goods are universally known, especially those in pill form, but besides this there are their elegant pharmaceuticals of undoubted value. The book itself contains tables of ready reference, as well as many practical chapters on "Poisons and their Antidotes," "Signs of Pregnancy," diseases and their appropriate remedies, as well as hints on *post-mortem* examinations. This little book contains a heap for twenty-five cents. William R. Warner & Company, Philadelphia, New York or Chicago, will supply it.

Diseases of the Nose and Throat. By ERNEST L. SHURLEY, M.D., Vice-President and Professor of Laryngology and Clinical Medicine, Detroit College of Medicine; Laryngologist and late chief of staff, Harper Hospital; Consulting Laryngologist and Chief of Laryngological Clinic of St. Mary's Hospital; Consulting Laryngologist to the Woman's Hospital and Foundling's Home; Member of the American Laryngological Association; of the American Climatological Association; of the American Medical Association; of the Michigan State Medical Society, etc. Illustrated. New York: D. Appleton & Company.

In the introduction to this important treatise on the "Diseases of the Nose and Throat," the author, who is well and favorably known to the profession of Canada, states at the outset that the book is especially brought out as a means of help to students and the general practitioner; and we have no doubt that to such it will prove a valuable help. In the main it is practical and thorough and does not speculate in special theories which might perhaps interest the specialist in these departments of medicine, but which the student and the general practitioner have neither time nor taste to meddle with. The work is splendidly illustrated, gotten up in the finest style, from the publisher's standpoint, of the extent of over seven hundred pages, and at the back contains a list of valuable sprays, inhalations, gargles, etc., which will be found of practical advantage. Shurley's handbook will be sure to obtain a place amongst the crowded ranks of this class of literature.

Correspondence

ELIMINATIVE AND ANTISEPTIC TREATMENT OF TYPHOID FEVER.

To the Editor of DOMINION MEDICAL MONTHLY :

SIR,—In the reported proceedings of the Canadian Medical Association meeting published in the DOMINION MEDICAL MONTHLY there appears, under the heading of "Eliminative and Antiseptic Treatment of Typhoid Fever," a brief abstract of my paper. I had in that paper protested against the misrepresentation I had received in certain quarters. Your reporter furnished an apt illustration of what I complained of, and in this short abstract has managed to distort and misstate what I said to an extraordinary degree. For example, I am reported in this abstract as holding "the opinion that the drainage from the intestinal wall following upon the action of a purgative, such as calomel and magnesium sulphate, would tend to get rid of some of these bacilli in the *intestinal walls*, but would not effect their exit from the liver," etc.

I had in the first part of my paper quoted from the recently published Gouldstonian Lectures, delivered before the Royal College of Physicians of London, by Dr. P. Horton-Smith, on "Typhoid Fever and the Typhoid Bacillus," to show the correctness of my contention of seven years ago that the specific bacilli were present in the intestinal contents during the first days of the fever—not absent from the intestinal contents as has been asserted—and consequently that the soundness of my theory of their being swept out by the action of purgatives, thus limiting the infection of the body and of the glands in the intestinal walls, became perfectly obvious. Then followed the paragraph referred to, which I shall quote in its entirety :

"Elimination must not be confined to simply clearing out the intestine, but must apply to a much wider process; the clearing of poison from the body by way of the intestine either in the toxic bile or contained in the serous fluid poured from the intestinal wall.

"It is amusing, after having made so many explicit statements and having drawn attention so many times to this feature, to find Prof. Osler gravely pointing out to his readers: 'that, unlike cholera, the typhoid bacilli are not confined to the intestine, but are to be found in the spleen, intestinal glands, etc., and consequently that they cannot be dislodged by the use of purgatives.'

"I shall again be explicit in the statement that the eliminative plan of treatment does not contemplate removal of bacilli from the

spleen, intestinal wall and various tissues of the body, but does contemplate *elimination of bacilli and poisons from the intestine* and of *toxin from the body by way of the intestine.*"

A second example: I am made to say that I had never had a fatal hemorrhage and that I had had but few perforations. What I did state, after pointing out that twenty per cent. of the mortality of typhoid fever had been attributed to perforation and hemorrhage, was that, "in my own experience *I had never had a fatal hemorrhage* and but few hemorrhages, nor had I had in all these years a *single perforation.*"

I am sure you will agree with me that it is most unfortunate when mistakes like the above occur; utterly false impressions are received by an immense number of readers, and it frequently happens that this impression remains, since many who have read the report will fail to notice the correction.

W. B. THISTLE.

171 College Street, November 1st, 1900.